



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Senate Bill 573: Prohibiting Health Insurance Policies from Excluding Coverage of Losses Sustained While Insured Individuals Are Intoxicated or Under the Influence of Controlled Substances

A Report to the 2005-2006 California Legislature
April 07, 2005

CHBRP 05-04



Established in 2002 to implement the provisions of Assembly Bill 1996 (*California Health and Safety Code*, Section 127660, et seq.), the California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates. The statute defines a health insurance benefit mandate as a requirement that a health insurer and/or managed care health plan (1) permit covered individuals to receive health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, made up of experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes sound scientific evidence relevant to the proposed mandate but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment of health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at CHBRP's Web site, www.chbrp.org.

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PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 573, a proposal to amend Section 10369.12 of the California Insurance Code. Under the proposed legislation, health insurers would no longer be able to write policies that exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Other types of disability insurance would continue to be able to use the exclusion. In response to a request from the California Senate Committee on Insurance on February 15, 2005, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Assembly Bill 1996 (2002) as chaptered in Section 127660, et seq., of the California Health and Safety Code. SB 573 is a revision of SB 1157 (2004); CHBRP submitted an analysis of SB 1157 to the State Legislature on April 27, 2004.

Wade Aubry, MD, Patricia Franks, BA, Noelle Lee, BA, Harold S. Luft, PhD, and Edward Yelin, PhD, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Helen Halpin, PhD, Sara McMenamain, PhD, and Nicole Bellows, MHSA, all of the University of California, Berkeley, prepared the public health impact analysis. Gerald Kominski, PhD, Miriam Laugesen, PhD, and Nadereh Pourat, PhD, all of the University of California, Los Angeles, prepared the analysis of the cost impact. Robert Cosway, FSA, MAAA, and Christopher Girod, FSA, MAAA, of Milliman, provided actuarial analysis. Susan Philip, MPP, of CHBRP staff prepared the background section and contributed to preparing the individual sections into a single report. Other contributors include Sachin Kumar, BA, Cynthia Robinson, MPP, and Bob O'Reilly, BA of CHBRP staff, and Sarah Ordody, who provided editing services. Rebecca R. Paul, MPH, MA formerly of CHBRP staff also contributed to the previous version of this report. In addition, a subcommittee of CHBRP's National Advisory Council (see page 14) reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

Jay Ripps, FSA, MAAA, of Milliman recused himself from contributing to this and all other CHBRP analyses, beginning March 1, 2005. His recusal is valid through his duration as acting chief actuary at Blue Shield of California.

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

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION 5

I. MEDICAL EFFECTIVENESS 6

II. UTILIZATION, COST, AND COVERAGE IMPACTS 7

 Present Baseline Cost and Coverage 7

 Impacts of Mandated Coverage 8

III. PUBLIC HEALTH IMPACTS 8

APPENDICES 9

REFERENCES 12





EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 1157

Senate Bill (SB) 573 proposes to amend Section 10369.12 of the California Insurance Code. Under the proposed legislation, health insurers would no longer be able to write policies that exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Other types of disability insurance would continue to be able to use the exclusion

Under the provisions of Assembly Bill 1996 (California Health and Safety Code, Section 127660, et seq.), the California Legislature has asked the California Health Benefits Review Program (CHBRP) to conduct an evidence-based assessment of the medical, financial, and public health impacts of the proposed legislation. SB 573 is a revision of SB 1157 (2004); CHBRP submitted an analysis of SB 1157 to the State Legislature on April 27, 2004.¹ Because SB 573 is identical to SB 1157 in terms of language relevant to health insurers, the impacts of the previous and current bill are identical. This analysis updates the previous analysis by reviewing the literature of any new studies, and soliciting new information from interested parties, health insurers, the Office of the Patient Advocate of the Department of Managed Health Care, and the California Department of Insurance.

I. Medical Effectiveness

- Unlike most proposed health benefit mandates; this bill repeals an existing law that allows insurers to deny coverage for medical services under certain circumstances. It is not possible to assess the medical effectiveness of SB 573 because there is no published data about the medical effects of removing existing coverage exclusions.
- No published evidence of assessments of the impacts of health insurance coverage exclusions related to intoxication on physician behavior or on the use of particular health care services was found.
- No published evidence of denial of health insurance claims under Section 10369.12 in California or under similar provisions in other states was identified.

II. Utilization, Cost, and Coverage Impacts

- No evidence was found that California health insurers either use the exclusion in Section 10369.12 or deny claims based on it.
- No evidence was found of consumer complaints of denials of coverage based on Section 10369.12.

¹ The CHBRP analysis of SB 1157 may be found at http://www.chbrp.org/documents/sb_1157anal.pdf



- There are no utilization or cost impacts for this bill because no evidence was found that Section 10369.12 has been used to exclude payments for health care or that its existence affects provider behavior.

III. Public Health Impacts

- It is estimated that SB 573 would have no measurable effects on the health of the people of California. This assessment results from the lack of evidence related to the medical effectiveness of the provision's amendment to current law and the lack of evidence that the public is currently affected by the ability of health insurers to use the exclusion permitted by Section 10369.12 of the California Insurance Code.



INTRODUCTION

Senate Bill (SB) 573 proposes to amend Section 10369.12 of the California Insurance Code, by prohibiting health insurers from having the ability to use a specific exclusion in insurance policies.

The exclusion in Section 10369.12 allows that:

A disability policy may contain a provision in the form set forth herein.

Intoxicants and controlled substances: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.²

The exclusion in Section 10369.12 is contained in a model law developed by the National Association of Insurance Commissioners (NAIC). This law is commonly referred to as the Uniform Accident and Sickness Policy Provision Law (UPPL).

Under the proposed legislation, health insurers would not be able to include this exclusion in their policies and, thus, could not deny claims for any losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance

SB 573 is a revision of SB 1157 (2004); CHBRP submitted an analysis of SB 1157 to the State Legislature on April 27, 2004.³ Because SB 573 is identical to SB 1157 in terms of language relevant to health insurers, the impacts of the previous and current bill are identical.

The previous bill, SB 1157, and the current bill, SB 573, are unlike most proposed legislation reviewed by CHBRP. These bills do not mandate coverage of a specific service, procedure, or device, but rather restrict an insurer's ability under specific conditions to deny payment for an unknown range of services. The analysis that follows describes the background of the model law—the UPPL—that contains the exclusion and identifies constraints on an analysis of medical effectiveness; utilization, financial, and coverage impacts; and public health impacts relevant to SB 573. This analysis updates the previous analysis by reviewing the literature of any new articles, and soliciting new information from interested parties, health insurers, Office of the Patient Advocate of the Department of Managed Health Care, and the California Department of Insurance

The Original Model UPPL

The original model UPPL, which includes many required and optional provisions, was created and approved in 1947 by the NAIC. An organization of insurance regulators from the 50 states, the District of Columbia, and four U.S. territories, the NAIC coordinates regulation of multistate insurers by developing model laws and regulations that states can adopt. The original provision of the UPPL that was the model for Section 10369.12 of the California Insurance Code read as follows:

² California Insurance Code, Division 2, Section 10369.

³ The previous CHBRP analysis of SB 1157 may be found at http://www.chbrp.org/documents/sb_1157anal.pdf



Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Thus, insurers using this exclusion were allowed to deny payment for alcohol- or narcotic-related claims. Forty-two states, including California, and the District of Columbia adopted the original or a modified version of the model UPPL provision (Ensuring Solutions, 2004).

The New Model UPPL

In the late 1990s, a national advocacy effort began to press for modification or repeal of the UPPL provision addressing denial of payment for intoxication-related claims. Advocates were concerned that, if emergency department physicians believed that insurers would deny payment for intoxication-related claims, these physicians would avoid screening for alcohol intoxication or use of controlled substances and thus miss opportunities for counseling. In June 2001, the National Conference of Insurance Legislators (NCOIL) adopted a resolution in support of an amendment to the model UPPL provision. Subsequently, the NAIC voted unanimously to repeal the provision of the UPPL relating to intoxicants and narcotics and to adopt a new model law that bars health insurers from denying payment on the basis of intoxication or use of narcotics. The revised model legislation reads as follows:

- (10) (a) A provision as follows:
Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
- (b) **This provision may not be used with respect to a medical expense policy.**
[emphasis added]
- (c) For purposes of this provision, "medical expense policy" means an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage.

Although the NAIC adopted the new model law, individual states must enact their own laws in order for this provision to be in effect. Since 2001, five states have passed laws that effectively prohibit health insurers from denying claims based on the insured's being intoxicated or under the influence of a narcotic, including Iowa, Maryland, North Carolina, Vermont, and Washington. (Ensuring Solutions, 2005).

I. MEDICAL EFFECTIVENESS

It was not possible to assess the medical effectiveness of SB 573 because this bill does not mandate coverage of a particular health care service, but rather prohibits coverage exclusions, and there is a lack of published data on the medical effects of removing such coverage exclusions. One peer-reviewed article relating to the denial of health insurance claims based on use of intoxicants and narcotics was found (Rivara et al., 2000). No published assessments of the impacts of UPPL intoxication-related exclusions, or of the repeal of such exclusions, on physician behavior or on the use of particular health care services were found. In one study, investigators found that alcohol screening was perceived by 27% of trauma surgeons surveyed to threaten reimbursement. However, no studies have determined the



extent that providers are deterred from screening due to the risk of non-reimbursement (Schermer et al., 2003). No published evidence of denial of health insurance claims under Section 10369.12 in California or under UPPL provisions in other states was identified.

Some materials produced by advocates for the repeal of this UPPL provision assert that screening for alcohol intoxication and controlled substance use and counseling patients in the emergency room are effective interventions. SB 573, however, is silent on the issues of screening and counseling, and there was no evidence that medical professionals in California are less likely to perform such services because of the ability of insurers to use the exclusion. Therefore, analysis of the medical effectiveness of SB 573 does not include an assessment of screening or counseling services.

II. UTILIZATION, COST, AND COVERAGE IMPACTS

CHBRP queried seven of the 16 California health insurers with the largest number of covered lives about their use of the exclusion in Section 10369.12 in March 2004. All responded that their California health insurance products do not contain the exclusion and none had denied claims based on it. Four of these insurers responded to a similar CHBRP query in March 2005 and indicated that their earlier responses were still true. The California Department of Insurance (CDI) also confirmed that no current policies contain the exclusion and that it has received no consumer complaints about claims denied because of the exclusion. CHBRP uncovered no evidence or anecdote about denied claims. Accordingly, CHBRP estimates that the cost impact of SB 573 would be negligible. Without any evidence that the current exclusion affects health care or insurance coverage in California, a quantitative cost analysis of its removal is not appropriate.⁴

Present Baseline Cost and Coverage

Current utilization levels and costs of the mandated benefit (Section 3(h))

In the absence of evidence on the exclusion of payment for services related to use of alcohol or other controlled substances, no baseline utilization or cost data could be developed.

Current coverage of the mandated benefit (Section 3(i))

A survey of seven of the 16 health insurers in March 2004 with the most covered lives in the state identified no health insurance policies that included the exclusion in Section 10369.12 of the California Insurance Code, a finding confirmed by four of these plans in March 2005.

Public demand for coverage (Section 3(j))

Nationally, organizations such as the National Conference of Insurance Legislators (NCOIL) and the National Associations of Insurance Commissioners (NAIC) are in favor of repealing the provision of the UPPL relating to intoxicants, or effectively prohibiting insurers from denying coverage for claims based

⁴ It is possible that passage of the bill might lead to more claims for detoxification and post-traumatic rehabilitation care because the providers of these services would see the legislation as a signal that insurers were more likely to cover the full range of services associated with intoxication without restriction. Evaluation of the likelihood or magnitude of this possibility is beyond the scope of this analysis. However, as stated elsewhere in this report, CHBRP's research suggested that emergency room personnel may not even know about the exclusion, and the exclusion does not appear to affect the services or referrals they provide in California.



on intoxication. However, as summarized above, since health plans and insurers do not appear to be using this provision in California, there is no evidence of public demand for this mandate.

Impacts of Mandated Coverage

How will changes in coverage related to the mandate affect the benefit of the newly covered service and the per-unit cost? (Section 3(a))

SB 573 is unlikely to have any measurable impact on the benefits or per-unit cost of services, for reasons discussed above.

How will utilization change as a result of the mandate? (Section 3(b))

There is no evidence that health insurers in California refuse payment for health services when alcohol or a controlled substance is involved. There is also no evidence that the existing law affects physician behavior in California. Expert opinion from practicing emergency department physicians in California suggests that physician behavior is guided primarily by treatment need and appropriateness. Consequently, there is no evidence that the amendment of Section 10369.12 would impact utilization of services.

To what extent does the mandate affect administrative and other expenses? (Section 3(c))

There are no expected effects of the bill on administrative and other costs.

Impact of the mandate on total health care costs (Section 3(d))

There are no expected impacts of the bill on total health care costs.

Costs or savings for each category of insurer resulting from the benefit mandate (Section 3(e))

There are no expected costs or savings for various categories of insurers resulting from this mandate.

Current costs borne by payers (both public and private entities) in the absence of the mandated benefit (Section 3(f))

Because no incremental costs are expected as a result of this bill, there are no costs borne by other payers.

Impact on access and health service availability (Section 3(g))

There are no expected impacts of the bill on access or service availability.

III. PUBLIC HEALTH IMPACTS

Assessing the public health impact of the proposed legislation requires two pieces of information: (1) baseline or premandate health outcomes in the California population as they relate to the legislation, and (2) the expected change in health outcomes postmandate, based on evidence identified in the review of the scientific literature. In the case of SB 573, no evidence was found that health insurers in California are denying claims for health care associated with alcohol- or controlled substance–related injuries. Also, no evidence was identified in the literature on the effects of removing the provision in the state insurance code that permits health insurers to deny claims involving alcohol or controlled substance use. Thus, it is estimated that SB 573 would have little or no effect on the health of the people of California.



APPENDIX A

Literature Review Methods

SB 573 is an act to amend Section 10369.12 of the California Insurance Code. Under the proposed legislation, health insurers would no longer be able to sell policies that exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Other types of disability insurance would continue to be able to use the exclusion.

Appendix A describes the literature search for studies on the medical effects of removing coverage exclusions, the impact of the exclusion on physician behavior, and the denial of health insurance claims in California under Section 10369.12. This appendix also discusses other approaches used to obtain empirical evidence relevant to the assessment of Senate Bill 573.

The first approach was to examine the literature for studies that might have assessed the impact of the Uniform Accident and Sickness Policy Provision Law (UPPL) intoxication and narcotics provision, as well as repeal or modification of this UPPL provision, on physician behavior, health care use, and patient outcomes as related to care of patients who are intoxicated or under the influence of controlled substances. Evidence was also sought in the literature for studies that assessed whether insurers use or enforce the UPPL provision with respect to health care, whether physicians alter their behavior based on UPPL provision, and whether patients have been affected by the UPPL provisions. The literature search focused on the effects of UPPL related to intoxication and narcotic use on physician practice and insurance claim denials in California and other states. The search was limited to English abstracts. The MEDLINE/PubMed database was searched for studies published from 1994 to 2005, using a combination of Medical Subject Headings (MeSH) and text words aimed at locating meta-analyses, systematic reviews, individual randomized controlled trials, and clinical practice guidelines.

The keyword and MeSH terms used by the librarian in the PubMed search were:

Keyword:

UPPL, uniform individual accident and sickness policy provision law, obstacle*, barrier*
* truncation

MeSH terms:

Alcohol Drinking/prevention & control
Alcoholic Intoxication/blood
Alcoholism/diagnosis
Alcoholism/blood/diagnosis
Cost-Benefit Analysis
Counseling
Emergency Service, Hospital
Insurance Coverage
Insurance, Health
Mass Screening
Outcome and Process Assessment (Health Care)
Physician's Practice Patterns



Practice Guidelines
Psychotherapy, Brief
Referral and Consultation
Substance Abuse Detection
Substance-Related Disorders
Trauma Centers
Treatment Outcome

Web resources were searched to locate the following information: 1) Latest status of states that have repealed or amended the UPPL law; 2) Any public health organizations or emergency care-related associations recently supporting the repeal or amendment of the UPPL; and 3) clinical practice guidelines.

No studies that directly assessed the effects of the UPPL were found. Results from the PubMed search included 33 English abstracts. The title and abstract of each citation returned by the literature search were reviewed to determine eligibility for inclusion. Most of the studies returned from the literature search examined the benefits of alcohol screening and intervention in the emergency department. One study (Schermer et al., 2003) found that trauma surgeons believed that alcohol screening threatened reimbursement, but the authors did not assess the impact of the perceived threat on screening practices, nor did the authors specify that the UPPL was the source of the surgeons' beliefs regarding non-reimbursement. There have not yet been any studies published that quantify the impact of the UPPL on physicians' screening practices, nor have there been any studies that measure how often the UPPL has been the basis for denying claims. Scientific evidence regarding the medical effectiveness of amending Section 10369.12 of the California Insurance Code is currently unpublished.

The second approach was to assess whether insurers include the UPPL provision in their health policies. Staff contacted seven of the 16 largest insurers in California with respect to whether they include the allowed provisions in their policies and, if so, whether they enforce them with respect to health care. Insurers indicated they do not currently include this exclusion in their policies and, therefore, do not deny claims based on it.

The third approach was to query physicians about the impact of this UPPL provision. Although a formal survey of physicians with respect to whether this UPPL provision affects their behavior was not conducted, several senior physicians in the state involved in emergency medicine practice and policy were contacted. When asked whether the UPPL provision was an issue in clinical practice, the physicians said either the provision was not an issue or that they did not know about the provision and later confirmed its lack of impact after discussing it with their administrative staff.

The fourth approach was to explore whether denials under this UPPL provision were problematic for patients. Both the Health Rights Hotline and the California Department of Insurance (CDI) were queried about receipt of complaints about denials for alcohol-related emergency room claims. The Health Rights Hotline had never received such a complaint. CDI reported that no one in their consumer services department could confirm receiving this type of complaint. CDI staff also queried their database of hotline calls and formal written complaints; this database tracks general information about the calls received by the hotline and more detailed information about all written complaints and requests for assistance. CDI reported no complaints about having claims denied for health care services because the insured was intoxicated or under the influence of a controlled substance.



APPENDIX B
Information Submitted by Outside Parties for Consideration for CHBRP Analysis

In accordance with its policy to analyze evidence submitted by outside parties during the first two weeks of each 60-day review of a proposed benefit mandate, CHBRP received the following submissions:.

From Larry M. Gentilello, MD, C. James Carrico MD Distinguished Chair in Surgery for Trauma and Critical Care, UT Southwestern Medical Center, on March 11, 2005

1. Gentilello LM, Ebel BE, Wickizer TM, Salkever DS, Rivara FP. (forthcoming, 2005). Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals: a Cost Benefit Analysis. *Annals of Surgery*. 241(4).
2. Preliminary and partial results of a survey of trauma physicians conducted by Dr. Larry Gentilello, funded by the Robert Wood Johnson Foundation. Information is not yet available for publication.

CHBRP analyzes all evidence received during the public submission period according to its relevance to the proposed legislation and the program's usual methodological criteria. For more information about CHBRP's methods, to learn how to submit evidence relevant to an on-going mandate review, or to request email notification of new requests CHBRP receives from the California Legislature, please visit: <http://www.chbrp.org>.



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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 the UC system. 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 CHBRP's 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, to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP's 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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