



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 137:
Mammography

A Report to the 2011-2012 California Legislature
March 18, 2011

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 137

The California Assembly Committee on Health requested on January 14, 2011, 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) 137 Mammography, 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.¹

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.² Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws. Similarly, AB 137 would not directly affect "Every Woman Counts," a program operated by the California Department of Public Health that does not provide health insurance coverage but does provide screening for breast cancer to the uninsured.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)³ regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers⁴, which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans and/or CDI-regulated policies would be subject to AB 137. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

Breast cancer is a disease that affects primarily women. It is one of the most commonly diagnosed cancers in California, but survival rates are high when it is diagnosed at an early stage.

AB 137 contains two separate mandates, one involving mammography coverage and the other related to notification regarding timelines for breast cancer screening.

AB 137 would require CDI-regulated policies to cover medically necessary mammography upon a provider's referral. The bill does not alter the current requirement for DMHC-regulated plans to do the same. The current Insurance Code requires CDI-regulated policies to cover mammography for women at particular ages and specifies particular frequencies (one test between the ages of 35 and 39; one test every 2 years between the ages of 40 and 49; annual tests at age 50 and beyond).

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

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

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

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

AB 137 would also require that both DMHC-regulated plans and CDI-regulated policies notify subscribers/policyholders regarding recommended timelines for an individual to undergo tests for the screening or diagnosis of breast cancer. The bill indicates that the information may be provided by written letter, by publication in a newsletter, by publication in evidence of coverage (EOC) document, by direct telephone call, by electronic transmission, by Web-based portal, or by any other means that will reasonably notify the subscriber or policyholder of the recommended timelines for testing. In prior years, CHBRP analyzed bills (AB 2234 in 2008 and AB 56 in 2009), that would have placed different and more specific information requirements on plans and policies.

The notification requirement in AB 137 is much less prescriptive than the notification requirements contained in the 2008⁵ and 2009⁶ bills, that CHBRP projects no measurable notification-related utilization, cost, and public health impacts for AB 137.

CHBRP is aware that most states have mammography requirements but is unaware of any states that require plans or insurers to provide notification regarding the timelines for breast cancer screening.

Medical Effectiveness

The medical effectiveness analysis addresses three questions pertinent to AB 137:

- Does mammography screening (i.e., providing mammograms to asymptomatic women) reduce mortality due to breast cancer for women of all eligible ages?
- Does mammography screening reduce breast cancer mortality rates for women ages 40-49 years?
- Does notification of recommended timelines for mammography screening increase the rate at which women are screened?

Effectiveness of Screening Mammography

- There is a preponderance of evidence that, among women ages 40 years and older, mammography screening reduces breast cancer mortality by:
 - 15% for women age 39 to 49 years (need to invite 1,904 women for screening to avoid 1 death)
 - 14% for women age 50 to 59 years (need to invite 1,339 women for screening to avoid 1 death)

⁵ See: http://www.chbrp.org/completed_analyses/index.php.

⁶ See: http://www.chbrp.org/completed_analyses/index.php.

- 32% for women age 60 to 69 years (need to invite 377 women for screening to avoid 1 death)
- The evidence does not support mammography screening for most women under age 40 years.
- There is insufficient evidence to determine whether mammography screening is effective for women over age 74 years.
- The evidence supporting recommended mammography screening differs by age cohort due to the heterogeneity of breast cancer studies, the greater incidence of breast cancer among older women, the difference in the accuracy of mammography (due to breast tissue density), and the resulting impact of screening on breast cancer mortality.
- Harms associated with mammography screening are primarily false-positive readings that result in additional outpatient visits, additional diagnostic imaging, and biopsies. The estimated risk of a false-positive reading after 10 screening mammograms is 63%.

Effectiveness of Notification Regarding Recommended Timelines for Breast Cancer Screening

- No studies were identified that assessed the effectiveness of providing subscribers, regardless of age or gender, with information about recommended timelines for mammography screening on screening rates.
- No studies were identified that examined the effectiveness of providing notification of recommended timelines for breast cancer screening in newsletters, evidence of coverage documents, or Web portals.
- There is a preponderance of evidence that for women for whom national guidelines recommend mammography screening, notification through written notices or telephone calls increases the percentage of eligible women screened.

Benefit Coverage, Utilization, and Cost Impacts

- The provision of medically necessary mammography upon provider referral is estimated to be already compliant with AB 137 among DHMC-regulated plans and CDI-regulated policies. Therefore, no measurable change is expected.
- Notification regarding timelines for breast cancer screening is estimated to be already compliant with AB 137 among both DHMC-regulated plans and CDI-regulated policies. Therefore, no measurable change is expected.

- Approximately 4.7 million women receive mammograms each year. The average per unit cost of mammograms (including additional services due to false positive results) is \$190.
- As no measurable change in benefit coverage is expected, no measurable change in utilization is projected.
- As no measurable change in benefit coverage is expected, no measurable change in cost is expected.
- As no measurable change in benefit coverage or cost is expected, no measurable change in the number of uninsured persons is expected.

Public Health Impacts

- In California, 84.6% of women aged 40-64 years with health insurance had a mammogram within the last 2 years. There is evidence that mammography can reduce mortality from breast cancer; however, no public health impact is projected due to the implementation of AB 137.
- There is evidence to suggest that the use of mammography is not without risk, and there are potential harms of this screening procedure, such as discomfort and pain during the procedure, consequences of false-positive and false-negative tests, overdiagnosis, and radiation exposure. However, there are no estimated increases in harms as a result of AB 137 due to no changes in utilization or coverage.
- The vast majority of breast cancer cases (99.3%) occur among women. Racial and ethnic disparities exist, not only in breast cancer prevalence, but also in early diagnoses and mortality rates as well. The research on mammography utilization by race/ethnicity suggests that some of the differences in health outcomes among non-White women can be explained by their lower rates of mammography utilization. However, since AB 137 is not expected to increase the utilization of mammography, AB 137 would not impact these disparities.
- There are approximately 4,200 deaths each year in California due to breast cancer, a rate of 21.4 deaths per 100,000 women. It is estimated that for each life lost prematurely to breast cancer, there is a loss of 22.9 life-years and a cost of lost productivity of \$272,000. Although breast cancer is related to economic loss, AB 137 is not estimated to change the utilization of mammography or result in a corresponding reduction in economic loss.

Potential Effects of the Federal Affordable Care Act

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws (together referred to as the “Affordable Care Act [ACA]”) are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years would affect the baseline, or current enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically 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.

A number of ACA provisions will need to be further clarified through guidance or regulation. One example is the ACA’s requirement for certain health insurance to cover “essential health benefits.” Effective 2014, Section 1302(b) will require small group and individual health insurance, including “qualified health plans” (QHPs) that will be sold in the California Exchange, to cover specified categories of benefits. These essential health benefits (EHBs) are defined as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Secretary of Health and Human Services (HHS) is charged with defining these categories through regulation, ensuring that the EHB floor “is equal to the scope of benefits provided under a typical employer plan.” In addition, the ACA would allow a state to “require that a qualified health plan offered in [the Exchange] offer benefits in addition to the essential health benefits.” If the state does so, the state must make payments to defray the cost of those additionally mandated benefits, either by paying the individual directly, or by paying the qualified health plan (QHP). This ACA requirement could interact with existing and proposed California benefit mandates, especially if California decided to require qualified health plans to cover California-specific mandates, and those mandates were determined to go beyond the EHB floor. Federal regulations regarding which benefits are to be covered under these broad EHB categories and other details, such as how the subsidies for purchasers of qualified health plans are structured, are forthcoming.⁷

Essential health benefits included in qualified health plans in the Exchange and potential interactions with AB 137

As noted, EHBs are defined to include ambulatory patient services; laboratory services; and preventive and wellness services and chronic disease management. In addition, HHS, when promulgating regulations on EHBs is to ensure that the EHB floor “is equal to the scope of benefits provided under a typical employer plan.” Virtually all employer-based plans provide

⁷ For further discussion on EHBs and potential interaction with state mandates, please see, *California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"* available here: http://www.chbrp.org/other_publications/index.php.

coverage for mammography services. As mentioned, the ACA requires states, beginning 2014, to “make payments...to defray the cost of any additional benefits” required of QHPs sold in the Exchange.⁸ This potential liability would depend on three factors:

- differences in the scope of “benefits in the final EHB package and the scope of mandated benefits in AB 137;
- the number of enrollees in QHPs; and
- the methods used to define and calculate the cost of additional benefits.

Because mammography services as defined under AB 137 is considered standard coverage for employer-based plans, and because it is likely to be considered part of EHBs, it is unlikely that there would be any additional fiscal liability to the state as a result of this mandate.

Preventive Services Required under ACA and AB 137

“New plans” (i.e., those not covered under the ACA’s “grandfather” provisions) were required to cover certain preventive services zero cost sharing beginning September 23, 2010. The U.S. Preventive Services Task Force (USPSTF) recommends screening every 2 years for women age 50 to 74 years. For women age 40 to 49 years, the USPSTF recommends that the decision to initiate biennial screening be made by individual women on the basis of their level of risk for breast cancer and their values regarding the benefits and harms of screening. Mammography, therefore, can be considered one of the preventive benefits that must be covered at zero cost sharing per the ACA. Based on CHBRP’s analysis of current coverage rates, virtually all health plans and policies have coverage for mammography services. AB 137 does not affect the cost sharing of mammography services. Any premium impacts resulting from the ACA’s requirements to cover preventive services at zero cost sharing is already reflected in the baseline premiums presented in this report and does not affect the marginal impact of AB 137.

⁸ Affordable Care Act, 1311(d)(3)(B).

Acknowledgments

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 137. In response to a request from the California Assembly Committee on Health on January 14, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, and Margaret Fix, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego conducted the literature search. Heather J. Hether, PhD, of the University of California, Davis, prepared the public health impact analysis. Arturo Vargas Bustamante, PhD, MA, MPP, of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Diana L. Miglioretti, PhD, of Group Health Research Institute, 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 member of the CHBRP Faculty Task Force, Wayne Dysinger, MD, MPH, of Loma Linda University, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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