



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary

Analysis of Assembly Bill 1738: Health Care Coverage: Tobacco Cessation

A Report to the 2011-2012 California Legislature
April 20, 2012

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1738

The California Assembly Committee on Health requested on February 17, 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) 1738, 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

Analysis of AB 1738

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.

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

All DMHC-regulated plans and/or CDI-regulated policies would be subject to AB 1738. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

AB 1738 would require health care service plans and health insurance policies to provide coverage for at least two courses of treatment within a 12-month period for all tobacco cessation services rated "A" or "B" by the U.S Preventive Services Task Force (USPSTF). Specifically, AB 1738 mandates the following tobacco cessation services and treatments:

- Telephone, group, or individual counseling (requiring four or more sessions, each of at least 10 minutes duration);
- Food and Drug Administration (FDA)-approved prescription medications;⁵ and
- FDA-approved over-the-counter (OTC) medications.⁶

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

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

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

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

⁵ FDA-approved prescription medications for smoking cessation include Chantix (varenicline tartrate), Zyban (bupropion), and the nicotine replacement therapy (NRT), Nicotrol, as a nasal spray and oral inhaler.

AB 1738 would prohibit CDI-regulated policies and DMHC-regulated plans from:

- Imposing copayments, coinsurance, or deductibles for those services; and
- Imposing prior authorization or stepped care⁷ requirements on tobacco cessation treatments.

The Affordable Care Act of 2010 (ACA) already requires that non-“grandfathered”⁸ plans provide coverage for specified preventive services with “A” and “B” recommendations from the USPSTF—including tobacco cessation treatments and services—without cost sharing. AB 1738 would mandate that grandfathered DMHC-regulated plans and CDI-regulated policies in California, currently exempt from the ACA mandate, also provide tobacco cessation treatments and services.

CHBRP is aware of similar mandates in seven other states (Colorado, Maryland, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont). Illinois requires health insurers to offer the option of tobacco cessation benefit coverage. North Dakota requires a \$150 lifetime smoking cessation benefit for specific group plans.

Medical Effectiveness

Efficacy of Smoking Cessation Treatments

The literature on the efficacy of behavioral interventions (e.g., counseling, brief advice) and pharmaceuticals for smoking cessation is large and includes numerous meta-analyses of randomized controlled trials (RCTs), the strongest form of evidence for CHBRP analyses. These meta-analyses provide clear and convincing evidence that behavioral and pharmacological treatments and combinations of the two improve quit rates and increase the likelihood of sustained abstinence from smoking. These conclusions about the efficacy of smoking cessation interventions are not likely to be diminished or altered with the publication of new studies, because of the large quantity of literature summarized in the meta-analyses.

Behavioral interventions

- There is clear and convincing evidence that use of multiple types of counseling increases smoking cessation.
- Individual, group, and telephone counseling by physicians and other health professionals increases smoking cessation.

⁶ FDA-approved, over-the-counter (OTC) nicotine replacement products include skin patches, chewing gum, and lozenges.

⁷ *Stepped care* requires an enrollee to try a first-line of treatment (often a generic alternative) prior to receiving coverage for a second-line of treatment (often a brand-name medication).

⁸ 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 ACA. 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>).

- Brief counseling interventions (as little as a few minutes) are effective, and the preponderance of evidence suggests that more intensive counseling is associated with larger effects.
- Psychologists, physicians, pharmacists, and nurses are all effective in providing smoking cessation counseling.
- RCTs that enrolled smokers at high risk for adverse health outcomes (e.g., persons with coronary heart disease, pregnant women) report similar findings to RCTs that enrolled smokers who were not at increased risk relative to other smokers.

Pharmacotherapy

- Pharmacological agents for smoking cessation are commonly divided into those used in initial attempts to quit smoking (“first-line agents”), followed by those used when initial attempts to quit have not been successful (“second-line agents”). First-line agents for smoking cessation include the following: nicotine replacement therapy (NRT) administered by gum, patch, lozenge, nasal spray, and inhaler; varenicline, a nicotine receptor partial agonist;⁹ and the non-nicotine agent bupropion SR, an antidepressant useful in treating certain addiction syndromes. Second-line agents include clonidine and nortriptyline.
- Among first-line agents:
 - There is clear and convincing evidence that NRT administered by gum, lozenge, patch, nasal spray, and inhaler increases smoking cessation.
 - There is also clear and convincing evidence that varenicline and bupropion¹⁰ increase smoking cessation.
 - There is a preponderance of evidence that varenicline is more effective than bupropion.
 - There is a preponderance of evidence that smokers who receive NRT combined with varenicline or bupropion are more likely to abstain from smoking than persons who receive a single pharmacological agent.
- Among second-line agents:
 - There is clear and convincing evidence that clonidine and nortriptyline also increase smoking cessation relative to placebo.
- There is a preponderance of evidence that smokers who receive both counseling and pharmacological agents are more likely to abstain from smoking than smokers who only receive counseling.

⁹ The nicotine receptor partial agonist simulates the effects of nicotine to reduce cravings and the pleasurable effect of smoking cigarettes.

¹⁰ Although bupropion SR at strengths of 100 or 150 milligrams is the only formulation of bupropion approved by the FDA for smoking cessation, meta-analyses regarding the efficacy of bupropion for smoking cessation do not indicate whether all of the RCTs they included in their analyses assessed bupropion SR. Some of the RCTs included may have evaluated other formulations of bupropion or other strengths of the medication.

Effects of Coverage for Smoking Cessation Treatments

The evidence base from which conclusions can be drawn about the effects of coverage on utilization of smoking cessation treatments and abstinence from smoking is much less robust than the evidence base regarding the efficacy of these treatments.

Use of smoking cessation treatments

- The preponderance of evidence suggests that persons who have full coverage¹¹ for NRT and/or bupropion are more likely to use these smoking cessation medications than are persons who do not have coverage for them.
- The evidence of the effect of full coverage for smoking cessation counseling on receipt of counseling relative to no coverage is ambiguous.
- Findings from studies suggest that persons who have more generous coverage for NRT and/or counseling are more likely to use these smoking cessation treatments than are persons who have less generous coverage for them.

Abstinence from smoking

- The preponderance of evidence suggests that full coverage for smoking cessation counseling and pharmacotherapy is associated with improved abstinence from smoking relative to no coverage for smoking cessation treatments.
- The evidence of the effect of more generous coverage for smoking cessation counseling and pharmacotherapy relative to less generous coverage on abstinence from smoking is ambiguous.

Benefit Coverage, Utilization, and Cost Impacts

Nearly 21.9 million Californians are currently enrolled in DMHC-regulated health care service plans and CDI-regulated health insurance policies. AB 1738 mandates that all enrollees in DMHC-regulated plans or CDI-regulated policies would be offered no-cost smoking cessation services. Therefore, the coverage increase in 2012 would immediately affect the 4.5 million enrollees who currently do not have full coverage for counseling, the 17.2 million enrollees who do not currently have full coverage for OTC medications, and the 16.7 million enrollees who do not currently have full coverage for prescription smoking cessation treatments (Table 1). Under AB 1738, all enrollees would have full coverage for smoking cessation services, including counseling, NRT (either available OTC or through a prescription), or prescription medication for smoking cessation, at no cost to the individual. In this section, we focus on the impact of AB 1738 on increasing premium costs among all 21.9 million enrollees with plans or policies subject to the proposed mandate, and on the estimated increase of utilization of smoking cessation

¹¹ For purposes of this report, full coverage for smoking cessation treatments is defined as coverage of all three treatments of smoking cessation with no cost sharing.

treatment among the 1.92 million adult smokers, since they will be the population who might attempt to quit using services covered by this newly mandated benefit coverage.

Coverage Impacts

- Eight in 10 (79.4%) enrollees have full coverage for smoking cessation-related counseling, 21.5% have full coverage for OTC smoking cessation treatment, and 23.5% have full coverage for prescription smoking cessation treatment (Table 1). If AB 1738 were enacted, 100% of insured adults would have full coverage for smoking cessation services. CHBRP defines full tobacco cessation benefit coverage as having benefit coverage for all three treatments with no cost sharing.
- Adults in Medi-Cal Managed Care (Medi-Cal HMOs), Major Risk Medical Insurance Program, Access for Infants and Mothers, and Healthy Families (11.2% of adults subject to the proposed mandate) already have comprehensive smoking cessation benefits, which includes smoking cessation-related counseling, OTC smoking cessation treatment, and prescription smoking cessation treatment benefits at no charge to enrollees.

Utilization Impacts

- CHBRP used the 2008 California Tobacco Survey data and the RAND Health Insurance Experiment's (HIE) estimated impact of cost sharing for well care to estimate pre- and postmandate utilization. Premandate, of the 1.92 million adult smokers enrolled in DMHC-regulated plans or CDI-regulated policies, 304,400 used one or more smoking cessation treatments, with 252,000 using treatments covered through their existing insurance and 52,400 enrollees using treatments that were not covered.
- Postmandate, of the 1.92 million insured adult smokers, CHBRP estimated that the utilization of counseling services would increase by 13.2%, OTC treatments by 44.0%, and prescription treatments by 25.4%.
- Postmandate utilization of one or more smoking cessation treatments would increase by 27.5%, representing an additional 83,300 insured adult smokers using smoking cessation treatment.

Cost Impacts

- Increases in per member per month (PMPM) premiums for the newly mandated benefit coverage vary by market segment (see Table 11 in *Benefit Utilization, Cost, and Benefit Coverage Impacts*). Increases, as measured by percentage changes in PMPM premiums, are estimated to range from a low of 0.00% (for DMHC-regulated Medi-Cal HMO plans) to a high of 0.28% (for CDI-regulated individual policies) in the affected market segments. Increases, as measured by PMPM premiums, are estimated to range from \$0.00 to \$0.58.

- In the privately funded large-group market, the increase in premiums is estimated to range from \$0.26 PMPM among DMHC-regulated plans to \$0.39 PMPM among CDI-regulated policies (Table 11).
- For enrollees in the privately funded small-group market, health insurance premiums are estimated to increase by approximately \$0.29 PMPM for DMHC-regulated plan contracts and \$0.46 PMPM for CDI-regulated policies.
- In the privately funded individual market, health insurance premiums are estimated to increase by \$0.29 PMPM and by \$0.58 PMPM in the DMHC- and CDI-regulated markets, respectively.
- For publicly funded DMHC-regulated health plans, CHBRP estimates that premiums would decrease slightly or remain flat for Medi-Cal HMOs and Managed Risk Medical Insurance Board (MRMIB) programs (including Healthy Families), with the impact ranging from 0.00% to 0.03% (\$0.00 to \$0.03). For California Public Employees' Retirement System HMOs, CHBRP estimates that premiums would increase 0.09% (\$0.38 PMPM).
- Total net annual health expenditures are projected to increase by \$38.4 million (0.04%) (Table 1). This change in expenditures is due to a \$65.8 million increase in health insurance premiums partially offset by reductions in both enrollee out-of-pocket expenses (\$11.1 million) and noncovered expenditures (\$16.3 million).
- The net increase of \$38.4 million could be reduced by a savings of \$1.6 million in health care spending, representing the potential short-term (i.e., 1-year) savings resulting from a reduction in low birth weight deliveries and hospitalizations due to acute myocardial infarction (AMI) among those who quit smoking.

Public Health Impacts

- CHBRP estimates that AB 1738 would produce a positive public health impact by increasing the number of successful quitters by 5,287 enrollees annually. This is due to the fact that AB 1738 would increase the number of enrollees with coverage for smoking cessation treatments, that there is clear and convincing evidence of the effectiveness of smoking cessation treatment, and that the preponderance of evidence is that full coverage increases smoking cessation rates. This would suggest real improved health outcomes for these new quitters in the long term. Although CHBRP cannot quantify the reduction in harms from secondhand smoke due to lack of data, the medical literature indicates that the additional quitters enabled by AB 1738 would reduce harms from secondhand smoke postmandate.

- CHRBP estimates that, for the overall population, any cost increase or physical harms from rare serious adverse events resulting from pharmacotherapy would be outweighed by the benefits of smoking cessation.
- Due to lack of data, CHRBP cannot quantify the precise impact of AB 1738 on reducing existing gender disparities in smoking prevalence nor on the relevant health outcomes in the insured population. Therefore, the impact of AB 1738 on reducing gender disparities is unknown.
- Due to lack of data, CHRBP cannot quantify the precise impact of AB 1738 on reducing racial/ethnic disparities in smoking prevalence nor on the relevant health outcomes in the insured population. Therefore, the impact of AB 1738 on reducing racial/ethnic disparities is unknown.
- There is clear and convincing evidence that AB 1738 would contribute to the reduction in premature death from smoking-related conditions such as cancer, low birth weight infants, and cardiovascular and respiratory diseases. However, CHRBP cannot estimate the precise magnitude.
- CHRBP estimates that AB 1738 would increase utilization of smoking cessation treatments and increase quit rates postmandate. This increase would contribute to a reduction in economic loss due to reductions in lost productivity from smoking-related illness and premature death, but the magnitude cannot be estimated.
- CHRBP finds clear and convincing evidence that smoking cessation is a cost-effective preventive treatment that results in long term improvements in multiple health outcomes and reduces both direct medical costs and indirect costs associated with smoking. CHRBP estimates between 37,009 to 65,559 life years would be gained annually under the new mandate. The expected reduction in smoking prevalence and mortality attributable to AB 1738 would bring California closer to achieving *Healthy People 2020* goals of 80% of smokers attempting to quit, and 12% rate of smoking among adults (USDHHS, 2010).

Effects of the 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). The provisions that have gone into effect since 2010—including a federal mandate to cover preventive services with no cost sharing—are reflected in baseline enrollment, expenditures, and premiums for AB 1738. It is unclear, however, to what extent DMHC-regulated plans and CDI-regulated policies are “grandfathered”—in existence before March 2010—and therefore exempt from the ACA’s preventive services requirements. A special Addendum (Addendum A) to this Executive Summary discusses potential interactions of the mandated services proposed in AB 1738 and the ACA, including:

- A comparison of services mandated by AB 1738 with preventive services mandated in the ACA beginning September 2010.

- A review of the potential interaction between AB 1738 and essential health benefits in 2014-2015, as defined by the various benchmark plans options so far specified in a federal bulletin.¹²

It is important to note that CHBRP's analyses 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.

¹² CCIIO, *Essential Health Benefits Bulletin* (December 2011). Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Table 1. AB 1738 Impacts on Benefit Coverage, Utilization, and Cost, 2012

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
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 1738	21,882,000	21,882,000	0	0%
Number of Enrollees with Counseling Coverage				
No coverage	3,765,607	0	-3,765,607	-100.0%
Coverage, with cost sharing	735,467	0	-735,467	-100.0%
Full coverage, no cost sharing	17,380,926	21,882,000	4,501,074	25.9%
Number of Enrollees with OTC Drug Coverage				
No coverage	8,417,064	0	-8,417,064	-100.0%
Coverage, with cost sharing	8,757,726	0	-8,757,726	-100.0%
Full coverage, no cost sharing	4,707,211	21,882,000	17,174,789	364.9%
Number of Enrollees with Prescription Smoking Cessation Coverage				
No coverage	2,176,676	0	-2,176,676	-100.0%
Coverage, with cost sharing	14,566,190	0	-14,566,190	-100.0%
Full coverage, no cost sharing	5,139,133	21,882,000	16,742,867	325.8%
Percentage of Enrollees with Counseling Coverage				
No coverage	17.2%	0.0%	-17.2%	-100.0%
Coverage, with cost sharing	3.4%	0.0%	-3.4%	-100.0%
Full coverage, no cost sharing	79.4%	100.0%	20.6%	25.9%
Percentage of Enrollees with OTC Drug Coverage				
No coverage	38.5%	0.0%	-38.5%	-100.0%
Coverage, with cost sharing	40.0%	0.0%	-40.0%	-100.0%
Full coverage, no cost sharing	21.5%	100.0%	78.5%	364.9%
Percentage of Enrollees with Prescription Smoking Cessation Coverage				
No coverage	9.9%	0.0%	-9.9%	-100.0%
Coverage, with cost sharing	66.6%	0.0%	-66.6%	-100.0%
Full coverage, no cost sharing	23.5%	100.0%	76.5%	325.8%
Utilization and Cost				
Number of Enrollees who Smoke and Use:				
Counseling	159,313	180,268	20,955	13.2%
OTC drugs	195,100	280,896	85,796	44.0%
Prescription drugs	91,201	114,329	23,128	25.4%
Total (at least one or more services)	304,370	387,638	83,268	27.4%

Table 1. AB 1738 Impacts on Benefit Coverage, Utilization, and Cost, 2012 (Cont'd)

	Before Mandate	After Mandate	Increase/Decrease	Change After Mandate
Average Cost per Course of Treatment				
Counseling	\$200	\$200	\$0	0.0%
OTC drugs	\$236	\$236	\$0	0.0%
Prescription drugs	\$240	\$240	\$0	0.0%
Expenditures				
Premium expenditures by private employers for group insurance	\$60,279,820,000	\$60,319,646,000	\$39,826,000	0.0661%
Premium expenditures for individually purchased insurance	\$7,094,708,000	\$7,107,133,000	\$12,425,000	0.1751%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	\$14,706,245,000	\$14,716,413,000	\$10,168,000	0.0691%
CalPERS HMO employer expenditures (c)	\$3,651,121,000	\$3,654,263,000	\$3,142,000	0.0861%
Medi-Cal Managed Care Plan expenditures	\$7,637,700,000	\$7,637,700,000	\$0	0.0000%
MRMIB Plan expenditures (d)	\$1,046,243,000	\$1,046,522,000	\$279,000	0.0267%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$8,397,404,000	\$8,386,259,000	(\$11,145,000)	-0.1327%
Enrollee expenses for noncovered benefits (e)	\$16,338,000	\$0	(\$16,338,000)	-100.0%
Total Expenditures	\$102,829,579,000	\$102,867,936,000	\$38,357,000	0.0373%

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, and 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 employer-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 58% or \$1,821,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(d) 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.

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. In addition, 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: 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.

Provisions of the ACA that go into effect during the transitional years (2010-2013) affect current enrollment (the baseline), 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, and where data allow, CHBRP has made adjustments to the Cost and Coverage Model to reflect changes in enrollment and/or baseline premiums. These adjustments are discussed in further detail in Appendix D.

Some provisions of the ACA enacted federal health insurance benefit mandates.¹³ The mandates relevant to AB 1738 are discussed below.

Effective 2010: Preventive services

The ACA requires that non-grandfathered¹⁴ health plans and policies cover certain preventive services with no cost sharing beginning September 23, 2010. Tobacco cessation-related services and treatments that fall under the ACA’s preventive services requirement are defined as those having an “A” or “B” recommendation from the USPSTF. These services include:

- Tobacco-use counseling and FDA-approved pharmacotherapy for nonpregnant adults. Specifically, the USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Grade A, April 2009 (USPSTF, 2010).
- Tobacco-use counseling for pregnant women. The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. Grade A, April 2009 (USPSTF, 2010).

¹³ 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.

¹⁴ 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 ACA. . 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>).

AB 1738’s requirements, therefore, would broaden the ACA’s preventive services tobacco cessation mandate to include grandfathered DMHC-regulated plans and CDI-regulated policies (Table 3). It is not clear how many DMHC-regulated plans 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.¹⁵

Table 3: Comparison of Benefit Coverage Mandated by AB 1738 and Recommended by the U.S. Preventive Services Task Force, as part of the Affordable Care Act Preventive Services Mandate

Benefits Specified	AB 1738	USPSTF “A” or “B” Recommendations (c)
Counseling	Yes (a)	Yes (b)
FDA-approved prescription medications	Yes	“FDA-approved pharmacotherapy includes nicotine replacement therapy, sustained-release bupropion, and varenicline”
FDA-approved OTC medications	Yes	“FDA-approved pharmacotherapy” including nicotine replacement therapy

Source: California Health Benefits Review Program, 2012 (Based on AB 1738 and U.S. Preventive Services Task Force Clinical Guidelines)

(a) Four sessions, lasting at least 10 minutes each.

(b) USPSTF recommends tobacco cessation counseling for both pregnant and nonpregnant adults. USPSTF finds counseling sessions longer than 3 minutes to be effective, but does not specify a minimum length (USPSTF, 2009).

(c) The ACA preventive services mandate defers to the USPSTF “A” and “B” recommendations for tobacco cessation services.

Key: ACA=Affordable Care Act; FDA=U.S. Food and Drug Administration; OTC=over-the-counter.

In addition, effective October 1, 2010, all states are required to extend comprehensive tobacco cessation services to all pregnant women enrolled in Medicaid program (ALA, 2011b). Section 4107 of the ACA mandates coverage of comprehensive tobacco cessation services, defined as counseling and pharmacotherapy without cost sharing, for pregnant women enrolled in Medicaid.

Effective 2014: Essential health benefits

The ACA requires non-grandfathered 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)¹⁶ 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

¹⁵ 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).

¹⁶ ACA Section 1302(b)

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.

In 2014 and 2015, HHS has proposed that each state define its own EHBs for those years 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.¹⁷ Any state-mandated benefit enacted after December 31, 2011 may not be part of the EHBs for 2014 and 2015.¹⁸ If passed, AB 1738 would be effective January 1, 2013. Therefore, if any proposed benefit coverage mandates included in AB 1738 exceed EHBs, as defined in 2014 and 2015, California may be required to defray the cost for QHPs sold through the California 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.¹⁹ 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.”*²⁰

Effects beginning in 2014: Essential health benefits and AB 1738

Because the state would be fiscally responsible for mandates exceeding EHBs, CHBRP is providing the following consideration of how the benefit mandate in AB 1738 might interact with EHBs. As mentioned, the 10 EHB categories in the ACA explicitly include “preventive and wellness services and chronic disease management.”

For 2014 and 2015, states will define EHBs by selecting a benchmark plan option, which could include benefit mandates in effect by December 31, 2011, effectively wrapping up those mandates into the definition of EHBs. Because AB 1738 would not be in effect prior to December 31, 2011, it appears that the benefit mandate in AB 1738 would not be part of the EHBs for 2014 and 2015.

However, regardless of the ultimate definition of EHBs for 2014 and 2015, the ACA already requires tobacco cessation benefit coverage for non-grandfathered health plans and policies through its preventive services requirements. As presented in Table 4, it seems likely that at least

¹⁷ CCIIO, *Essential Health Benefits Bulletin* (December 2011). Available at:

http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

¹⁸ CCIIO, *Frequently Asked Questions on Essential Health Benefit Bulletin*, (February 2012)

<http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

¹⁹ 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 to the manner in which CHBRP estimates marginal cost impacts when assessing benefit mandate bills on behalf of the California Legislature.

²⁰ Available at http://www.chbrp.org/other_publications/index.php

two of the treatments—counseling and prescription medications—that would also be mandated under AB 1738 would fall “within” EHBs because of the ACA’s preventive services requirement. For the third treatment, OTC medications, the interaction with EHBs is “unclear.” While the USPSTF recommendations do include FDA-approved nicotine replacement therapies (NRT)—some of which are OTC—it is unclear how health insurers are interpreting this requirement.

Table 4. Potential Interaction of Essential Health Benefits in 2014-2015 with Benefit Mandates in AB 1738

ACA Essential Health Benefits	Benefits Mandated in AB 1738		
	Tobacco Cessation Counseling With No Cost Sharing	FDA-approved Prescription Medications With No Cost Sharing	FDA-approved OTC Medications With No Cost Sharing
10 ACA EHB categories	Unclear(a)	Unclear	Unclear
HHS’ proposed regulatory approach for 2014-2015			
Benchmark plan option 1: small group insurance product(b)	Within(c)	Within	Unclear
Benchmark plan option 2: state employee health benefits plan—CalPERS HMO(b)	Within	Within	Unclear
Benchmark plan option 2: nongrandfathered state employee health benefits plan—CalPERS self-insured PPO(b)	Within	Within	Unclear
Benchmark plan option 3: nongrandfathered Federal Employees Health Benefits Program(b)	Within	Within	Unclear
Benchmark plan option 4: largest commercial HMO(b)	Within	Within	Unclear

Source: California Health Benefits Review Program, 2012.

Notes: (a) Indicates that it is *unclear* how the benefit would be included as an EHB under the selected benchmark plan option for 2014 and 2015.

(b) Assumes a non-grandfathered plan or policy (therefore subject to the federal preventive services health benefit mandate).

(c) Indicates that the benefit would likely fall *within* the definition of EHBs under the selected benchmark plan option for 2014 and 2015.

Key: ACA=Affordable Care Act; CalPERS=California Public Employees’ Retirement System; FDA=U.S. Food and Drug Administration; FEHBP=Federal Employees’ Health Benefits Program; HMO=health maintenance organization; PPO=preferred provider organizations.

Effects beginning in 2016: Essential health benefits and AB 1738

As previously mentioned, HHS has not yet defined EHBs for the period after 2014 and 2015. As it relates to AB 1738, it is unclear whether the EHB category “preventive and wellness services and chronic disease management” would require non-grandfathered health plans and policies to include tobacco cessation benefit coverage in 2016 and beyond.

In spite of the uncertainty surrounding EHBs in 2016 and beyond, non-grandfathered plans will continue to be subject to the preventive services requirement in the ACA, as they have since September 2010. As stated earlier, this federal mandate requires coverage of tobacco cessation counseling and FDA-approved medications without cost sharing—although it is unclear whether

OTC medications are included as part of tobacco cessation benefit coverage. This federal mandate, and its interaction with AB 1738, would continue to apply post-2016.

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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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