



CALIFORNIA  
HEALTH BENEFITS REVIEW PROGRAM

---

## Analysis of Assembly Bill 1927 Vision Care Providers

---

A Report to the 2003-2004 California Legislature  
April 16, 2004  
*Revised October 8, 2004*



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 during 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](http://www.chbrp.org).

# **A Report to the 2003-2004 California State Legislature**

## **Analysis of Assembly Bill 1927 Vision Care Providers**

**April 16, 2004**  
***Revised October 8, 2004***

**California Health Benefits Review Program**  
**1111 Franklin Street, 11<sup>th</sup> Floor**  
**Oakland, CA 94607**  
**Tel: 510-287-3878**  
**Fax: 510-987-9715**  
**[www.chbrp.org](http://www.chbrp.org)**

Additional free copies of this and other CHBRP bill analyses and publications may be obtained by visiting the CHBRP Web site at [www.chbrp.com](http://www.chbrp.com)

**Suggested Citation:**

California Health Benefits Review Program (CHBRP). (2004). *Analysis of Assembly Bill 1927: Vision Care Providers*. Report to Calif. State Legislature. Oakland, CA: CHBRP. CHBRP 04-0



## PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 1927, a proposal to require full-service health care service plans to contract with both optometrists and physicians to provide vision and medical eye care services and to allow optometrists to participate to the full scope of their license. In response to a request from the California Assembly Committee on Health on March 4, 2004, 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*.

Rebecca R. Paul, MPH, MA, manager/principal analyst for CHBRP, prepared this report. Robert Cosway, FSA, MAAA, and Jay Ripps, FSA, MAAA, both of Milliman, Inc., provided actuarial analysis. Catherine Jackson, PhD, of the RAND Corporation provided technical assistance with the literature review, and Stephanie Lewis, JD, of Georgetown University contributed legal expertise. Katrina Mather, freelance editor, copy edited the report. In addition, a balanced subcommittee of CHBRP's National Advisory Council (see final pages of this report), 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 CHBRP:

**California Health Benefits Review Program**  
**1111 Franklin Street, 11<sup>th</sup> Floor**  
**Oakland, CA 94607**  
**Tel: 510-287-3878**  
**Fax: 510-987-9715**  
**[www.chbrp.org](http://www.chbrp.org)**

All CHBRP bill analyses and other publications are available on CHBRP's Web site, [www.chbrp.org](http://www.chbrp.org).

Michael E. Gluck, PhD  
Director

*Revision:*

October 8, 2004: Added a standard preface and appendix to appear in all CHBRP reports, identifying individual contributions to the analysis.





## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	3
INTRODUCTION .....	5
IMPLEMENTATION OF AB 1927 .....	7
Contracting with Optometrists .....	7
Contracting with Clinics.....	9
IMPACT ON MEDICAL EFFECTIVENESS, COST, AND PUBLIC HEALTH .....	10
Contracting with Optometrists .....	10
Contracting with Clinics.....	10







## EXECUTIVE SUMMARY

### California Health Benefits Review Program Analysis of Assembly Bill 1927

Assembly Bill 1927 (AB 1927), introduced February 10, 2004, would require full-service health care service plans to contract with both optometrists and physicians to provide vision and medical eye care services and to allow optometrists to participate to the full scope of their license. AB 1927 is similar to a bill that the California Health Benefits Review Program (CHBRP) has already analyzed, AB 1084,<sup>§</sup> which would have assured health care service plan enrollees a choice between an optometrist and a physician.

AB 1927 also differs from AB 1084 in that it establishes certain requirements related to vision care for health care service plans that want to participate in Medi-Cal and Healthy Families. Because this section of the bill does not meet the definition of a health insurance benefit mandate as laid out in CHBRP's authorizing legislation, AB 1996 (*California Health and Safety Code* Section 127660 *et seq.*), this analysis does not analyze this particular provision of the legislation.

This analysis discusses potential differences between the impact of AB 1084 and AB 1927 and highlights changes in the analysis due to the modification of the bill language.

#### I. Impacts on Health Care Service and Vision Care Plans

- Some health care service plans may have to modify their provider networks to include additional optometrists. The specific plans that would need to modify their networks, and the extent of any necessary changes, depend on the legal interpretation of some provisions of the bill and on the access standards required for the implementation of AB 1927.
- Most plans generally cover the treatment of medical eye conditions by optometrists, although two plans report that policies and practices related to delivery of services or referrals are handled at the medical group level.

#### II. Utilization, Cost, and Coverage Impacts

- Members of health care service plans are generally required to have a referral to see a provider for treatment of medical eye care services. It is uncertain if plans' referral policies and procedures would need to be modified under AB 1927, and it is unknown whether such changes would lead to variance in the relative utilization of vision care provider types. AB 1927 does not require direct access to vision care providers and plans that require referrals may continue to do so.
- As with AB 1084, health care service plans under AB 1927 may experience an increased administrative workload associated with changes to provider networks and referral policies and procedures.

---

<sup>§</sup> AB 1084 was introduced February 20, 2003. CHBRP's report on AB 1084, dated February 9, 2004, can be found at [http://www.chbrp.org/completed\\_analyses/index.php](http://www.chbrp.org/completed_analyses/index.php)



- Premiums are not projected to change.
- Total medical costs are not projected to change.

### **III. Medical and Public Health Impacts**

There is a lack of reliable information regarding the quality-of-care differentials associated with optometrists versus ophthalmologists and other physicians and the public demand for access to either provider type; therefore, the medical and public health impacts of AB 1927 are inconclusive.

## INTRODUCTION

Assembly Bill 1927 (AB 1927) would amend the California Health and Safety Code to require full-service health care service plans that provide vision or medical eye care services or procedures to contract with both optometrists and physicians to provide vision and medical eye care services and to allow optometrists to participate to the full scope of their license. AB 1927 is similar to a bill that the California Health Benefits Review Program (CHBRP) has already analyzed, AB 1084,<sup>1</sup> which would have assured health care service plan enrollees a choice between an optometrist and a physician. AB 1927 applies only to health care services and vision care plans that are licensed under Knox-Keene<sup>2</sup> and regulated by the Department of Managed Health Care (DMHC), not to health insurers regulated by the Department of Insurance.

AB 1927 also differs from AB 1084 in that it establishes certain requirements related to vision care for health care service plans that want to participate in Medi-Cal and Healthy Families. Because this section of the bill does not meet the definition of a health insurance benefit mandate as laid out in CHBRP's authorizing legislation, AB 1996 (*California Health and Safety Code* Section 127660 *et seq.*), this analysis does not analyze this particular provision of the legislation.

Current California state law does not allow health care service plans that cover vision care services to prevent members "from selecting any ... optometrist" who is affiliated, or under contract, with the plan.<sup>3</sup> In addition, current law requires California agencies that are funded by the state to ensure that patients have adequate choice between an optometrist and a physician or surgeon for vision care services that fall within the providers' scope of practice.<sup>4</sup>

### Provisions of AB 1927 and AB 1084

Whereas AB 1084 focused on assuring enrollee choice of vision providers, AB 1927 focuses on plan contracting with vision providers. AB 1927 provides for the following:

- Effective January 1, 2005, every full-service health care service plan "that provides vision or medical eye services or procedures shall contract with both optometrists ... and physicians." The bill explicitly exempts specialized health care service plans, including vision plans, from this and the following requirement.
- "A health care service plan shall allow contracting optometrists to provide vision and medical eye care services and procedures and to participate to the full extent of their license."
- The definition of "vision and medical eye care services and procedures" in AB 1927 is the same as the definition of "vision care services" in AB 1084 and "include, but are not limited to, comprehensive primary eye care service, treatment of medical eye conditions, and emergency care."

---

<sup>1</sup> AB 1084 was introduced February 20, 2003. CHBRP's report on AB 1084, dated February 9, 2004, can be found at [http://www.chbrp.org/completed\\_analyses/index.php](http://www.chbrp.org/completed_analyses/index.php)

<sup>2</sup> Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

<sup>3</sup> Section 1373 (h) of the California Health and Safety Code.

<sup>4</sup> Section 690 of the California Business and Professions Code.



- Plans are permitted to require optometrists to “abide by the terms and conditions of the health care service plan contract,” “comply with the plan’s credentialing standards for optometrists,” and “provide evidence of current licensure in good standing.”
- All health care service plans (both full-service and specialized health care service plans) that provide “for coverage of, or for payment for, vision care services” are prohibited from discriminating against or refusing to contract with clinics that provide vision care services. The penalty for noncompliance is ineligibility to contract under the Medi-Cal or Healthy Families programs.<sup>5</sup>

Provisions that were in AB 1084 but are not in AB 1927 include the following:

- A requirement that health care service plans “that offer vision care benefits” contract with “sufficient providers to offer enrollees a meaningful, accessible, and adequate choice between an optometrist ... and a physician.”
- A requirement that plans “not prohibit an enrollee who is entitled to vision care that may be rendered by either an optometrist or a physician or surgeon within the scope of the provider’s license from selecting a provider from either profession to render the service as long as the provider has not been removed or suspended from participation in the plan for cause.”
- A requirement that plans that prepare a list of providers from which enrollees are to select include in that list “a sufficient number of both types of providers to assure enrollees an adequate choice.”

Since emphasis on enrollee choice has been removed, some of the questions addressed by the California Health Benefits Review Program’s (CHBRP’s) analysis of AB 1084 are no longer applicable,<sup>6</sup> and the following analysis of AB 1927 addresses the questions relevant to this new bill.

---

<sup>5</sup> The chief sponsor of this section of the bill has reported that there is a proposed amendment that would more specifically define discrimination in contracting with clinics.

<sup>6</sup> For example, the question of how AB 1084 would be implemented and whether the requirement for a “meaningful choice” of vision providers would necessitate specific numbers of each type of vision provider in various geographic areas appears to be moot under AB 1927. AB 1084’s requirements pertaining to member choice appeared to have a more direct implication for plans’ referral policies than do the requirements of AB 1927, although the implementation of both bills could potentially lead to changes in referral policies and practices. As previously discussed in CHBRP’s analysis of AB 1084, the extent to which such changes in referral policies would happen would depend in part on the interpretation of the oversight agency, the California Department of Managed Health Care, regarding compliance with bill requirements.

## IMPLEMENTATION OF AB 1927

### **Contracting with Optometrists (Section 2 of AB 1927)**

This section of the analysis focuses on AB 1927's requirements that full-service health care plans that provide vision or medical eye care services do the following: (1) contract with both optometrists and physicians and surgeons, and (2) allow optometrists "to provide vision and medical eye care services and procedures and to participate to the full extent of their license."

Although not all plans cover complete vision services in each contract, all health care service plans appear to cover medical eye services (treatment of diseases or injuries to the eye). Therefore, AB 1927 would apply to all full-service health care service plans.

As CHBRP's analysis of AB 1084 showed, both vision plans and full-service health care service plans that provide vision benefits within their own networks use optometrists to provide basic vision services. Because AB 1927 requires health care service plans to allow contracting optometrists to provide vision and medical eye care services to the full extent of their license, and because optometrists appear to be used consistently to provide basic vision services, the remainder of this analysis focuses on the potential impact of AB 1927 on the treatment of medical eye conditions.

### Composition of provider networks

When asked about vision providers in their own networks—either through direct contracts or in contracted medical groups—the seven largest health care service plans in California responded as follows:

- One health care service plan has neither optometrists nor ophthalmologists in its provider network.
- Two plans have some ophthalmologists but no optometrists in their provider network.
- Four plans have both optometrists and ophthalmologists in their provider network.<sup>7</sup>

In order to fully assess the impact of Section 2 of AB 1927 on the composition of provider networks, several issues would need to be addressed. First, how health care service plans would meet the requirement that they "shall contract with" both optometrists and ophthalmologists may need to be further clarified if AB 1927 is enacted. Whether health care service plans would be in compliance only by contracting directly with vision providers, or whether they could also comply by contracting with medical groups or subcontracting with vision plans, is not clear and would depend in part on the interpretation and enforcement activities of the Department of Managed Health Care (DMHC). Similarly, although this provision does not apply to specialized health care service plans, it is not clear if full-service health care service plans would be out of compliance if they provided access to vision providers only through a subcontract with a vision plan (assuming that the subcontracting vision plans met the requirement that optometrists are used to the full extent of their licenses).

---

<sup>7</sup> Representatives from two plans explained that their plans use the vision providers in their own network to provide services under their core vision benefit (typically used by people who do not have separate vision coverage) and to treat medical eye conditions.



Another issue is how many optometrists each plan would need to contract with to be in compliance with AB 1927. The extent of changes needed in plans' provider networks is dependent on the access standards applied. Already-existing accessibility standards require that, "[w]ithin each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees" (*California Code of Regulations*, Title 28, Division 1, Chapter 2, Article 7, Section 1300.67.2). Further, applications for Knox-Keene licenses require plans to describe the geographical area they serve and to demonstrate that, "throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees." DMHC states that it evaluates the "the geographic aspects of availability and accessibility" in part by taking into account "the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area" (*California Code of Regulations*, Title 28, Division 1, Chapter 2, Article 3, Section 1300.51).

If more extensive requirements related to the number of contracting optometrists are established, definitions of these different standards would be needed for implementation purposes. If that is the case, it is possible that a larger number of plans would need to make changes in their provider networks and that changes would need to be more extensive.

AB 1927 does not appear to require health care service plans to contract with an unlimited number of vision provider types, in that it only requires full-service health care service plans to contract with both optometrists and physicians and does not prohibit placing a limit on the number of vision providers in plans' networks.

#### Participation of optometrists

Plans do not generally appear to have policies prohibiting optometrists from treating medical eye conditions. Of the health care service plans surveyed, only one stated that it uses ophthalmologists or a primary care physician to treat medical eye conditions. Four of the seven plans replied generally, either stating that their use of provider types depended on the respective scope of practice or that they did cover treatment of medical eye conditions by optometrists. Two plans specifically reported that the decisions regarding the composition of the provider network and/or referrals are made at the medical group level, not by the plan.

Six of the seven health care service plans reported that they require a referral to a vision provider for the treatment of medical eye conditions.<sup>8</sup> The seventh plan responded that, although a referral is not required, one is often provided, because patients may not know whom to see for treatment of their medical eye condition and may first go to their primary care physician.

AB 1927 does not specify what plans would need to do to "allow contracting optometrists to provide vision and medical eye care services and procedures to the full extent of their license." It is not clear whether health care service plans could show a pattern of practice that includes optometrists performing at the full extent of their license or if each optometrist must be given

---

<sup>8</sup> Most surveyed plans noted that a referral is not required in their preferred provider organizations and that patients are also able to access out-of-network providers under those policies, presumably for a higher cost-sharing amount.

such work. The extent of the impact of this provision on plans' (or their contracted medical groups') determinations about network composition, the utilization of individual providers, and possibly referral policies and practices would be dependent on such an interpretation.

Although AB 1927 is silent regarding referral policies and practices, presumably a plan policy that only ophthalmologists can treat conditions that are in the optometric scope of practice would need to be changed. Similarly, a plan with a referral policy that allows optometrists to practice within the scope of their license, but with a pattern of practice that results in referral practices that prevent this, may need to make changes in its referral policies and/or practices. However, the extent of these possible changes is currently undeterminable. Further, it is not clear whether changing referral policies and practices would lead to changes in utilization patterns of optometrists and ophthalmologists for the treatment of medical eye conditions, given that enrollee preferences are not well known.

### **Contracting with Clinics (Section 3 of AB 1927)**

Section 3 of AB 1927, which requires health care service plans to contract on a nondiscriminatory basis with clinics, effectively applies only to plans that have an interest in contracting under the Medi-Cal or Healthy Families programs, since the penalty for not complying with this section is inability to contract under those two programs.

This provision does not require health care service plans to permit members to obtain health care treatment or services from a particular type of provider, e.g., an optometrist; to offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or to offer or provide coverage of a particular type of health care treatment or service—the types of mandated benefits that AB 1996 authorizes the University of California to analyze. Instead, this section of the bill would affect payment based on the type of facility in which the service is provided.

The Managed Risk Medical Insurance Board, which administers the Healthy Families program, contracts directly with one vision plan to administer the program's vision benefit for its 683,787 enrollees;<sup>9</sup> the full-service health care service plans are not responsible for administering this benefit. Therefore, this section of the bill would only apply to one vision plan in this circumstance.

Medi-Cal managed care contracts include vision coverage,<sup>10</sup> and plans may delegate the responsibility for administering the vision benefit to a subcontractor. Many plans subcontract with the same vision plan,<sup>11</sup> which covers the majority of Medi-Cal beneficiaries enrolled in

---

<sup>9</sup> Healthy Families enrollment as of 12/30/03. Healthy Families program enrollment summary, <http://www.mrmib.ca.gov/MRMIB/HFP/HFPRptSum.pdf>, accessed on March 24, 2004.

<sup>10</sup> Contracts for vision services provided to Medi-Cal enrollees commonly do not include the fabrication of eyewear. The California Department of Health Services (DHS) contracts with the California Prison Industry Authority (PIA) to supply lenses and optional frames for eligible Medi-Cal recipients. Enrollees in certain counties (e.g., San Mateo, Santa Barbara) are ineligible for PIA optical laboratory services, as are enrollees in certain other state-funded health care programs and those who have vision coverage from other sources (Medi-Cal Vision Care Provider Manual; Vision Care – Part 2; PIA Optical Laboratories, December 2003, page 1).

<sup>11</sup> Personal communication, DHS, March 2004.



managed care.<sup>12</sup> Currently, this vision plan has contracts under both Medi-Cal and Healthy Families and reports that it does contract with “any clinics as defined in AB 1927.”

## **IMPACT ON MEDICAL EFFECTIVENESS, COST, AND PUBLIC HEALTH**

### **Contracting with Optometrists (Section 2 of AB 1927)**

Although AB 1927 takes a different approach than AB 1084 (as discussed above), it is similar to that of AB 1084 in seeking the inclusion and broader use of optometrists to provide vision and medical eye care services and procedures to health plan members). With the exceptions discussed below, CHBRP’s findings regarding medical effectiveness, cost, or public health impacts are the same as those presented in its analysis of AB 1084.

#### Medical Effectiveness

There is no new analysis of medical effectiveness regarding the use of vision care providers in the provider networks of health care service plans.

#### Utilization, Cost, and Coverage Impacts

There is no new analysis of utilization, cost, and coverage impacts regarding the inclusion and utilization of vision care providers in the provider networks of health care service plans. Although the outcomes of the cost analysis for AB 1927 are not different from those for AB 1084, it is anticipated that the administrative changes spurred by AB 1927 would be smaller in scale. AB 1084’s provisions would likely have had a similar or greater impact on provider network composition as AB 1927’s requirement to contract with optometrists (although the previous bill did not explicitly require contracting with optometrists). Further, although AB 1927 has some potential for resulting in modifications in plans’ referral policies and practices, AB 1084 more directly suggested that such changes should be made. Also, AB 1927 does not have AB 1084’s requirements for enrollee choice, compliance with which would have been potentially more complex to assess. In the case of either bill version, however, the costs are anticipated to be administrative in nature and not of a scale to affect premium costs. Such administrative changes may include modifications to provider networks and referral policies and practices.

#### Public Health Impacts

There is no new analysis of public health impacts regarding the use of vision care providers in the provider networks of health care service plans.

### **Contracting with Clinics (Section 3 of AB 1927)**

Because this section of the bill does not meet the criteria of AB 1996, it has not been analyzed regarding its medical, cost, and public health impacts.

---

<sup>12</sup> Personal communication with the DHS and the health plan, March 2004.





## 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 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 USA, to assist in assessing the financial impact of each benefit mandate bill. Milliman USA 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.

### Faculty Task Force

**Helen Halpin, PhD**, *Vice Chair for Public Health Impacts*, University of California, Berkeley

**Gerald Kominski, PhD**, *Vice Chair for Financial Impacts*, University of California, Los Angeles

**Harold Luft, PhD**, *Vice Chair for Medical Effectiveness*, University of California, San Francisco

**Wayne S. Dysinger, MD, MPH**, Loma Linda University Medical Center

**Theodore Ganiats, MD**, University of California, San Diego

**Sheldon Greenfield, MD**, University of California, Irvine

**Richard Kravitz, MD**, University of California, Davis

**Thomas MaCurdy, PhD**, Stanford University

**Thomas Valente, PhD**, University of Southern California

### Other Contributors

**Wade Aubry, MD**, University of California, San Francisco

**Patricia Franks**, University of California, San Francisco

**Miriam Laugesen, PhD**, University of California, Los Angeles

**Sara McMenamain, PhD**, University of California, Berkeley

**Nadereh Pourat, PhD**, University of California, Los Angeles

**Edward Yelin, PhD**, University of California, San Francisco

## National Advisory Council

**Susan Dentzer**, Health Correspondent, *News Hour with Jim Lehrer*, PBS, Alexandria, VA, *Chair*

**John Bertko, FSA, MAAA**, Vice President and Chief Actuary, Humana, Inc., Oakland, CA

**Deborah Chollet, PhD**, Senior Fellow, Mathematica Policy Research, Washington, DC

**Michael Connelly, JD**, President and CEO, Catholic Healthcare Partners, Cincinnati, OH

**Joe Ditre, JD**, Executive Director, Consumers for Affordable Health Care, Augusta, ME

**Jack Ebeler, MPA**, President and CEO, Alliance of Community Health Plans, Washington, DC

**Allen D. Feezor**, Chief Planning Officer, University Health System of Eastern Carolina,  
Greenville, NC

**Charles “Chip” Kahn, MPH**, President and CEO, Federation of American Hospitals,  
Washington, DC

**Lauren LeRoy, PhD**, President and CEO, Grantmakers In Health, Washington, DC

**Trudy Lieberman**, Health Policy Editor, Consumers Union, Yonkers, NY

**Devidas Menon, PhD, MHSA**, Executive Director and CEO, Institute of Health Economics,  
Edmonton, AB

**Marilyn Moon, PhD**, Vice President and Director, Health Program, American Institutes for  
Research, Silver Spring, MD

**Michael Pollard, JD, MPH**, Consultant, Federal Policy and Regulation, Medco Health Solutions,  
Washington, DC

**Christopher Queram**, Chief Executive Officer, Employer Health Care Alliance Cooperative,  
Madison, WI

**Richard Roberts, MD, JD**, Professor of Family Medicine, University of Wisconsin-Madison,  
Madison, WI

**Frank Samuel, LLB**, Science and Technology Advisor, Governor’s Office, State of Ohio,  
Columbus, OH

**Roberto Tapia-Conyer, MD, MPH, MSc**, Senior Professor, National University of Mexico,  
Cuauhtémoc, Mexico

**Prentiss Taylor, MD**, Vice President, Medical Affairs, Amerigroup, Chicago, IL

**Reed V. Tuckson, MD**, Senior Vice President, UnitedHealth Care, Minnetonka, MN

**Judith Wagner, PhD**, Scholar-in-Residence, Institute of Medicine, Washington, DC

**Ronald A. Williams**, President, Aetna, Inc., Hartford, CT

## CHBRP Staff

**Michael E. Gluck, PhD**, Director

**Rebecca R. Paul, MPH, MA**,  
Manager/Principal Analyst

**Susan Philip, MPP**, Principal Analyst

**Jill Hedgepeth**, Administrative Assistant

The California Health Benefits Review Program is administered by the Division of Health  
Affairs at the University of California Office of the President, Michael V. Drake, MD, Vice  
President.

**California Health Benefits Review  
Program**

**1111 Franklin Street, 11<sup>th</sup> Floor  
Oakland, CA 94607**

**Tel: 510-287-3878 Fax: 510-987-9715**

**[info@chbrp.org](mailto:info@chbrp.org) [www.chbrp.com](http://www.chbrp.com)**

