CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 185: Maternity Services

A Report to the 2011-2012 California Legislature
March 27, 2011

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Maternity Services

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 185

The California Assembly Committee on Health requested on February 4, 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) 185, a bill that would require coverage of maternity services. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

AB 185 would apply only to policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations), which represent approximately 17% of privately funded insurance subject to California regulation. Health care service plans (including health maintenance organizations, point-of-service plans, and some preferred provider organizations) regulated by the Department of Managed Health Care (DMHC) make up the remaining portion of the privately funded, California-regulated market. Although DMHC-regulated plans constitute the majority of this market, which contains both the group and individual market segments, CDI-regulated policies represent a substantial portion of the *individual* market—about 65%.

Current laws and regulations governing DMHC-regulated health care service plans require coverage for maternity services under provisions related to "basic health care services." DMHC-regulated plans are required to cover maternity and pregnancy-related care under laws governing emergency and urgent care.[2] Regulations defining basic health care services specifically include prenatal care as preventive care that must be covered.[3] CDI-regulated policies currently have no such requirements.

The federal Civil Rights Act requires employers that offer health insurance and have 15 or more employees to cover maternity services benefits at the same level as other health care benefits.[4] Complications of pregnancy are generally covered regardless of whether the health insurance policy provides coverage for maternity benefits. Insurers are also required to cover newborns for the first 30 days of life regardless of whether the health insurance policy covers maternity services.[5]

The bill's definition of maternity services is generally consistent with the definitions of maternity services under health insurance: prenatal care (such as office visits and screening tests), labor and delivery services (including hospitalization), care resulting from complications related to a pregnancy, and postpartum/postnatal care.

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[1] CHBRP's authorizing statue is available at: www.chbrp.org/documents/authorizing_statute.pdf
[2] Section 1317.1 of the California Health and Safety Code
[3] Section 1300.67 of the California Code of Regulations, Title 28
[4] The Pregnancy Discrimination Act under Title VII of the Civil Rights Act of 1964
[5] Insurance Code Section 10119 and Redlands Community Hospital v. New England Mutual (1994) 23 Cal. App. 4th 898.

Analysis of AB 185

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.[6] 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 DMHC[7] regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The CDI regulates health insurers[8], which offer benefit coverage to their enrollees through health insurance policies.

AB 185 would require health insurance policies regulated by the CDI to cover maternity services,[9] therefore affecting the health insurance of approximately 2.86 million Californians (13% under state-regulated health insurance).

Medical Effectiveness

The *Medical Effectiveness* and *Public Health Impacts* sections of this report focus on the outcomes associated with prenatal care services because (1) a majority of births occur in the hospital setting regardless of insurance status, (2) prenatal care services use would be most affected by the potential for out-of-pocket costs and thus most directly affected by AB 185, and (3) AB 185 would not affect coverage for infants. The *Benefit Coverage, Utilization, and Cost Impacts* analysis includes the full range of services that are considered to be "maternity services."

Studies of prenatal care can be divided into two major groups:

- Studies of the impact of variation in the number of prenatal care visits that pregnant women receive, and

- Studies of the effectiveness of specific medical services provided to pregnant women (e.g., laboratory tests and medications).

Randomized controlled trials (RCTs) have consistently found no statistically significant association between the number of prenatal visits pregnant women receive and birth outcomes for either infants or for mothers. However, there is clear and convincing evidence from multiple RCTs that the following prenatal care services are effective in producing better birth outcomes for mothers and infants:

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[6] CHBRP's estimates are available at: http://www.chbrp.org/other_publications/index.php.
[7] The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan Act of 1975; see Health and Safety Code, Section 1340.
[8] The 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.
[9] AB 185 would add Section 10123.865 to the California Insurance Code.

- Smoking cessation counseling
- Ultrasound to identify structural abnormalities and determine gestational age
- Folic acid to prevent neural tube defects
- Screening and treatment for asymptomatic bacteriuria
- Screening for hepatitis B
- Screening and treatment for human immunodeficiency virus
- Calcium supplements and aspirin for prevention of preeclampsia
- Magnesium sulfate for prevention of eclamptic seizures in women with preeclampsia
- Screening and prophylactic and therapeutic treatment for Rh(D) incompatibility
- Progestational agents to prevent recurrent preterm delivery
- Maternal corticosteroids to promote maturation of lungs in fetuses delivered preterm
- Magnesium sulfate to prevent neurological impairment in fetuses at risk for preterm delivery
- External cephalic version for breech presentation at term
- Membrane sweeping and induction of labor for prevention of postterm pregnancies

In addition, there is a preponderance of evidence from nonrandomized studies and/or a small number of RCTs that the following prenatal care services are effective:

- Screening for domestic violence
- Screening for Down syndrome, hemoglobinopathies, and Tay-Sachs disease
- Screening and treatment for chlamydia, gonorrhea, and syphilis
- Screening and prophylaxis for group B streptococcus
- Screening and treatment for gestational diabetes
- Screening and treatment for bacterial vaginosis, trichomonas vaginalis, and Candida species to prevent preterm delivery
- Iron supplements for treatment of iron deficiency anemia
- Blood pressure monitoring to screen for hypertensive disorders
- Screening for atypical red blood cell alloantibodies other than Rh(D) incompatibility
- Ultrasound to diagnose placenta previa

Benefit Coverage, Utilization, and Cost Impacts

Benefit Coverage Impacts

- AB 185 would apply only to CDI-regulated health insurance policies subject to the California Insurance Code. It would require all CDI-regulated policies to cover maternity services. About 2,858,000 Californians, or 13% of enrollees in health insurance plans and policies subject to state regulation, are in the CDI-regulated market.

- CHBRP's survey of the largest health plans and insurers in the state indicates the following:

  - *Entire CDI-regulated market*: Among the Californians who are estimated to be currently enrolled in CDI-regulated policies, 59% have coverage for maternity benefits, including prenatal care and delivery services. All enrollees have coverage for complications of pregnancy.
  - *CDI-regulated policies in the large- and small-group insurance markets*: An estimated 100% of enrollees currently have maternity benefits. Therefore, the proposed mandate would impact only the enrollees in individual (non-group) CDI-regulated policies.
  - *CDI-regulated policies in the individual (non-group) insurance market:* An estimated 12% of all enrollees and 13% of female enrollees aged 20 to 44 currently have maternity coverage.
  - Of those who do not currently have coverage for maternity services, about 25% are women of childbearing age (19 to 44).

- There is evidence that risk segmentation (which results in individuals at lower risk able to purchase less expensive policies) and the resulting adverse selection (where premiums for individuals that wish to purchase coverage are subjected to disproportionate increases) have already had a substantial impact on the CDI- regulated individual market. This is evidenced by the rise in the proportion of individuals uninsured for maternity services from 18% to 87% in the last 7 years.

Public programs:

- The Medi-Cal and Access for Infants and Mothers (AIM) programs cover maternity services for women who qualify. Pregnant women who are in households with incomes less than or equal to 200% of the federal poverty level (FPL) generally qualify for Medi-Cal. AIM provides coverage for both uninsured and underinsured women between 200% and 300% of the FPL. AIM defines underinsured women as those with privately funded insurance who face out-of-pocket costs for maternity services greater than $500. CHBRP estimates that approximately 3,683 or 29% of women with privately funded insurance who will deliver babies during 2011 and have no maternity benefits when they become pregnant may qualify for Medi-Cal or AIM.

- Based on data from AIM, there is evidence of current cost-shifting to that program. As of 2011, 1,565 or 9.6% of the women enrolled in AIM were simultaneously enrolled in privately funded health insurance policies that did not cover maternity services. Another

1,933 or 11.9% of AIM enrollees were enrolled in privately funded insurance policies that did cover maternity services.

- CHBRP estimates that 12,663 or 1.1% of women enrolled in CDI-regulated policies with no maternity benefits at the time of pregnancy would give birth during 2011.
    - Of these women, CHBRP estimates that 2,773 would obtain Medi-Cal coverage and another 909 would enroll in AIM following pregnancy. This is because their income eligibility would change following pregnancy (since pregnant women are considered a household of two and presumably their household income would not increase).
    - Another 407 of these women are expected to transfer to policies covering maternity that are offered by their existing carrier.
    - The remaining 8,574 women would not have insurance coverage premandate for their prenatal care and delivery.
- AB 185 would expand maternity services coverage to approximately 1,184,000 enrollees with CDI-regulated individual policies, including about 268,181 women aged 19 to 44 years.
- CHBRP estimates that there would be no decrease in Medi-Cal enrollment as a result of AB 185. Those 2,773 women who currently have no maternity coverage and qualify for Medi-Cal after pregnancy would still shift to Medi-Cal postmandate due to their income levels.
- There are 1,565 women enrolled in AIM who are currently enrolled in CDI-regulated individual policies that do not cover maternity services; these women would have maternity coverage postmandate. However, the out-of-pocket cost of maternity services in those policies would likely still be greater than $500 (adding up deductibles and copayments), so those women would still qualify for AIM. As AIM would be the secondary payer if women retain their privately funded policies, there may be a shift of costs from AIM onto the private insurers, depending on whether AIM plans seek reimbursement from those insurers.
- The estimated premium increases, enumerated below, may result in approximately 9,778 newly uninsured. It is likely that these newly uninsured would disproportionately consist of younger people as they are most likely to experience the greatest premium increases and because they are price-sensitive purchasers.

<u>Utilization Impacts</u>

- CHBRP estimates that approximately 8,574 pregnancies would be newly covered under CDI-regulated insurance policies postmandate. The impact of expanded benefit coverage on utilization is summarized below:
    - Overall, the mandate is estimated to have no impact on the number of deliveries, since the birth rate is not expected to change postmandate.
    - Most women are likely to continue to face large out-of-pocket expenditures for maternity services regardless of whether or not their insurance policy includes maternity benefits.

This is because about 76% of the women in CDI-regulated individual policies are currently in high-deductible health plans (HDHPs) and prenatal care is usually subject to an HDHP minimum annual deductible of $1,200 for individual plans and $2,400 for family plans as reported by the federal Internal Revenue Service (IRS). HDHPs generally do not exempt maternity/prenatal services from the high deductibles, so a high level of cost sharing is required for maternity services. Even the women currently enrolled in non-HDHPs frequently face high cost-sharing requirements in the CDI- regulated individual market, and some might also choose to switch to HDHPs postmandate in order to save on premiums.

- Certain types of screening tests that are not current standard of care and yet are included in the standard prenatal care fee might be used more frequently postmandate if they are part of the maternity benefit, thereby affecting costs. The amount of the increase is difficult to estimate, as these tests would be subject to HDHP deductibles and women may treat them as out-of-pocket costs.

<u>Cost Impacts</u>

- Among all enrollees in state-regulated policies (both CDI-regulated and DMHC-regulated), total annual health expenditures are estimated to increase by $22.2 million, or 0.02%, as a result of this mandate ("Total Annual Expenditures" in Table 1). As the total number of deliveries and average cost associated with each delivery is not expected to increase since the number of newly covered mothers is too small to have a measurable effect on costs, the mandate primarily shifts costs from individuals to insurers. CHBRP assumes that the administrative expenses for health policies would increase in proportion to the increase in their covered health care costs, leading to an estimated increase in overall expenditures. Note that the increase in total expenditures is a total of:
  - The increase in premium expenditures in the individual market: $111.5 million, or 1.66%, ("Premium expenditures for individually purchased insurance" in Table 1).
  - The increase in out-of-pocket expenditures for maternity benefits covered by insurance (e.g., copayments and deductibles): $32.1 million, or 0.43%, ("Enrollee out-of-pocket expenditures for covered benefits" in Table 1).
  - The reduction in out-of-pocket expenditures for maternity benefits not currently covered by insurance: $121.5 million. This assumes that all women without coverage pay out of pocket. ("Enrollee expenses for noncovered benefits" in Table 1).
  - All of the costs of the mandate would be concentrated in the CDI-regulated individual market, where total expenditures are estimated to increase by 0.52% and premiums by 3.48% ("Total Expenditure" and "Insured Premiums", Table 7). Per member per month (PMPM) premiums are estimated to increase by an *average* of $6.92 in this market.
- In 2009, California passed AB 119 into law prohibiting insurers from gender rating, or charging differential premiums based on gender for contracts issued, amended, or renewed on or after January 1, 2011. Therefore, the premium and cost calculations in this report assume all gender-rated policies have been converted to gender-neutral pricing prior to the implementation of AB 185.

- Insurance premiums in the individual market are stratified by age bands, so premiums are likely to increase more for younger individuals (particularly ages 19 to 29) than for older individuals (ages 30 to 64). CHBRP estimates that for the majority of individuals in the CDI-regulated individual market who do not currently have maternity benefits, AB 185 would *increase* average premiums by 2% to 28% among those aged 19 to 44 years, depending on the age of the enrollee. Among the minority of individuals aged 19 to 44 years in the CDI-regulated individual market who currently have maternity benefits, AB 185 is expected to *decrease* average premiums by 0.5% to 23%.

- In addition to varying with age, premium changes could vary across policies. Postmandate, women of a given age might self-select into policies with a high or low level of cost sharing based on their expected need for maternity care.

Public Health Impacts

- CHBRP is unable to estimate the precise impact AB 185 would have on the utilization of prenatal care. However, given data on current utilization of prenatal serves, CHBRP assumes an upper bound estimate that all 8,574 newly covered pregnancies would have financial barriers to prenatal care reduced and thus an increase in the utilization of effective prenatal care services would be expected. To the extent that AB 185 increases utilization of effective prenatal care services, there is a potential that this mandate could lead to a reduction in infant and maternal mortality and improve health outcomes, such as the rates of low birth weight or preterm births, infectious disease transmissions, and respiratory distress syndrome.

- Females enrolled in plans in the individual health insurance market without coverage for maternity benefits currently are potentially responsible for $121.5 million in out-of-pocket costs for noncovered maternity services, if they all sought prenatal health care services. AB 185 would shift these costs from female enrollees to increased premiums across both male and female enrollees. Therefore, this mandate would differentially reduce the out-of-pocket costs for female enrollees.

- Racial disparities in utilization of prenatal care exist in California, with black women utilizing prenatal care at lower rates. In addition, babies born to black women have poorer health outcomes, such as increased rates of preterm birth, low birth weight, and infant mortality. However, the racial/ethnic distribution of pregnant women with the type of coverage affected by the mandate is unknown, so the specific impact of AB 185 cannot be established.

- In California, 10.1% of babies are born preterm and there are just under 3,000 infant deaths each year. It is estimated that each premature birth costs society approximately $51,600. To the extent that AB 185 increases the utilization of effective prenatal care that can reduce outcomes such as preterm births and related infant mortality, there is a potential to reduce morbidity and mortality and the associated societal costs.

- As a result of AB 185, premiums in the CDI-regulated individual market are estimated to increase by greater than 1%, thus increasing the number of uninsured by approximately 9,778 people. Losing one's health insurance has many harmful consequences beyond the health outcomes presented in this analysis.

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 addresses 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.

Essential health benefits offered by qualified health plans in the Exchange and potential interactions with AB 185

Essential Health Benefits (EHBs) explicitly include "Maternity and newborn care."[10] In addition, the U.S. Department of Health and Human Services 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 coverage includes maternity services and the scope of services under AB 185 is considered standard maternity care coverage under most employer-based plans (i.e., prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care). Therefore, it is highly likely that any impacts of AB 185 projected in this report in the longer term (beyond 2014) would be mitigated by these ACA requirements.

Due to the fact that "maternity services," as defined under AB 185 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 an additional fiscal liability to the state as a result of this mandate for qualified health plans offered in the Exchange.

[10] Affordable Care Act, Section 1302(b)(1)(E).

Preventive services required under ACA and AB 185

"New plans" (i.e., those not covered under the ACA's "grandfather" provisions) were required to cover certain preventive services at zero cost sharing beginning September 23, 2010. Required preventive services include those rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF); recommended immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women (effective 6 months after enactment). Certain prenatal care services are recommended by the USPSTF and have a Grade A or B recommendation. These would be covered and therefore could diminish the marginal cost impact and public health impacts presented in this analysis.[11] It is possible that certain policies technically cover certain prenatal care services at zero cost sharing, but still exclude maternity services. For the purposes of this analysis, the more relevant question is whether CDI-regulated individual policies currently cover the bundle of maternity services, including prenatal care services. Therefore, this analysis does not attempt to parse out the portion of the market that may have coverage for recommended prenatal care services but does not have coverage for maternity services.

[11] For example, USPSTF "strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care (USPSTF, 2008).

Table 1. AB 185 Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0.00%
Total enrollees with health insurance subject to AB 185				
In large- and small-group plans	1,515,000	1,515,000	0	0.00%
In individual plans	1,343,000	1,343,000	0	0.00%
Total	2,858,000	2,858,000	0	0.00%
Percentage of enrollees with maternity coverage				
In large- and small-group plans	100%	100%	0.00%	0.00%
In individual plans	12%	100%	88.16%	744.65%
Total	59%	100%	41.43%	70.73%
Number of enrollees with maternity coverage				
In large- and small-group plans	1,515,000	1,515,000	0	0.00%
In individual plans	159,000	1,343,000	1,184,000	744.65%
Total	1,674,000	2,858,000	1,184,000	70.73%
Utilization and cost				
Number of enrollees with uncomplicated pregnancies				
Covered by insurance	19,072	27,646	8,574	44.96%
Covered by AIM or Medi-Cal	3,682	3,682	0	0.00%
Not covered by insurance	8,574	0	-8,574	-100.00%
Total	31,328	31,328	0	0.00%
Average cost per uncomplicated delivery	$14,044	$14,044	$0	0.00%
Expenditures				
Premium expenditures by private employers for group insurance	$52,713,266,000	$52,713,266,000	$0	0.00%
Premium expenditures for individually purchased insurance	$6,724,851,000	$6,836,376,000	$111,525,000	1.66%
Premium expenditures by enrollees with privately funded and publicly funded group insurance (b)	$15,173,472,000	$15,173,472,000	$0	0.00%
CalPERS HMO employer expenditures	$3,465,785,000	$3,465,785,000	$0	0.00%
Medi-Cal Managed Care Plan state expenditures	$8,657,688,000	$8,657,688,000	$0	0.00%
MRMIB plan expenditures (c)	$1,050,631,000	$1,050,631,000	$0	0.00%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	$7,548,415,000	$7,580,553,000	$32,138,000	0.43%
Enrollee expenses for noncovered benefits (d)	$121,468,000	$0	-$121,468,000	-100.00%
Total Annual Expenditures	$95,455,576,000	$95,477,771,000	$22,195,000	0.02%

Source: California Health Benefits Review Program, 2011.
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, MRMIP) health insurance products regulated by the DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment sponsored insurance.
(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.
(c) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP and 7,000 enrollees of the AIM program.
(d) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: 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.

Acknowledgments

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 185. In response to a request from the California Assembly Committee on Health on January 26, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, and Chris Tonner, MPH, both of the University of California, San Francisco prepared the medical effectiveness analysis. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Joy Melnikow, MD, MPH, and Heather J. Hether, PhD, both of the University of California, Davis, prepared the public health impact analysis. Jennifer Lewsey, MS, of the University of California, San Diego, prepared the cost impact analysis. Robert Cosway, FSA, MAAA of Milliman, provided actuarial analysis. Aaron Caughey, MD, PhD, of the Oregon Health & Science University provided technical assistance with the literature review and expert input on the analytic approach. Garen Corbett, MS, of CHBRP staff prepared the introduction and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, 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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