CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 652: Child Health Assessments

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

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Child Health Assessments

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 652

The California Assembly Committee on Health requested on February 17, 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) 652, a bill that would impose a health benefit mandate for two services: initial health assessments for children with out-of-home placements, and forensic medical evaluations for potential victims of child abuse. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

Analysis of AB 652: Overall Approach

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.

DMHC-regulated plans (including publicly funded plans such as Medi-Cal Managed Care Plans) and CDI-regulated policies for both individual and group policies would be subject to AB 652. Therefore, the mandate would affect the health insurance of approximately 21.9 million Californians (59%).

AB 652 Bill Language and Relevant Definitions

The full text of AB 652 can be found in Appendix A.

AB 652 includes two benefit mandates that fall under CHBRP's purview for analysis. The first would require health plans and insurers to provide an **initial health assessment** for children who have "out-of-home" placements. AB 652 defines initial health assessment as "a medical or dental

[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] The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.
[4] 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.

examination, or both, performed on a child for whom a case plan must be prepared, pursuant to Section 16501.1 of the Welfare and Institutions Code and who has been placed in an out-of-home placement within the last 30 days, and that is designed to determine the child's medical and dental status and further health care needs." The guidelines for these assessments are established by the Child Health and Disability Prevention Program (CHDP). According to the guidelines, complete health assessments are provided for the early detection and prevention of disease and disabilities for low-income children and youth.

The second benefit mandated by AB 652 pertains to coverage of **forensic medical evaluations.** AB 652 defines forensic medical evaluations per Section 324.5 of the Welfare and Institutions Code (WIC), which states that these examinations are "performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and, whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody."

Section 1 and Section 2 of AB 652 would require DMHC-regulated plans and CDI-regulated policies, including MRMIB programs, CalPERS HMOs, and Medi-Cal Managed Care Plans, to provide reimbursement for these services, and these services must be covered even if it they are rendered by a non-plan provider. Furthermore, AB 652 stipulates that prior authorization requirements would be prohibited. Additionally, AB 652 requires that reimbursements that are paid to providers for both benefits be no less than the amount that the Medi-Cal program would pay for the same service when rendered by the same provider to a Medi-Cal beneficiary on a fee-for-service basis.

Section 3 of AB 652 would also require the Medi-Cal program to cover initial health assessments and forensic medical evaluations. CHBRP's authorizing statute requests the program to analyze a health insurance benefit mandate as it relates to DMHC-regulated plans and CDI-regulated policies. Because the Medi-Cal fee-for-service (FFS) program provides reimbursement to Medi-Cal providers directly (rather than through a contracted DMHC-regulated health plan) the provisions affecting the Medi-Cal FFS program does not fall within CHBRP's purview for analysis. Therefore, this analysis does not address the potential impacts of Section 3 of AB 652.

Report Structure and Analytic Approach

Initial health assessments for children who have out-of-home placements are predominantly children who are in the foster care system.[5] Children in foster care are enrolled in Medi-Cal and health assessments are already a covered benefit under Medi-Cal. This is discussed in the *Background and Potential Impacts of the Mandate to Cover Initial Health Assessments* portion of the report. The *Medical Effectiveness* analysis summarizes the evidence base for those

[5] Other children who are considered to have an out-of-home placement are those (1) who are on probation or incarcerated or (2) who after a removal order issued by a judge, are waiting for a disposition hearing in court that decides whether the child should be removed or returned home. According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 62,248 children who were placed out of the home and of those, 4,294 were in probation or categorized as "other." CHBRP's analysis is restricted to children in the child welfare system and considered "in foster care."

services that fall under "initial health assessments." In addition, the *Medical Effectiveness* section summarizes the protocols for forensic medical evaluations.

Currently, forensic medical evaluations are not generally covered by health plans and policies, therefore the *Benefit Coverage, Utilization, and Cost Impacts* and *Public Health Impacts* sections focus the impact analysis on the provision mandating coverage of forensic medical evaluations.

Medical Effectiveness of Initial Health Assessments

CHBRP examined whether the services delivered in an initial health assessment are considered to be medically effective based on existing literature. Conclusions were drawn from the U.S. Preventive Services Task Force (USPSTF) recommendations, Centers for Disease Control (CDC) recommendations, and National Institutes of Health (NIH) guidelines. When there was no evidence-based recommendation for a service, CHBRP relied on other authoritative sources such as the American Academy of Pediatrics (AAP). Initial health assessment services are delivered through the California's Child Health and Disability Program, the State of California's health promotion and disease prevention program for children with Medi-Cal or children whose families are income-eligible. The components of the initial health assessment include health and developmental history; complete physical exam; oral health assessment; nutritional assessment; immunizations; vision screening; hearing screening; screening tests for anemia, lead, urine abnormalities, tuberculosis, and other problems as needed; and health education and anticipatory guidance.

Efficacy of Initial Health Assessment Services

Findings regarding the medical effectiveness of the services included in the initial health assessment for which coverage could be included under AB 652 are as follows:

- There is *a preponderance of evidence*[6] that the following preventive services for children and adolescents are *effective*:
    - Immunizations recommended by the Centers for Disease Control Advisory Committee on Immunization Practices
    - Screening children younger than 5 years for visual impairment
    - Screening of children age 6 and older for obesity
    - Screening of adolescents for major depressive disorder
    - Screening newborns for hearing loss
    - Providing Pap smears to sexually active adolescent females
    - Screening sexually active females for chlamydial infections
    - Counseling to prevent sexually transmitted infections among sexually active adolescents

[6]Appendix B lists CHBRP's definitions for the classifications of strength of evidence.

- There is *insufficient evidence*[7] to recommend for or against the following preventive services:
    - Screening asymptomatic children for iron deficiency anemia
    - Screening for elevated blood lead levels among those at increased risk for it
    - Counseling children and adolescents regarding nutrition
    - Screening for tobacco use or interventions to prevent and treat tobacco use
    - Counseling adolescents regarding alcohol use

- No meta-analyses, systematic reviews, or evidence-based guidelines could be located for some recommended preventive services for children and adolescents. In these cases, CHBRP relied on expert consensus or opinion. These services include:
    - Medical and developmental history
    - Physical examinations
    - Developmental and behavioral assessments
    - Preventive dental examinations
    - Urine testing at 5 years and for adolescents
    - Tuberculin testing for children and adolescents at high risk for tuberculosis
    - Screening for sexual activity and pregnancy risk for adolescent patients

Cost and Public Health Impacts of the Mandate to Cover Initial Health Assessments

AB 652 would require DMHC- and CDI-regulated plans and policies to cover initial health assessments for children who have been placed in an out-of-home placement within the last 30 days. The initial health assessment is to be covered whether it is provided in or out of network. Since most children with out-of-home placements are in foster care, CHBRP restricts this analysis to children in foster care. Initial health assessments for children in foster care are generally covered since children in foster care are enrolled in Medi-Cal and health assessments are already a covered benefit under Medi-Cal. All health plans and policies that are subject to AB 652 would be required to cover these initial health assessments (in or out of network), regardless of whether they are currently covered by Medi-Cal. Therefore, 21.9 million Californians are enrolled in plans and policies subject to AB 652.

- According to the Center for Social Services Research Child Welfare Dynamic Report System, as of October 2010, there were approximately 57,954 children who were in foster care. To obtain an annual estimate of the number of children who receive an initial health assessment, CHBRP relied on the number of children who *entered* foster care. For the most recent available annual data (time period covering October 2009 to September 2010)

[7]The lack of evidence for the effectiveness of these health education services is not evidence that such services are not beneficial.

approximately 28,244 children entered foster care in California and would have likely had an initial health assessment. Note that this estimate is a likely overestimate since this includes children who have been removed from the home for eight days and some children return home within the first 30 days. Others may have other placements, including at a shelter, with a family member, or with a foster family.

- CHBRP anticipates no measurable impact in terms of coverage, since these children are in the foster care system, are Medi-Cal eligible, and Medi-Cal provides reimbursement for initial health assessments for all children entering foster care regardless of the type of health insurance (if any) they had prior to entering foster care.

- CHBRP estimates no measurable change in utilization, nor any impacts on premiums or health care expenditures.

- Because no measurable changes in utilization are expected, no measurable impacts on public health are expected as a result of this provision in AB 652.

- It is possible for a foster child to also be covered by another form of health insurance while being enrolled in Medi-Cal. Therefore, it is possible that the effect of the mandate to cover initial health assessments would be to shift some costs incurred by Medi-Cal to health plans and policies that are subject to AB 652 for those services that are provided to foster children by out-of-network providers. However, reliable statewide data sources to validate or quantify this potential shift are not available. Therefore, CHBRP is unable to determine the magnitude of potential shifts in costs from Medi-Cal to health plans and insurers for in-network or out-of-network initial health assessments.

Medical Effectiveness of Forensic Medical Evaluations

The standard medical effectiveness evaluation criteria are not applicable for assessing forensic medical evaluations. Forensic medical evaluations are specialized interventions that are conducted to determine whether a child is a victim of child abuse or neglect. CHBRP's medical effectiveness review examines the California state protocols for performing forensic medical evaluations to determine whether children have been victims of physical abuse, neglect, or sexual abuse, and summarizes the methods for performing such evaluations. The literature on performing forensic medical evaluations derives from the following reports: California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, and California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims.

<u>Methods for Performing Forensic Medical Examinations</u>

- Physical Abuse
    - Attend to acute and trauma care needs
    - Take a complete history of the child's circumstance, medical history, and injuries from the parent or guardian and separately from the child if the child is verbal

- Perform a comprehensive physical exam including the child's head, eyes, mouth, and musculoskeletal system
- Indicated laboratory studies and X-rays should be performed to determine the full extent of inflicted injuries
- Perform an exam of the genitals and anus
- Collect and preserve the evidence of suspected physical abuse
- Report suspected child abuse and refer for consultation
- Complete the form *Medical Report: Suspected Child Physical Abuse and Neglect Examination CalEMA 2-900*
- Document the transfer of evidence from the medical providers to law enforcement, crime laboratories, and others

- Neglect
  - Take a complete medical history including, but not limited to, immunization history, developmental milestones, and information on schooling, and household information
  - Obtain and review past medical records from other medical providers
  - Perform a comprehensive physical and examine for substandard provision of hygiene, nutrition, medical care, and dental care
  - Perform an exam of the genitals and anus
  - Collect and preserve the evidence of suspected neglect
  - Complete the form *Medical Report: Suspected Child Physical Abuse and Neglect Examination CalEMA 2-900*
  - Document the transfer of evidence from the medical providers to law enforcement, crime laboratories, and others

- Sexual Abuse
  - Provide a coordinated approach to patient care when such care is available
  - Provide developmentally and psychologically appropriate care
  - Attend to acute and trauma care needs
  - Take a history of the sexual acts as reported by the historian and separately from the child
  - Take a medical history that assesses pre-existing abuse and sexual activity (among adolescents only)
  - Perform a general physical, rectal, and genital exam
  - Obtain tests for sexually transmitted diseases as indicated based on the history of contact

- Offer postcoital contraceptive medication to appropriate adolescents at risk of pregnancy from the sexual assault
- Offer prophylactic antibiotics to prevent sexually transmitted disease if indicated as well as prophylactic antiviral medication to prevent HIV if indicated
- Collect and preserve the evidence of sexual abuse
- Complete the form *Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination* when the incident of abuse occurred within the past 72 hours or the form *MedicalReport: Acute (>72 hours) Child/Adolescent Sexual Abuse Examination* when the incident of abuse occurred more 72 hours ago
- Record the names of persons to whom the evidence is distributed and obtain the signature of the officer receiving the evidence

Benefit Coverage, Utilization, and Cost Impacts of the Mandate to Cover Forensic Medical Evaluations

AB 652 would require DMHC- and CDI-regulated plans and policies to cover forensic medical evaluations at the request of local child welfare agencies or law enforcement. Table 1 provides a summary of the impact of this mandate on premiums paid by private and public employers and employees in the first year after implementation of the mandate. Among individuals in all plans subject to state regulation, AB 652 is estimated to increase premiums by about $6.86 million. Note that the total population in Table 1 reflects the full 21.9 million enrollees in DMHC- or CDI-regulated plans or policies that are included in the mandate under AB 652. The premium increases are estimated to be spread among all enrollees in all plans or policies, even though the forensic medical evaluations are assumed to be provided to enrolled children aged 0 through 17 years.

Table 1 summarizes the expected benefit coverage, cost, and utilization impacts for AB 652.

Benefit Coverage Impacts

- Of the population subject to the mandate, 13.5% of enrollees have coverage for forensic medical evaluations (Table 1). If AB 652 were enacted, 100% of this population would have full coverage for forensic medical evaluations paid for by their health insurance.
- CHBRP estimates no measurable impact of the mandate on the number of uninsured due to premium increases.

Utilization Impacts

- CHBRP estimated that 9.1% of physical and sexual abuse allegations receive a forensic medical evaluation each year. According to the Center for Social Services Research Child Welfare Dynamic Report System, in 2009 there were 133,169 child abuse allegations (for physical and sexual abuse) in California. Therefore, among individuals in health plans and policies affected by the mandate, CHBRP estimates that there are approximately 9,000

forensic medical evaluations performed yearly and of those, about 1,000 enrollees receiving an evaluation currently have coverage.

- Postmandate, for enrollees affected by AB 652, forensic medical evaluations could be paid for by health insurance plans and policies, representing a possible maximum shift from local child welfare agencies and law enforcement funding to insurance of an estimated $5.95 million.

Cost Impacts

- CHBRP estimated the average per-unit cost of forensic medical evaluations to be $735.
- The mandate is estimated to increase premiums by about $6.86 million. The distribution of the impact on premiums is as follows:
    - Total employer premium expenditures for CalPERS HMOs are estimated to increase by $177,000, or 0.0051%.
        - Of the amount CalPERS would pay in additional premium, about 58% or $103,000 would be state expenditures for CalPERS HMO members who are state employees or their dependents.
    - Enrollee contributions toward premiums for group insurance are estimated to increase by $817,000, or 0.0054%.
    - Total premiums for purchasers of individual market health insurance are estimated to increase by $464,000, or 0.0069%.
- Expenditures for Medi-Cal Managed Care Plans are estimated to increase by $2.17 million, or 0.0250%.
- Expenditures for MRMIB Plans are estimated to increase by $737,000, or 0.0701%.
- Increases in per member per month (PMPM) total premiums for the newly mandated benefit coverage vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from an average of 0.0022% (for CDI-regulated large-group market) to an average of 0.0701% (for MRMIB plans) in the affected market segments. Increases as measured by PMPM premiums are estimated to range from an average of $0.01 to $0.08.
- Total health expenditures are projected to increase by approximately $911,000 (0.0010%) for the year following implementation of the mandate (Table 1).

Public Health Impacts of the Mandate to Cover Forensic Medical Evaluations

- The standard public health outcomes for evaluating health benefit coverage are not applicable in the case of forensic medical evaluations. Forensic medical evaluations are a specialized

type of medical intervention used for the purposes of determining and documenting whether a child is a victim of child abuse or neglect.

- CHBRP found no evidence in the literature related to forensic exams and health outcomes. Therefore, the public health impact is unknown. Please note that the "absence of evidence" is not "evidence of no effect." It is possible that an impact—positive or negative—could result. However, currently available scientific evidence does not allow CHBRP to project either.

- Although AB 652 could impact utilization of forensic medical evaluations, CHBRP is unable to estimate any change in utilization. Therefore, the public health impact is unknown.

Potential Effects of the Federal Affordable Care Act

The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (H.R.4872) were enacted in March 2010. These laws—together referred to as the "Affordable Care Act" (ACA)—are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years would affect the baseline, or current, enrollment, expenditures, and premiums. It is important to note that CHBRP's analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report.

Essential Health Benefits for Qualified Health Plans Sold in the Exchange and Potential Interactions with AB 652

Beginning 2014, the ACA requires states to "make payments…to defray the cost of any additional benefits" required of qualified health plans (QHPs) sold in the Exchange. In addition, the U.S. Department of Health and Human Services is to ensure that the definition of essential health benefits (EHBs) "is equal to the scope of benefits provided under a typical employer plan." It is likely that EHBs may be defined to include many components of an initial health assessment under the EHB categories "preventive and wellness services" and "pediatric services, including oral and vision care."[8] It is conceivable that EHBs may be defined to include forensic medical examinations for children (e.g., under "pediatric services"); however, these services are typically not provided by employer-sponsored health insurance. Therefore, it is unclear whether EHBs would be defined to include all the services mandated by AB 652 and it is unclear that whether, beginning in 2014, AB 652 would incur a fiscal liability for the state for QHPs sold in the Exchange. This potential liability would depend on three factors:

- Differences in the scope of benefits in the final EHB package and the scope of mandated benefits in AB 652;

[8] The ACA creates four benefit tiers for the state exchange; bronze, silver, gold, and platinum. All tiers include a pediatric dental requirement for all levels of coverage.

- The number of enrollees in QHPs; and
- The methods used to define and calculate the cost of additional benefits.

All of these factors are unknown at this time, and are dependent upon the details of pending federal regulations, state legislative and regulatory actions, and enrollment into QHPs after the Exchange is implemented.

Table 1. AB 652 (Forensic Medical Evaluations) Impacts on Benefit Coverage, Utilization, and Cost, 2011

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0%
Total enrollees with health insurance subject to AB 652	21,902,000	21,902,000	0	0%
Percentage of enrollees with coverage for the mandated benefit	13.5%	100.0%	86.5%	639%
Number of enrollees with coverage for the mandated benefit	2,963,000	21,902,000	18,939,000	639%
Utilization and cost				
Enrollees having undergone a forensic medical evaluation—with coverage	976	9,068	8,093	829%
Enrollees having undergone a forensic medical evaluation—without coverage	8,093	-	-8,093	-100%
Average per unit cost of forensic medical evaluation	$735	$735	-	0%
Expenditures				
Premium expenditures by private employers for group insurance	$52,713,266,000	$52,715,761,000	$2,495,000	0.0047%
Premium expenditures for individually purchased insurance	$6,724,851,000	$6,725,315,000	$464,000	0.0069%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP (b)	$15,173,472,000	$15,174,289,000	$817,000	0.0054%
CalPERS HMO employer expenditures (c)	$3,465,785,000	$3,465,962,000	$177,000	0.0051%
Medi-Cal Managed Care Plan expenditures	$8,657,688,000	$8,659,855,000	$2,167,000	0.0250%
MRMIB Plan expenditures (d)	$1,050,631,000	$1,051,368,000	$737,000	0.0701%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	$7,548,415,000	$7,548,415,000	$0	0.0000%
Enrollee expenses for noncovered benefits (e)	$0	$0	$0	0.0000%
Expenses incurred by County (f)	$5,946,000	$0	-5,946,000	-100%
Total Expenditures	$95,340,054,000	$95,340,965,000	$911,000	0.0010%

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) Of the increase in CalPERS employer expenditures, about 58% or $103,000 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, 8,000 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. 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.
(f) Includes only expenses relating to forensic medical evaluations that are currently paid by the requesting party, typically either law enforcement agencies or local child welfare agencies.
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 652. In response to a request from the California Assembly Committee on Health on February 17, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, Chris Tonner, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Yali Bair, PhD (Consultant), and Dominique Ritley, MPH, of the University of California, Davis, prepared the public health impact analysis. Todd Gilmer, PhD, and Meghan Martinez, MPH, (Consultant) of the University of California, San Diego, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Michael Cabana, MD, MPH, of the University of California, San Francisco, and Marilyn Kaufhold, MD, of the Chadwick Center for Children and Families, Rady Children's Hospital, provided technical assistance with the literature review and expert input on the analytic approach. Susan Philip, MPP, and Garen Corbett, MS, of CHBRP staff prepared the background on impact analysis of initial health assessments and 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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