



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Executive Summary
Analysis of Assembly Bill 1800:
Health Care Coverage

A Report to the 2011-2012 California Legislature
April 23, 2012

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1800

The California Assembly Committee on Health requested on February 27, 2012, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1800, a bill that would impact the terms and conditions of coverage of plans and policies. On March 13, 2012, the Assembly Committee on Health requested CHBRP to analyze proposed amended language to AB 1800 (AB 1800 was amended in Assembly on March 20, 2012). In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

Analysis of AB 1800

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.² Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate), and another portion has health insurance subject to other state law or only to federal laws.

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

All DMHC-regulated plans would be subject to AB 1800, but only CDI-regulated policies that provide outpatient prescription drug coverage would be subject to AB 1800. Therefore, the mandate would affect the health insurance of approximately 21.7 million Californians.

AB 1800 contains multiple requirements. As noted below, the requirements have differing effective dates and apply to differing segments of the health insurance market.

- In 2013, for all DMHC-regulated plans, and for CDI-regulated policies that provide outpatient prescription drug coverage, AB 1800 would require a limit on annual out-of-pocket expenses for all covered benefits, including prescription drugs. Throughout this report, the "limit on annual out-of-pocket expenses" is referred to as an "annual out-of-pocket maximum." The annual out-of-pocket maximum that AB 1800 would establish

¹ Available at: http://www.chbrp.org/documents/authorizing_statute.pdf.

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

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

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

includes copayments, coinsurance, deductibles, and any other form of cost sharing.⁵ AB 1800 indicates that the annual out-of-pocket maximum is not to exceed the limit established in Section 1302(c) of the Affordable Care Act (ACA).⁶ Section 1302(c) of the ACA references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines maximum annual out-of-pocket expenses for high deductible health plans (HDHPs). In 2012, the maximum annual out-of-pocket expenses in effect for HDHPs are \$6,050 for self-only coverage and \$12,100 for family coverage.⁷

- In 2013, for all DMHC-regulated plans, AB 1800 would prohibit limitations on maximum coverage of basic health care services.
- In 2013, for all DMHC-regulated plans, AB 1800 would allow enrollees to challenge exclusions of prescription drug coverage through the independent medical review (IMR) process.
- In 2014, for all DMHC-regulated plans and all CDI-regulated policies, AB 1800 would prohibit a separate deductible applied to prescription drugs. A general deductible can apply to prescription drugs, but there cannot be a general deductible *and* a separate deductible for prescription drugs.

Existing California requirements

DMHC has regulatory authority to review cost-sharing arrangements and other limitations to ensure that the contract requirements are “fair, reasonable, and consistent with the objectives of the chapter” and are not held to be objectionable by the director.⁸ Copayments, deductibles, and other limitations cannot “render the benefit illusory.”⁹ This concept is not further defined in regulation or policy, except in regulations for outpatient prescription drug benefits. Under these regulations, copayment or percentage coinsurance cannot exceed 50% of the cost to the plan, and these regulations specify how such costs are to be calculated.¹⁰ These regulations also require for *coinsurance* on prescription drugs that it either: (1) have a per prescription out-of-pocket maximum; (2) apply toward the plan’s total annual out-of-pocket maximum; or (3) apply toward a prescription drug-specific annual out-of-pocket maximum. CDI-regulated policies are not subject to these requirements.

⁵ Cost sharing is generally understood to not include premiums. Premium payments would not accrue towards the annual out-of-pocket maximum.

⁶ 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 are together referred to as the “Affordable Care Act.”

⁷ Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 sets a baseline maximum annual out-of-pocket expense for HDHPs of \$5,000 for self-only coverage and \$10,000 for family coverage, but these dollar amounts are altered annually by a cost-of-living adjustment [Section 223(g) of the Internal Revenue Code]. Because the U.S. Department of the Treasury Internal Revenue Service has not released the annual out-of-pocket maximum dollar values for HDHPs for 2013, this report reflects estimates based on the maximum annual out-of-pocket expenses for HDHPs in effect in 2012.

⁸ Health & Safety Code Section 1367(h) and 1367(i). AB 1800 would alter Health & Safety Code Section 1367(i).

⁹ California Code of Regulations, Title 28, section 1300.67.4.

¹⁰ California Code of Regulations, Title 28, section 1300.67.24.

CDI-regulated policies place limits on expenses paid by the insured by focusing on establishing an “economic value” for the product. All policies (group and individual) are to be economically sound.¹¹

In addition, both DMHC-regulated plans and CDI-regulated policies are subject to the IMR process for covered benefits.¹² And, both DMHC-regulated plans and CDI-regulated policies are required to comply with Section 2711 of the federal Public Health Service Act, which prohibits lifetime limits or unreasonable annual limits on the dollar value of benefits.¹³

Requirements in other states

CHBRP is aware of similar mandates in Massachusetts (enacted in 2006), New Jersey (enacted in 1992), and Vermont (enacted in 2011) that place restrictions on out-of-pocket maximums and benefit limits. Maine (enacted in 2012) and New York (enacted in 2010) have mandates that place restrictions on cost sharing for prescription drugs.

Medical Effectiveness

CHBRP’s medical effectiveness analysis for AB 1800 focuses on the impact of annual out-of-pocket maximums and deductibles. The analysis does not address the effectiveness of specific treatments because AB 1800 would not mandate coverage for any specific treatments, but instead would impact the terms and conditions of coverage.

Study Findings

Cost sharing in general

- A large number of studies have been published on the effects of cost sharing (e.g., the portion of expenditures paid by enrollees in such forms as copayments, coinsurance, deductibles, and annual out-of-pocket maximums that are applied when enrollees use treatments) on the use of health care services by persons with health insurance.
- Studies of the effects of cost sharing on privately insured, nonelderly adults, the population to which AB 1800 would apply, have generally demonstrated:
 - Persons who face higher cost sharing for a particular type of health care service use less of that service than persons who face lower cost sharing.
 - Persons who face higher cost sharing reduce use of both essential and nonessential health care services.
 - Cost sharing has stronger effects on use of health care services by low-income persons than high-income persons.

¹¹ Insurance Code Section 10291.5(a)(1).

¹² Health & Safety Code Section 1374.30; Insurance Code Section 10169.

¹³ Health and Safety Code Sections 1367.001 and 1367.003; Insurance Code Sections 10112.1 and 10112.25.

- The literature on cost sharing has several important limitations:
 - The only randomized controlled trial, the RAND Health Insurance Experiment, was conducted in the 1970s.
 - More recent studies have made valuable contributions to understanding the effects of cost-sharing, but lack of randomization limits the strength of the evidence they provide.
- Most studies of cost sharing do not address annual out-of-pocket maximums or deductibles.
 - The vast majority of studies examine small changes in copayments. Persons may respond differently to changes in annual out-of-pocket maximums or deductibles, which are often much larger than copayments.
 - Copayments also function differently from annual out-of-pocket maximums and deductibles. Copayments must be paid every time a treatment subject to the copayment is provided. In contrast, persons who have a deductible must pay the full cost of treatments subject to the deductible until they reach their deductible. How persons respond to deductibles may differ depending on whether they anticipate reaching their deductible.

Annual out-of-pocket maximums

- CHBRP found no studies of the impact of implementing an annual out-of-pocket maximum that were conducted in the United States.
- CHBRP found a few studies of annual out-of-pocket maximums that were carried out in other countries. These studies are not directly relevant to AB 1800 because the annual out-of-pocket maximums assessed were much smaller than the annual out-of-pocket maximums that AB 1800 would establish and were instituted simultaneously with other changes in cost sharing that may have affected the results.

Deductibles

- CHBRP found no studies that compared the effect of having a single deductible for prescription drugs and other covered benefits versus having separate deductibles for prescription drugs and other covered benefits.
- Most of the recent literature on the impact of deductibles has addressed HDHPs, also known as consumer-directed health plans, which are defined in 2012 as health plans that have a deductible of at least \$1,200 for an individual and \$2,400 for a family.
- Studies of HDHPs have compared persons in these plans to persons enrolled in health maintenance organizations (HMOs) or preferred provider organizations (PPOs).
- Studies of HDHPs in which prescription drugs were subject to the deductible had the following findings:
 - A single well-designed study found that persons enrolled in HDHPs were as likely to fill any prescriptions as persons enrolled in PPOs.

- The evidence regarding effects of HDHPs on the number of prescriptions filled is ambiguous because findings vary widely across studies.
- The preponderance of evidence from two studies suggests that persons enrolled in HDHPs are more likely than persons enrolled in PPOs to discontinue use of some classes of prescription drugs for chronic conditions.
- The preponderance of evidence from two studies suggests that persons enrolled in HDHPs are less likely than persons enrolled in PPOs to be adherent to daily prescription drug therapy for some chronic conditions.
- Studies of adherence to prescription drug therapy for chronic conditions generally find that poorer adherence is associated with worse health outcomes and higher rates of hospitalization and emergency department visits.
- Findings regarding effects of HDHPs on use of other types of treatments were not reviewed because the provision of AB 1800 that concerns deductibles specifically addresses deductibles for prescription drugs.

Benefit Coverage, Utilization, and Cost Impacts

AB 1800 would apply an annual out-of-pocket maximum for all covered benefits to all DMHC-regulated plans, and to CDI-regulated policies that provide outpatient prescription drug coverage, affecting the health insurance of approximately 21.7 million people. Table 1 summarizes the expected benefit coverage, utilization, and cost impacts of this specific requirement of AB 1800.

Only the effect of the annual out-of-pocket maximum on all covered benefits is reflected in the benefit cost, coverage, and utilization estimates in this report and in Table 1.

Analytic Approach and Assumptions

- For this analysis, CHBRP does not assume any changes to existing out-of-pocket cost sharing aside from the mandated change specified in AB 1800 (e.g., no changes in copayments or coinsurance).

Benefit Coverage Impacts

- 63.9% of enrollees (or 13.9 million) have coverage that is not compliant with the mandate.
- Among the enrollees with an outpatient prescription benefit, CHBRP estimates that:
 - 61.0% of enrollees (or 13.2 million) have an annual out-of-pocket maximum for their plan or policy, but prescription drugs are excluded from the annual out-of-pocket maximum.

- The California Public Employees' Retirement System (CalPERS) HMO, Medi-Cal Managed Care plans, and the Managed Risk Medical Insurance Board (MRMIB) plans provide all covered benefits either at no charge, with minimal cost-sharing requirements, or with cost-sharing requirements already compliant with the annual out-of-pocket maximum. Hence, CHBRP estimates no impact on these publicly funded plans.
- Of the 21.7 million enrollees in plans and policies subject to AB 1800, CHBRP estimates that 3.3% would have their cost sharing reduced as a result of the annual out-of-pocket maximum AB 1800 would require. CHBRP estimates that for a majority of these enrollees their cost sharing would be reduced by \$213 or less.
- Due to premium increases among enrollees in CDI-regulated policies, CHBRP estimates that the number of uninsured will increase by 5,151.¹⁴

Utilization Impacts

- CHBRP projects no overall change in the number of users of health care. However, CHBRP estimates an increase in utilization by users as a result of the decrease in enrollee out-of-pocket cost-sharing expenses. This increase in utilization by existing users would result in costs being shifted from enrollees to plans and policies. CHBRP estimates that the total medical cost per user paid by a plan or policy would increase by 1% and the total medical cost per enrollee would decrease by 3%.

Cost Impacts

- Increases in per member per month (PMPM) premiums vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from 0.00% (CalPERS HMO, Medi-Cal Managed Care plans, and MRMIB plans) to 2.06% (for CDI-regulated small-group market).
- Increases as measured by PMPM premiums are estimated to range from \$0.00 to \$8.52 (for CDI-regulated small-group market).
- In the privately funded large-group market, the increase in premiums is estimated to range from an average \$2.12 PMPM among the DMHC-regulated plans to \$7.11 PMPM among CDI-regulated policies.
- In the privately funded small-group market, the increase in premiums is estimated to range from an average \$1.28 PMPM among the DMHC-regulated plans to \$8.52 PMPM among CDI-regulated policies.
- Total expenditures are estimated to increase by \$246.5 million (or 0.24%). This is due to a \$522.0 million increase in total premiums partially offset by reductions in employee cost sharing of \$275.5 million.

¹⁴ Implementation of the ACA in 2014 could alter this estimate.

Public Health Impacts

CHBRP's public health analysis for AB 1800 focuses on the impact of annual out-of-pocket maximums and deductibles.

- AB 1800's requirement establishing an annual out-of-pocket maximum on all covered benefits, including prescription drugs if covered, may have a public health impact in reducing the financial burden for enrollees who exceed the limit proposed. However, given the insufficient evidence on the effects of instituting an annual pocket maximum for all covered benefits, the potential magnitude of the public health impact is unknown.
- AB 1800's requirement prohibiting separate deductibles for prescription drugs and other covered benefits may have a public health impact. However, given the lack of data on the effects of this requirement, the potential magnitude of the public health impact is unknown.
- CHBRP expects that AB 1800 has the potential to improve health outcomes and reduce premature mortality for individuals with chronic conditions. However, evidence is limited in this area, and therefore, CHBRP cannot estimate the magnitude of the effects on disparities, premature mortality, economic burden, or long-term health impacts for people with chronic conditions.
- Due to premium increases among enrollees in CDI-regulated policies, CHBRP estimates that the number of uninsured will increase by 5,151. Losing health insurance can have harmful consequences.

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. Some provisions of the ACA enacted federal health insurance benefit mandates.¹⁵ Please see *Addendum A* of this executive summary for a more in-depth discussion of AB 1800's interaction with these federal health insurance benefit mandates.¹⁶ Below is a brief

¹⁵ The benefit mandates enacted by the ACA and other federal benefit mandates appear in a list updated regularly by CHBRP. See *Current Mandates: Health Insurance Benefit Mandates in California State Law*, available at: http://www.chbrp.org/other_publications/index.php.

¹⁶ For further discussion on how state benefit mandates may interact with essential health benefits and the benchmark plan regulatory approach, please see CHBRP issue brief, *Interaction Between California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits,"* available at: http://www.chbrp.org/other_publications/index.php.

summary of how the annual out-of-pocket maximum requirement in AB 1800 may interact with the essential health benefits (EHBs) requirement in the ACA.

Effects beginning in 2014: essential health benefits and AB 1800

The ACA requires non-grandfathered small-group and individual health insurance, including but not limited to qualified health plans (QHPs) sold through the California Exchange, to cover specified categories of benefits, EHBs,¹⁷ beginning January 1, 2014. The ACA allows a state to require QHPs sold through an exchange to provide benefits that are “in addition to” EHBs. However, if the state does so, the state must defray the cost of those additionally mandated benefits that exceed EHBs, either by paying the purchaser directly, or by paying the QHP.

In 2014 and 2015, the U.S. Department of Health and Human Services (HHS) has proposed that each state define its own EHBs for those years by selecting one of a set of specified benchmark plan options.¹⁸ The choice of benchmark plan is expected to dictate which state benefit mandates, if any, will be included in the state’s EHBs.¹⁹ HHS has not released final guidance on defining the EHBs or final guidance on how states will defray the costs of state benefit mandates that require QHPs to exceed EHBs. However, it seems likely that states would be required to defray the marginal cost impact associated with the state benefit mandates’ exceeding EHBs. Because the state would be fiscally responsible for mandates exceeding EHBs, CHBRP is providing the following consideration of how the benefit mandate in AB 1800 might interact with EHBs.

Section 1302(c) of the ACA places restrictions on cost sharing for plans and policies required to provide coverage for EHBs, regardless of the benchmark plan chosen for defining the EHBs. AB 1800 defines the annual out-of-pocket maximum it would place on all DMHC-regulated plans, and on CDI-regulated policies that provide outpatient prescription drug coverage, as the limit in Section 1302(c). Because AB 1800 does not mandate coverage for a specific benefit, but, rather, addresses cost sharing for covered benefits, it is not clear whether the state would be fiscally responsible for the requirements of AB 1800 were it to exceed those required for plans and policies that cover EHBs. However, plans and policies sold in California’s Exchange, for which the state would be fiscally responsible for any mandates that exceed the EHBs, will be required to comply with the cost-sharing requirements of Section 1302(c) of the ACA. Therefore, although AB 1800 applies more broadly than just to plans and policies required to cover EHBs, AB 1800 does not go beyond the cost-sharing requirements of the EHBs in regard to plans and policies sold in the Exchange. Table 0 below shows the annual out-of-pocket maximum requirement in AB 1800 as compared to the annual out-of-pocket maximum requirement in Section 1302(c) of the ACA.

¹⁷ ACA Section 1302(b).

¹⁸ The selected benchmark plan will have to provide services in each of the EHB categories specified in Section 1302(b) of the ACA: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

¹⁹ CCIIO, *Essential Health Benefits Bulletin*. (December 2011). Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Table 0. Comparison of the Annual Out-of-Pocket Maximum in AB 1800 With the Annual Out-of-Pocket Maximum in ACA Section 1302(c) Across Market Segments

	Large-Group Market	Small-Group Market	Individual Market
AB 1800—annual out-of-pocket maximum as defined by ACA Section 1302(c)	<ul style="list-style-type: none"> • All DMHC-regulated plans subject • CDI-regulated policies that provide outpatient prescription drug coverage subject 		
ACA Section 1302(c)—annual out-of-pocket maximum for plans/policies that are required to provide coverage for EHBs	Not required to cover EHBs nor meet the cost-sharing requirements for EHBs	Non-grandfathered DMHC-regulated plans and CDI-regulated policies subject	Non-grandfathered DMHC-regulated plans and CDI-regulated policies subject

Source: California Health Benefits Review Program, 2012.

Key: ACA=Affordable Care Act; CDI=California Department of Insurance; DMHC=Department of Managed Health Care; EHBs=essential health benefits.

Effects beginning in 2016: essential health benefits and AB 1800

As previously noted, HHS has not yet defined EHBs for the period after 2014 and 2015. However, AB 1800 does not require a specific benefit mandate, but places restrictions on cost-sharing terms for benefit mandates. The annual out-of-pocket maximum that would be applied to plans and policies under AB 1800 aligns with the annual out-of-pocket maximum required under Section 1302(c) of the ACA, which does not appear to change even if the definition of the EHBs changes.

Table 1. AB 1800 (Annual Out-of-Pocket Maximum Requirement Only) Impacts on Benefit Coverage, Utilization, and Cost, 2012

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,882,000	21,882,000	0	0%
Total enrollees with health insurance subject to AB 1800	21,660,000	21,660,000	0	0%
Percentage of enrollees with coverage for the mandated benefit				
No pharmacy coverage with OOPM >\$6,050 (DMHC)	0.5%	0.0%	-0.5%	-100%
Outpatient pharmacy coverage Rx cost share not included in OOPM	61.0%	0.0%	-61.0%	-100%
Outpatient pharmacy coverage Rx cost share included in OOPM >\$6,050	2.4%	0.0%	-2.4%	-100%
OOPM<\$6,050 for all covered benefits	36.1%	100.0%	63.9%	177%
Number of enrollees with coverage for the mandated benefit				
No pharmacy coverage with OOPM >\$6,050 (DMHC)	106,333	0	-106,333	-100%
Outpatient pharmacy coverage Rx cost share not included in OOPM	13,220,970	0	-13,220,970	-100%
Outpatient pharmacy coverage Rx cost share included in OOPM >\$6,050	511,317	0	-511,317	-100%
OOPM<\$6,050 for all covered benefits	7,821,380	21,660,000	13,838,620	177%
Utilization and Cost				
Number of utilizers	19,819,311	19,819,311	0	0%
Total medical cost per utilizer paid by plan	\$345.59	\$347.45	\$1.86	1%
Total medical cost per utilizer paid by member	\$34.67	\$33.51	-\$1.16	-3%

Table 1. AB 1800 (Annual Out-of-Pocket Maximum Requirement Only) Impacts on Benefit Coverage, Utilization, and Cost, 2012 (Cont'd)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Expenditures				
Premium expenditures by private employers for group insurance	\$60,279,820,000	\$60,640,964,000	\$361,144,000	0.5991%
Premium expenditures for individually purchased insurance	\$7,543,951,000	\$7,616,712,000	\$72,761,000	0.9645%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM, or MRMIP (b)	\$14,706,245,000	\$14,794,337,000	\$88,092,000	0.5990%
CalPERS HMO employer expenditures (c)	\$3,651,121,000	\$3,651,121,000	\$0	0.0000%
Medi-Cal Managed Care plan expenditures	\$7,637,700,000	\$7,637,700,000	\$0	0.0000%
MRMIB plan expenditures (d)	\$1,046,243,000	\$1,046,243,000	\$0	0.0000%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$8,521,470,000	\$8,245,975,000	-\$275,495,000	-3.2330%
Total Expenditures	\$103,386,550,000	\$103,633,052,000	\$246,502,000	0.2384%

Source: California Health Benefits Review Program, 2012.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment sponsored insurance.

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

(c) No increase in CalPERS employer expenditures is expected. Where there an increase, about 58% would be state expenditures for CalPERS members who are state employees or their dependents.

(d) MRMIB plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 7,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

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; OOPM=out-of-pocket maximum.

Addendum A

Effects of the Federal Affordable Care Act

As stated previously, the federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws (together referred to as the “Affordable Care Act [ACA]”) are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014.

Provisions of the ACA that go into effect during the transitional years (2010–2013) affect current enrollment (the baseline), expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP’s estimates of these marginal effects are presented in this report. Each of the provisions that have gone into effect by January 2012 has been considered, and where data allow, CHBRP has made adjustments to the Cost and Coverage Model to reflect changes in enrollment and/or baseline premiums. These adjustments are discussed in further detail in Appendix D.

Some provisions of the ACA enacted federal health insurance benefit mandates.²⁰ The mandates relevant to AB 1800 are discussed below.

Effective 2010: lifetime and annual limits and external review

Lifetime and annual limits. The ACA amended Section 2711 of the PHSA, prohibiting lifetime or annual limits on the dollar value of benefits.²¹ This applies to large- and small-group and individual plans and policies, with some exceptions. These exceptions include:

- Prior to 2014, a group or individual health plan or policy can establish a restricted annual limit on the dollar value of benefits with respect to the scope of benefits that are essential health benefits (EHBs) under Section 1302(b) of the ACA;²² and
- The prohibition on lifetime and annual limits apply to grandfathered plans,²³ with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits.²⁴

²⁰ The benefit mandates enacted by the ACA and other federal benefit mandates appear in a list updated regularly by CHBRP. See *Current Mandates: Health Insurance Benefit Mandates in California State Law*, available at: http://www.chbrp.org/other_publications/index.php

²¹ ACA Section 1001 amending Section 2711 of the PHSA.

²² The Interim Final Rule in the Federal Register on June 28, 2010, clarified that prior to essential health benefits being defined, “good faith efforts to comply with a reasonable interpretation of the term ‘essential health benefits’” would be recognized. The Interim Final Rule is available at: <http://69.175.53.6/register/2010/jun/28/2010-15278.pdf>.

²³ A grandfathered health plan is defined as “A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their ‘grandfathered’ status if they make certain

AB 1800 deletes language from the Health and Safety Code that allows DMHC-regulated plans to place limitations on maximum coverage for BHCS. DMHC-regulated plans are already required to comply with Section 2711 of the PHSA, prohibiting lifetime limits and annual limits on the dollar value of benefits, with the above exceptions—restricted annual limits are allowed prior to 2014, and grandfathered plans in the individual market are not subject to the prohibitions on annual limits. However, AB 1800 applies more broadly than Section 2711 of the PHSA in some respects. AB 1800 appears to: (1) prohibit any DMHC-regulated plan, including grandfathered individual market plans, from placing an annual limit on the dollar value of benefits for BHCS; (2) not allow for restricted annual limits for BHCS; and (3) prohibit limits on the scope of benefits for BHCS (see Table 2 below). It is important to note that AB 1800 is only addressing limitations on maximum coverage for BHCS, whereas Section 2711 of the PHSA applies to covered benefits more broadly.

Table 2. Comparison of Prohibitions on Limits for DMHC-Regulated Plans Required by AB 1800 and by the ACA

Limit	AB 1800	ACA: 2010-2013*	ACA: 2014 and Beyond*
Prohibition on annual limits on the dollar value of benefits	Yes: <ul style="list-style-type: none"> All DMHC-regulated plans Only BHCS 	Yes—some exceptions: <ul style="list-style-type: none"> Grandfathered plans in the individual market excluded Restricted annual limits allowed for EHBs 	Yes—some exceptions: <ul style="list-style-type: none"> Grandfathered plans in the individual market excluded
Prohibition on lifetime limits on the dollar value of benefits	Yes: <ul style="list-style-type: none"> All DMHC-regulated plans Only BHCS 	Yes—applies to all DMHC-regulated plans	Yes—applies to all DMHC-regulated plans
Prohibition on limits on the scope of benefits (e.g., visit limits)	Yes: <ul style="list-style-type: none"> All DMHC-regulated plans Only BHCS 	No	No

Source: California Health Benefits Review Program, 2012.

Note: (*) ACA Section 1001 amending Section 2711 of the PHSA.

Key: BHCS=basic health care services; DMHC=Department of Managed Health Care; EHBs=essential health benefits; PHSA=Public Health Service Act.

It is not clear how many DMHC-regulated plans in the individual market are “grandfathered” and therefore currently not required to comply with the restrictions on annual limits, but would appear to be required to under AB 1800 for BHCS. However, the U.S. Departments of Labor and Treasury estimate that by 2013, between 40% and 67% of policies in the individual market will have relinquished their grandfathered status.²⁵

significant changes that reduce benefits or increase costs to consumers”

(www.healthcare.gov/glossary/g/grandfathered-health.html).

²⁴ ACA Section 1251(a)(4).

²⁵ U.S. Department of Labor and Department of Treasury. *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*. (June 17, 2010). Available at: www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf.

External review. The ACA requires plans and policies to provide for external review.²⁶ California's IMR process has been deemed to meet the external review requirements established under the ACA. It is not clear whether the component of AB 1800 that would allow approved exclusions to a prescription drug benefit to go to IMR would interact with the ACA's requirements for external review, but it seems likely it would not.

Effective 2014: essential health benefits

The ACA requires non-grandfathered small-group and individual health insurance, including but not limited to QHPs sold through the California Exchange, to cover specified categories of benefits, EHBs,²⁷ beginning January 1, 2014. The ACA defines EHBs as including these categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The Secretary of HHS is charged with defining these categories through regulation and ensuring that the EHB floor "is equal to the scope of benefits provided under a typical employer plan."

The ACA allows a state to require QHPs sold through an exchange to provide benefits that are "in addition to" EHBs. However, if the state does so, the state must defray the cost of those additionally mandated benefits that exceed EHBs, either by paying the purchaser directly, or by paying the QHP.

In 2014 and 2015, HHS has proposed that each state define its own EHBs for those years by selecting one of a set of specified benchmark plan options. The choice of benchmark plan is expected to dictate which state benefit mandates, if any, will be included in the state's EHBs.²⁸ Any state-mandated benefit enacted after December 31, 2011, may not be part of the EHBs for 2014 and 2015.²⁹ If passed, AB 1800 would be effective January 1, 2013. Therefore, if any proposed benefit coverage mandates included in AB 1800 exceed EHBs, as defined in 2014 and 2015, California may be required to defray the cost for QHPs sold through an Exchange.

HHS has not released final guidance on defining the EHBs or final guidance on how states will defray the costs of state benefit mandates that require QHPs to exceed EHBs. However, it seems likely that states would be required to defray the marginal cost impact associated with the state benefit mandates' exceeding EHBs. Such a marginal cost may be calculated in a fashion similar to the manner in which CHBRP estimates marginal cost impacts when assessing benefit mandate bills on behalf of the California Legislature. For further discussion on how state benefit mandates may interact with the EHBs and the benchmark plan regulatory approach, please see the CHBRP

²⁶ ACA Section 1001 modifying Section 2719 of the PHSA.

²⁷ ACA Section 1302(b).

²⁸ CCIIO, *Essential Health Benefits Bulletin*. (December 2011). Available at:

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

²⁹ CCIIO, *Frequently Asked Questions on Essential Health Benefit Bulletin*. (February 2012). Available at:

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

issue brief, *Interaction Between California’s State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits.”*³⁰

Effects beginning in 2014: essential health benefits and AB 1800

Because the state would be fiscally responsible for mandates exceeding EHBs, CHBRP is providing the following consideration of how the benefit mandate in AB 1800 might interact with EHBs.

Section 1302(c) of the ACA places restrictions on cost sharing for plans and policies required to provide coverage for EHBs, regardless of the benchmark plan chosen for defining the EHBs. AB 1800 defines the annual out-of-pocket maximum it would place on all DMHC-regulated plans, and on CDI-regulated policies that provide outpatient prescription drug coverage, as the limit in Section 1302(c). Because AB 1800 does not mandate coverage for a specific benefit, but rather addresses cost sharing for covered benefits, it is not clear whether the state would be fiscally responsible for the requirements of AB 1800 were it to exceed those required for plans and policies that cover EHBs. However, plans and policies sold in California’s Exchange, for which the state would be fiscally responsible for any mandates that exceed the EHBs, will be required to comply with the cost-sharing requirements of Section 1302(c) of the ACA. Therefore, although AB 1800 applies more broadly than just to plans and policies required to cover EHBs, AB 1800 does not go beyond the cost-sharing requirements of the EHBs in regard to plans and policies sold in the Exchange. Table 3 below shows the annual out-of-pocket maximum requirement in AB 1800 as compared to the annual out-of-pocket maximum requirement in Section 1302(c) of the ACA.

Table 3. Comparison of the Annual Out-of-Pocket Maximum in AB 1800 With the Annual Out-of-Pocket Maximum in ACA Section 1302(c) Across Market Segments

	Large-Group Market	Small-Group Market	Individual Market
AB 1800—annual out-of-pocket maximum as defined by ACA Section 1302(c)	<ul style="list-style-type: none"> All DMHC-regulated plans subject CDI-regulated policies that provide outpatient prescription drug coverage subject 		
ACA Section 1302(c)—annual out-of-pocket maximum for plans/policies that are required to provide coverage for EHBs	Not required to cover EHBs nor meet the cost-sharing requirements for EHBs	Non-grandfathered DMHC-regulated plans and CDI-regulated policies subject	Non-grandfathered DMHC-regulated plans and CDI-regulated policies subject

Source: California Health Benefits Review Program, 2012.

Key: ACA=Affordable Care Act; CDI=California Department of Insurance; DMHC=Department of Managed Health Care; EHBs=essential health benefits.

Effects beginning in 2016: essential health benefits and AB 1800

As previously mentioned, HHS has not yet defined EHBs for the period after 2014 and 2015. However, AB 1800 does not require a specific benefit mandate, but places restrictions on cost-sharing terms for benefit mandates. The annual out-of-pocket maximum that would be applied to plans and policies under AB 1800 aligns with the annual out-of-pocket maximum required under

³⁰ Available at: http://www.chbrp.org/other_publications/index.php.

Section 1302(c) of the ACA, which does not appear to change even if the definition of the EHBs changes.

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

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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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