



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Assembly Bill 1800: Health Care Coverage

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

CHBRP 12-2



The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002 by statute (California Health and Safety Code, Section 127660, et seq). The program was reauthorized in 2006 and again in 2009. CHBRP's authorizing statute defines legislation proposing to mandate or proposing to repeal an existing health insurance benefit as a proposal that would mandate or repeal a requirement that a health care service plan or health insurer (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty and staff from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate or repeal bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates or repeals, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment on health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP website, www.chbrp.org.

A Report to the 2011–2012 California State Legislature

Analysis of Assembly Bill 1800 Health Care Coverage

April 23, 2012

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PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 1800. In response to a request from the California Assembly Committee on Health on February 27, 2012, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, and Margaret Fix, MPH, 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. Stephen McCurdy, MD, MPH, and Julia Huerta, MPH, of the University of California, Davis, prepared the public health impact analysis. Arturo Vargas Bustamante, PhD, MA, MPP, of the University of California, Los Angeles, and Todd Gilmer, PhD, University of California, San Diego, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, and Dan Henry, ASA, MAAA, of Milliman, provided actuarial analysis. Geoff Joyce, PhD, of the University of Southern California, and Debi Reissman, PharmD, of Rxperts, Inc., provided technical assistance with the literature review and expert input on the analytic approach. Laura Grossmann, MPH, and John Lewis, MPA, 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, Kathleen Johnson, PharmD, MPH, PhD, of the University of Southern California, 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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TABLE OF CONTENTS

LIST OF TABLES	4
EXECUTIVE SUMMARY	5
INTRODUCTION	16
MEDICAL EFFECTIVENESS	28
Research Approach and Methods	28
Methodological Considerations	28
Outcomes Assessed.....	29
Study Findings	29
BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS.....	35
Impact of the Mandate on Benefit Coverage, Utilization, and Cost.....	37
PUBLIC HEALTH IMPACTS	44
Public Health Outcomes	44
Impact on Gender and Racial Disparities	45
Impacts on Premature Death and Economic Loss	47
Long-Term Public Health Impacts.....	48
APPENDICES	49
Appendix A: Text of Bill Analyzed.....	49
Appendix B: Literature Review Methods	65
Appendix C: Summary Findings on Medical Effectiveness.....	69
Appendix D: Cost Impact Analysis: Data Sources, Caveats, and Assumptions.....	70
Appendix E: Information Submitted by Outside Parties	81
REFERENCES	82

LIST OF TABLES

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.....	13
Table 1. AB 1800 (<i>Annual Out-of-Pocket Maximum Requirement Only</i>) Impacts on Benefit Coverage, Utilization, and Cost, 2012.....	14
Table 2. Comparison of Prohibitions on Limits for DMHC-Regulated Plans Required by AB 1800 and by the ACA.....	25
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.....	27
Table 4. Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2012.....	42
Table 5. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2012.....	43

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 the *Introduction* in the full report for a more in-depth discussion of AB 1800's interaction with these federal health insurance benefit mandates.¹⁶ Below is a brief 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

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

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.

INTRODUCTION

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 formally amended in the Assembly on March 20, 2012). In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.²⁰

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.²¹ 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)²² 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,²³ 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.

Bill language

The full text of AB 1800 can be found in Appendix A.

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

- 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-

²⁰ Available at: http://www.chbrp.org/documents/authorizing_statute.pdf.

²¹ CHBRP's estimates are available at http://www.chbrp.org/other_publications/index.php.

²² DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

²³ 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.

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 is inclusive of copayments, coinsurance, deductibles, and any other form of cost sharing.²⁴ 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).²⁵ 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). 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. 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.²⁶ AB 1800 further specified that this annual out-of-pocket limit would not affect the reduced cost sharing that some enrollees in qualified health plans (QHPs) in California’s Health Benefits Exchange will be eligible for under Section 1402 of the ACA.

- In 2013, for all DMHC-regulated plans, AB 1800 would prohibit limitations on maximum coverage of basic health care services (BHCS). DMHC-regulated plans would be prohibited from placing an annual or lifetime dollar value on BHCS as well as from placing a limit on the scope of covered benefits for BHCS. AB 1800 is silent in regard to maximum coverage limitations for CDI-regulated policies.
- 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. AB 1800 is silent in regard to enrollees in CDI-regulated policies challenging prescription drug exclusions through the 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.

²⁴ Cost sharing is generally understood to not include premiums. Premium payments would not accrue towards the annual out-of-pocket maximum.

²⁵ 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.”

²⁶ 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]. The annual out-of-pocket maximum dollar values used in this report reflect the maximum annual out-of-pocket expenses for HDHPs in effect in 2012.

Background on cost sharing

Cost sharing may include copayments, coinsurance, and/or deductibles. CHBRP refers to these as enrollee out-of-pocket expenses.²⁷

- Copayments are a form of cost sharing in which a health plan enrollee pays a specific amount out-of-pocket at the time of receiving a health care service or when paying for a prescription, after any applicable deductible. This amount can vary across covered benefits, and a plan or policy may not require any copayments or may only require copayments for some covered benefits.
- Coinsurance is the percentage of covered health care costs for which a health plan enrollee is responsible, after any applicable deductible. As with copayments, the percentage coinsurance an enrollee is required to pay can vary across covered benefits, and a plan or policy may not require any coinsurance or may only require coinsurance for some covered benefits.
- Deductibles are a fixed dollar amount an enrollee is required to pay out-of-pocket within a given time period (as a year) before reimbursement begins for eligible health care services. Not all plans and policies have deductibles. Often, if a plan or policy has a deductible it only applies to a specified set of covered benefits as opposed to all covered benefits. Additionally, a plan or policy can have more than one deductible (e.g., a general deductible that applies to a specified set of covered benefits and another deductible that applies to prescription drugs).

Annual out-of-pocket maximums are limits on cost sharing (copayments, coinsurance, deductibles). They place an annual limit on the total out-of-pocket expenses (excluding premium payments) associated with covered benefits that an enrollee is responsible for during a plan or policy year. As with deductibles, not all plans and policies have annual out-of-pocket maximums, and if a plan or policy has an annual out-of-pocket maximum, it may only apply to a specified set of covered benefits as opposed to all covered benefits.

Applicable cost sharing is complex and varies between and among plan contracts and policies. *Generally*, a plan or policy with a deductible requires that the enrollee pay the full cost for covered benefits subject to the deductible before the plan or policy pays for a portion of or all of the benefit. Plans or policies may further require copayments and/or coinsurance on covered benefits subject to a deductible once the deductible is reached. A plan or policy may also require copayments and/or coinsurance on covered benefits that are not subject to a deductible. If a plan has an annual out-of-pocket maximum, an enrollee will be responsible for the deductible, copayments, and/or coinsurance required under their plan or policy until he or she reaches the annual out-of-pocket maximum, after which the plan or policy is required to pay for the full cost of covered benefits. Plans or policies may place an annual out-of-pocket maximum only on some covered benefits, as opposed to all covered benefits. In such cases, an enrollee would not be responsible for the costs of covered benefits included in the annual out-of-pocket maximum if they meet the maximum, but may be subject to cost sharing for other covered benefits excluded from the annual out-of-pocket maximum.

²⁷ See CHBRP's Glossary of Key Terms available at:
http://www.chbrp.org/analysis_methodology/glossary_key_terms.php.

In 2013, for all DMHC-regulated plans and for CDI-regulated policies that provide outpatient prescription drug coverage, AB 1800 would require an annual out-of-pocket maximum for *all* covered benefits, including prescription drugs (if prescription drugs are covered). 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.

Background on cost sharing for prescription drugs in California. Cost-sharing arrangements for prescription drugs found in health insurance in California differ from what is present in other states or available nationally. These differences may alter the impact AB 1800 could have in California, as opposed to the impact similar legislation could have elsewhere.

Tiers may be used to differentiate cost-sharing levels for subcategories of prescription drugs covered under the outpatient pharmacy benefit. “Tiers” refer to variation in copayments (or other cost sharing) that is based on the drug that is being covered, the lower tiers usually being less costly to both the enrollee and to the health plan or insurer. A two-tier system would usually separate generic from nongeneric (brand name) medications, and a three-tier system would further divide nongeneric medications into “preferred” and “not preferred,” the latter being the third tier. When a system includes a fourth tier, the fourth tier includes “specialty drugs,” which are typically very costly. For costly medications, a four-tier structure for an outpatient pharmacy benefit frequently results in greater patient out-of-pocket expenses. Four-tier structures for outpatient pharmacy benefit cost sharing are less common in California than nationally (CHCF, 2011).

Copayments for prescription drugs are more common than coinsurance for prescription drugs in lower tiers (one-, two-, and three-tier structures) (KFF/HRET, 2011). As four-tier structures for Californians are less common, flat dollar copayments for prescription drugs are generally more common than coinsurance. For costly medications, flat dollar copayments frequently result in less patient out-of-pocket expenses than do other forms of cost sharing, such as coinsurance.

For the reasons listed, many Californians may not be exposed to the high levels of cost sharing for costly medications that have been reported in other states. A recent study of national health care costs supports this conclusion, finding that Californians have the lowest percentage of insured persons with a high financial burden (Cunningham, 2010).

Background on the independent medical review process and prescription drug exclusions for DMHC-regulated plans

If an enrollee in a DMHC-regulated plan is denied coverage for a covered benefit, an enrollee can file a complaint with the plan. If an enrollee disagrees with the plan’s decision, an enrollee can ask the regulator, DMHC, to review the decision through the IMR process. IMR is a review of the case by a provider external to the plan whose decision is being challenged. If the external provider judges that the benefit is medically necessary, the plan must provide coverage for the benefit.

In California, the IMR process judges medical necessity for covered benefits, but does not address excluded benefits. DMHC reviews complaints, and if it is determined that a plan does not cover a benefit, an enrollee cannot appeal the health plan's decision through the IMR process.

Plans often exclude specific prescription drugs and may exclude classes of prescription drugs (such as drugs for cosmetic use or drugs for infertility) from prescription drug benefit coverage. Additionally, plans may exclude all brand-name prescription drugs, instead covering only generic prescription drugs.

AB 1800 would allow approved exclusion of prescription drugs from a DMHC-regulated plan's prescription drug benefit to be challenged through the IMR process.²⁸

Analytic approach and key assumptions

AB 1800 is not a conventionally defined benefit mandate; it does not mandate coverage of specific treatments or services. Therefore, CHBRP's analysis regarding medical effectiveness, cost, and public health impacts have all been adjusted to address the requirements relevant to this bill.

Annual out-of-pocket maximum. In 2013, AB 1800 would require an annual out-of-pocket maximum on all covered benefits, including prescription drugs if covered. The annual out-of-pocket maximum includes copayments, coinsurance, deductibles, and any other form of cost sharing. However, AB 1800 has no requirements specific to these various forms of cost sharing. AB 1800 only requires that a DMHC-regulated plan, or a CDI-regulated policy that provides outpatient prescription drug coverage, have an annual out-of-pocket maximum that does not exceed the limit specified in Section 1302(c) of the ACA. Therefore, CHBRP's analysis focuses on the impact of an annual out-of-pocket maximum on all covered benefits, and not the individual impacts of copayments, coinsurance, and/or deductibles on covered benefits.

As stated, AB 1800 indicates that the annual out-of-pocket maximum is not to exceed the limit established in Section 1302(c) of the ACA. Section 1302(c) of the ACA references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines the maximum annual out-of-pocket expenses for HDHPs. For plan and policy years starting in 2015 and beyond, the annual out-of-pocket maximum may be further adjusted beyond the maximum annual out-of-pocket expenses for HDHPs in effect for that year. The annual out-of-pocket maximum can be further increased by a "premium adjustment percentage" established by the Secretary of Health and Human Services (HHS).²⁹ This is beyond the scope of this report.

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.

²⁸ Personal communication, A. Abu-Rahma, Department of Managed Health Care, March 2012.

²⁹ ACA Section 1302(c).

Limitations on maximum coverage of basic health care services. In 2013, AB 1800 would prohibit DMHC-regulated plans from placing limitations on maximum coverage for BHCS. The ACA modified Section 2711 of the federal Public Health Service Act (PHSA), prohibiting lifetime limits or unreasonable annual limits on the dollar value of benefits. Senate Bill (SB) 51, signed into law in 2011, requires DMHC-regulated plans (and CDI-regulated policies, but CDI-regulated policies are not addressed by this component of AB 1800) to comply with Section 2711 of the PHSA “to the extent required by federal law.”³⁰

AB 1800 expands the requirements beyond those of SB 51 and Section 2711 of the PHSA. By deleting language from the Health and Safety Code that allows DMHC-regulated plans to place limitations on maximum coverage for BHCS, AB 1800 would both prohibit *any* annual limits (as opposed to unreasonable annual limits) for BHCS and prevent DMHC-regulated plans from placing limitations on the scope of covered benefits (e.g., visit limits) and not just dollar limits for BHCS.³¹ However, historically, limitations on the scope of covered benefits for BHCS have generally not been allowed, and if they have, they have been very infrequent.³² Thus, CHBRP assumes that the change proposed by AB 1800 to the Health and Safety Code would not have a measurable impact.

Independent medical review for prescription drugs. In 2013, AB 1800 would eliminate language from the Health and Safety Code that currently prevents approved exclusions to a plan’s prescription drug benefit from being subject to the IMR process. Eliminating this language from the Health and Safety Code potentially opens the door to the IMR process for excluded drugs.³³ However, CHBRP cannot estimate how many enrollees would pursue the IMR process as a means of challenging exclusions of prescription drugs, or what the results of the IMR process would be. Therefore, CHBRP is unable to project the impacts this requirement may have.

Deductibles. In 2014, AB 1800 would place restrictions on deductibles for covered benefits for all DMHC-regulated plans and all CDI-regulated policies. 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. Because of the changes to take place in 2014 as a result of the ACA, CHBRP’s model does not yet reflect what the insurance market will look like in 2014. Therefore, CHBRP cannot, at this time, analyze the marginal impact that may result from this requirement of AB 1800.

Currently, deductibles often only apply to a subset of covered benefits, as opposed to all covered benefits. Plans and policies with deductibles often do not include prescription drugs in the deductible. The bill language for this requirement of AB 1800 is unclear and could be interpreted

³⁰ Health and Safety Code Section 1367.001(a).

³¹ Personal communication, S. Lowenstein, C. Hamilton, and E. Mackani, Department of Managed Health Care, March 2012.

³² Personal communication, S. Lowenstein, C. Hamilton, and E. Mackani, Department of Managed Health Care, March 2012.

³³ Personal communication, A. Abu-Rahma, Department of Managed Health Care, March 2012.

in more than one way. However, it appears that AB 1800 would not alter how plans and policies currently apply deductibles.³⁴ A DMHC-regulated plan or CDI-regulated policy could still apply a deductible to a limited set of covered benefits, and would not be required to include prescription drugs in a deductible. However, a DMHC-regulated plan or CDI-regulated policy could no longer have separate deductibles for covered prescription drugs and other covered benefits.

CHBRP's analysis addressed, when possible, the impact of deductibles on covered benefits generally, but focused on the impact of deductibles on prescription drugs because AB 1800 specifically references this benefit.

Other assumptions. CHBRP assumes that where AB 1800 references "prescription drugs," it is referring to prescription drugs covered through an enrollee's outpatient prescription drug benefit. Prescription drugs may also be covered through inpatient hospitalization or visits to an outpatient provider. However, when addressed in isolation, CHBRP assumes that the bill would affect an enrollee's outpatient prescription drug benefit because medications provided on an inpatient basis or provided in doctors' offices or clinics are usually considered part of medical benefits.

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.³⁵ Copayments, deductibles, and other limitations cannot "render the benefit illusory."³⁶ 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.³⁷ 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.

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.³⁸

In addition, both DMHC-regulated plans and CDI-regulated policies are subject to the IMR process for covered benefits.³⁹ And, as previously discussed, SB 51, which was signed into law in 2011, requires DMHC-regulated plans and CDI-regulated policies to comply with Section

³⁴ Personal communication, S. Lowenstein, C. Hamilton, and E. Mackani, Department of Managed Health Care, March 2012.

³⁵ Health & Safety Code Section 1367(h) and 1367(i). AB 1800 would alter Health & Safety Code Section 1367(i).

³⁶ California Code of Regulations, Title 28, section 1300.67.4.

³⁷ California Code of Regulations, Title 28, section 1300.67.24.

³⁸ Insurance Code Section 10291.5(a)(1).

³⁹ Health & Safety Code Section 1374.30; Insurance Code Section 10169.

2711 of the PHSA, which prohibits lifetime limits or unreasonable annual limits on the dollar value of benefits.⁴⁰

Requirements in other states

In 2006, Massachusetts became the first state to pass a law requiring all adult residents to show proof of health insurance coverage. This law places certain restrictions on out-of-pocket spending and maximum annual benefit limits. Plans are required to have an annual maximum on out-of-pocket spending of no more than \$5,000 for an individual and \$10,000 for a family.⁴¹

In 2011, Vermont enacted legislation that puts the state on a path towards a single payer system. Included in this legislation are restrictions on cost sharing.⁴²

In 1992, the New Jersey Legislature created the Individual Health Coverage (IHC) Program to regulate the individual market. Restrictions were placed on out-of-pocket maximums and limits for plans under this program, but they are not uniform across plans. Plans have a maximum coinsurance amount ranging from \$2,000 to \$5,000. Copayments do not generally count towards the maximum coinsurance for a plan.⁴³

In addition, some states have recently passed legislation aimed at addressing the high cost sharing some enrollees may have for costly prescription drugs. In 2012, Maine enacted legislation that places an out-of-pocket limit on prescription drugs subject to coinsurance, and in 2010, New York enacted legislation that placed restrictions on cost sharing for prescription drugs.

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

⁴⁰ Health and Safety Code Sections 1367.001 and 1367.003 and California Insurance Code Sections 10112.1 and 10112.25.

⁴¹ More information is available at:

www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/MCC%2520Background/MCCRequirements.pdf.

⁴² More information is available at: <http://hcr.vermont.gov/home>. The legislation is available at: www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf.

⁴³ More information is available at: www.state.nj.us/dobi/division_insurance/ihcseh/ihcompare.html.

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.⁴⁴ 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.⁴⁵ 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;⁴⁶ and
- The prohibition on lifetime and annual limits apply to grandfathered plans,⁴⁷ with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits.⁴⁸

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.

⁴⁴ 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.

⁴⁵ ACA Section 1001 amending Section 2711 of the PHSA.

⁴⁶ 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>.

⁴⁷ 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 significant changes that reduce benefits or increase costs to consumers” (www.healthcare.gov/glossary/g/grandfathered-health.html).

⁴⁸ ACA Section 1251(a)(4).

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.⁴⁹

External review. The ACA requires plans and policies to provide for external review.⁵⁰ 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,⁵¹ 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

⁴⁹ 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.

⁵⁰ ACA Section 1001 modifying Section 2719 of the PHSA.

⁵¹ ACA Section 1302(b).

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.⁵² Any state-mandated benefit enacted after December 31, 2011, may not be part of the EHBs for 2014 and 2015.⁵³ 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 issue brief, *Interaction Between California’s State Benefit Mandates and the Affordable Care Act’s “Essential Health Benefits.”*⁵⁴

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

⁵² CCIIO, *Essential Health Benefits Bulletin*. (December 2011). Available at:

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

⁵³ 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>.

⁵⁴ Available at: http://www.chbrp.org/other_publications/index.php

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

MEDICAL EFFECTIVENESS

Research Approach and Methods

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.

Literature Review Methods

Studies of the effects of cost sharing (i.e., the portion of health care expenditures paid by enrollees in such forms as deductibles, copayments, coinsurance, and annual out-of-pocket maximums) on use of health care services were identified through searches of the Cochrane Library, EconLit, Google Scholar, PubMed, and Web of Science. The search was limited to abstracts of peer-reviewed research studies that were published in English, conducted in the United States, and published from 2008 to present. For earlier studies, CHBRP relied on a literature search conducted in 2008 for its issue analysis for SB 1522, a bill that concerned standardization of cost sharing and other aspects of health plans and health insurance policies.

The medical effectiveness review focused on studies of the effects of annual out-of-pocket maximums and deductibles among persons with privately funded health insurance because AB 1800 would primarily affect coverage for persons with privately-funded health insurance. Findings from studies of persons enrolled in Medicare or Medicaid (Medi-Cal in California) are less generalizable to the population affected by AB 1800 because persons enrolled in Medicare and Medicaid tend to be older or poorer than persons who obtain coverage through privately funded health plans and health insurers. The review also focused on studies conducted in the United States, because findings from studies of annual out-of-pocket maximums and deductibles in countries with different types of health care systems may not be generalizable to Californians.

A total of 19 studies were included in the medical effectiveness review. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B: Literature Review Methods.

Methodological Considerations

The most authoritative study on the impact of cost sharing on use of health care services is the RAND Health Insurance Experiment (HIE), a multisite randomized controlled trial (RCT) conducted in the 1970s. Health insurance in the United States has changed considerably since that time, as has the treatment of many diseases and conditions. Newer studies of the impact of cost sharing on use of health care services have not randomized subjects. The lack of randomization limits confidence that differences in use of health care services between persons facing higher and lower cost sharing are due to cost sharing versus other factors that may affect use of health care. These factors include health behaviors of beneficiaries (e.g., smoking, physical inactivity), severity of illness, income, education, and health care expenses of other

family members. The best nonrandomized studies of cost sharing for prescription drugs have used rigorous methods to take such factors into account in their analyses. The best studies also examine the effects of changes in people's cost sharing that are beyond their control, such as an employer's decision to replace one type of health plan with another or to change cost-sharing options within existing health plan offerings, and compare persons who experience a change in cost sharing to similar persons who do not experience the change (Remler and Greene, 2009; Swartz, 2010).

Outcomes Assessed

For the assessment of the impact of annual out-of-pocket maximums, CHBRP searched for literature that analyzed the effects of annual out-of-pocket maximums on use of any type of health care service, because AB 1800 would require health plans and health insurance policies to establish an annual out-of-pocket maximum that would apply to all covered benefits.

For the assessment of the impact of deductibles, CHBRP limited its review to studies of effects of deductibles on use of prescription drugs, because the provision of AB 1800 that addresses deductibles specifically mentions prescription drugs. Studies of the impact of deductibles on use of prescription drugs have measured use in a variety of ways. Some studies have examined the probability of filling any prescriptions or the number of prescriptions filled. Other studies have focused on cost sharing for prescription drugs for chronic conditions that are taken on a daily basis. Some of these studies have evaluated the impact of differences in cost sharing on continuation or discontinuation of drug therapy. Others have used information on days of supply to calculate a *medication possession ratio*, a ratio of days of supply to the total number of days between prescription refills in the study period. Persons with a medication ratio above 0.8 are deemed to be adherent to daily drug therapy (e.g., had a sufficient supply of medication dispensed to enable them to take medication on 80% of days in the time period studied).

Some studies of deductibles have evaluated their impact on use of other types of health care services. CHBRP did not review these findings because the provision of AB 1800 that addresses deductibles specifically mentions prescription drugs.

CHBRP identified no studies that directly examined the impact of either annual out-of-pocket maximums or deductibles on health outcomes.

Study Findings

Cost Sharing in General

The RAND HIE found that persons enrolled in fee-for-service health insurance plans who paid a larger share of costs were less likely to be hospitalized, had fewer outpatient visits, and filled fewer prescriptions than persons with more generous coverage. Differences in use across cost-sharing levels were similar for all kinds of treatments studied, suggesting that persons did not distinguish between essential and nonessential treatments. Although the RAND HIE found no evidence of adverse effects of cost sharing among persons with average health, there was some

evidence that higher cost sharing was associated with worse health outcomes for low-income persons who were in poor health (Newhouse, 1993).

A number of additional studies of the effects of cost sharing have been published since that time. The largest amount of literature concerns cost sharing for prescription drugs. Findings from studies of the effects of cost sharing on privately insured, nonelderly adults (the population to which AB 1800 would apply) are largely consistent with findings from the RAND HIE (Austvoll-Dahlgren et al., 2008; Baicker and Goldman, 2011; Eaddy et al., 2012; Goldman et al., 2007; Remler and Greene, 2009; Swartz, 2010).

Most studies of cost sharing do not address annual out-of-pocket maximums or deductibles. The vast majority of studies examine changes in copayments. The magnitude of the changes in copayments that have been studied are usually small (Baicker and Goldman, 2011). Persons may respond differently to changes in annual out-of-pocket maximums or deductibles, which are often much larger. In addition, annual out-of-pocket maximums and deductibles function differently from copayments. Persons whose health insurance requires copayments are responsible for the copayment every time a treatment subject to the copayment is provided. By 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 that level of out-of-pocket expenditures. Persons who do not anticipate that their out-of-pocket costs will exceed their deductible may be less likely to obtain care than persons who face only a copayment. Conversely, cost sharing may not have much of an effect on the use of treatments by persons who expect to exceed their deductible.

Annual out-of-pocket maximums are limits on the total out-of-pocket expenses (excluding premium payments) associated with covered benefits that an enrollee is responsible for during a plan or policy year, above which health plans or health insurers are responsible for all expenses for covered services. These maximums only affect persons whose out-of-pocket expenses exceed the maximum. These persons may be systematically different from the broader population of persons affected by copayments.

The preponderance of evidence from studies of cost sharing for health care services indicates that persons who face higher cost sharing use fewer treatments than persons with lower cost sharing and that this effect occurs for both essential and nonessential treatments.

Annual Out-of-Pocket Maximums

CHBRP found no studies of the impact of annual out-of-pocket maximums that were conducted in the United States.

CHBRP found a few studies of annual out-of-pocket maximums that were carried out in Canadian provinces (Dormuth et al., 2006; Kephart et al., 2007; Kozyrskyj et al., 2001; Tamblyn et al., 2001). The relevance of these studies to AB 1800 is limited for several reasons. First, the annual out-of-pocket maximums were instituted or increased simultaneously with other changes in cost sharing, such as establishment of copayments or coinsurance, that may have affected the

results. AB 1800 would only require health plans and health insurance policies to establish annual out-of-pocket maximums. Second, in some cases, the annual out-of-pocket maximum was based on income, whereas for 2013, AB 1800 would establish fixed annual out-of-pocket maximums for all affected persons and families regardless of income. Third, the annual out-of-pocket maximums studied were much smaller (\$150 to \$1,000) than the annual out-of-pocket maximums that would be established by AB 1800 (\$6,050 for a single person and \$12,100 for a family). Fourth, findings from the studies may not generalize to the population whose coverage would be affected by AB 1800, because they examined effects on senior citizens and low-income persons receiving cash assistance from government agencies.

Other studies that have examined the impact of lowering cost sharing have assessed different interventions. Studies have been published on value-based insurance designs under which coinsurance or copayments are reduced for prescription drugs or classes of drugs that provide substantial clinical benefits relative to their costs, such as medications for diabetes, high blood pressure, and high cholesterol (Chernew et al., 2010). Although these studies offer some evidence about the impact of lowering cost sharing, their findings may not generalize to AB 1800. The drugs to which value-based insurance designs have been applied are relatively inexpensive generic drugs. Many persons who take them do not have out-of-pocket costs that would exceed the annual out-of-pocket maximums proposed in AB 1800. These maximums are likely to have more impact on persons who take specialty drugs for which there are no generic equivalents.

Another group of studies has examined the impact of Medicare Part D coverage for prescription drugs. Prior to the enactment of the Affordable Care Act (ACA), Medicare Part D had four levels of cost sharing depending on the level of drug spending. Beneficiaries paid all costs up to a deductible, above which they paid 25% coinsurance until they reached the so-called “doughnut hole” in which they again paid all costs. If drug costs exceeded the doughnut hole, they paid 5% coinsurance. To some extent, coming out of the “doughnut hole” is analogous to exceeding the annual out-of-pocket maximum. However, findings from these studies of Medicare beneficiaries may not generalize to the population whose coverage would be affected by AB 1800.

There is insufficient evidence to ascertain the effects of the provision of AB 1800 that would require health plans and health insurance policies to have an annual out-of-pocket maximum for all covered benefits because the few studies of annual out-of-pocket maximums that have been published are of limited relevance to AB 1800.

Deductibles

The impact of the provision of AB 1800 that would require health plans to have a single deductible for prescription drugs and other covered services on the use of drugs is unknown. ***CHBRP found no studies that compared the effect of having a single deductible with having separate deductibles for prescription drugs and other covered benefits.***

However, the literature provides some insights into how deductibles affect use of prescription drugs and adherence to recommended drug therapy. Most of the recent literature on impact of

deductibles has addressed high deductible health plans (HDHPs), also known as consumer-directed health plans. The federal Department of the Treasury Internal Revenue Service defines HDHPs in 2012 as health plans that have a deductible of at least \$1,200 for an individual and \$2,400 for a family. For covered benefits to which the deductible applies, persons enrolled in HDHPs must pay all charges until they reach their deductible. Some persons with HDHPs have a health reimbursement account (HRA) or a health savings account (HSA) that can be used to pay some of these charges. Employers that offer HDHPs to their employees may contribute to HRAs or HSAs (Chen S et al., 2010).

Effects on filling prescriptions

One study that compared samples of persons matched on demographic and health characteristics (the method is called “propensity score matching”) and who were enrolled in multiple HDHPs and preferred provider organizations (PPOs) examined the effect of switching from a PPO to a HDHP on the probability of filling any prescriptions. The authors found that persons who enrolled in HDHPs were more likely to fill at least one prescription per year (Waters et al., 2011). An important limitation of this study is that it did not distinguish persons who voluntarily switched from a PPO to a HDHP from persons who were compelled to switch because their employers replaced a PPO with a HDHP and offered no other health insurance options to their employees. Persons who voluntarily switch to a HDHP may be systematically different from persons whose employers make the choice for them (Lo Sasso et al., 2010).

Findings from studies that have assessed the effects of HDHPs on the number of prescriptions filled are ambiguous. The aforementioned study by Waters and colleagues (2011) reported that switching from a PPO to a HDHP was associated with an increase in the number of prescriptions filled. This finding was observed for both essential and nonessential drugs and did not change when the sample was limited to persons who had high expenditures for prescription drugs at baseline or who were predicted to have high expenditures for all health care services during the study period. By contrast, a study that compared persons who received coverage through an employer that replaced two PPO plans with two HDHP plans to persons who were continuously enrolled in a PPO found that the number of prescriptions filled per year decreased among persons whose coverage switched from a PPO to a HDHP (Nair et al., 2009). A cross-sectional study that compared persons enrolled in HDHPs to persons enrolled in PPOs reached the same conclusion (Wilson et al., 2008). Parente and colleagues’ (2004) study of persons employed by a single large employer found that switching from a health maintenance organization (HMO) or PPO to a HDHP was associated with a smaller increase in the number of prescriptions filled. A study that compared persons who received coverage through two medium-sized employers found no difference in the change in the number of prescriptions filled between persons whose coverage switched from a PPO to a HDHP and persons who were continuously enrolled in a PPO (Borah et al., 2011).

Adherence to prescription drug therapy

Studies of the effects of HDHPs on adherence to prescription drug therapy have focused on persons with chronic conditions. These studies have measured adherence to prescription drug therapy in several different ways. The two most common measures are: (1) rates of discontinuation of prescription drug therapy; and (2) adherence to daily drug therapy for chronic

conditions for which there is evidence that daily treatment is effective, such as asthma, high blood pressure, and high cholesterol.

One study (Chen S, 2010) compared adherence for eight therapeutic classes of chronic disease medications between persons who received coverage through employers that replaced a PPO with a HDHP and persons who received coverage through employers that continuously offered a PPO. They found no difference in the percentage of persons filling at least one prescription for a drug in any of the eight classes but found that persons whose employers replaced a PPO with a HDHP had fewer days with continuous supplies of drugs for treatment of epilepsy and high cholesterol and that the difference was statistically significant. A study that examined persons who received coverage through a single employer reported that persons who voluntarily switched from a PPO to a HDHP were more likely than persons who were continuously enrolled in a PPO to discontinue drug therapy for high blood pressure or high cholesterol and that the difference was statistically significant (Greene et al., 2008).

Two studies compared adherence to daily drug therapy for chronic conditions. Chen and colleagues (Chen S, 2010) found that persons whose employers replaced a PPO with a HDHP had lower odds than persons continuously enrolled in PPOs of having a medication possession ratio of above 0.8 for daily medications used to treat asthma, cardiac conditions, and high cholesterol. Nair and colleagues (2009) reported that persons whose employer replaced a PPO with a HDHP were less likely than persons continuously enrolled in PPOs to have a medication possession ratio above 0.8 overall and for daily medications for asthma, diabetes, gastroesophageal reflux disease, high blood pressure, and high cholesterol.

One study of persons who received coverage through a single firm measured adherence by asking persons whether they had taken a lower dose of a prescription drug than recommended by their physician. The authors found that persons who voluntarily switched from a PPO to a HDHP were less likely than persons who were continuously enrolled in a PPO to take the recommended dose of a prescription drug (Dixon et al., 2008).

The consistent reductions in adherence to drug therapy for high cholesterol across these three studies may reflect the nature of this condition. High cholesterol does not have any symptoms. A person may have high cholesterol for many years before the condition causes heart disease or a heart attack. By contrast, some of the other chronic conditions studied, such as depression and rheumatoid arthritis, have symptoms that can have substantial effects on a person's ability to engage in work or leisure activities. Persons may be more sensitive to cost sharing for prescription drugs for asymptomatic conditions than for symptomatic conditions.

Poor adherence to prescription drug therapy for chronic conditions reduces the effectiveness of treatment (WHO, 2003). Persons whose chronic conditions are not well controlled have poorer health outcomes and often have more emergency department visits and hospitalizations. A systematic review of studies of adherence to prescription drug therapy for diabetes, high cholesterol, and high blood pressure found that 30 of 41 studies that assessed the impact of adherence on clinical outcomes reported that worse adherence was associated with worse outcomes (Cramer et al., 2008). Outcomes assessed included blood pressure control, heart attack, stroke, and mortality. More recent studies have examined effects on hospitalizations and emergency department visits. One study found that poorer adherence to statins (a medication

used to lower cholesterol) is associated with a higher probability of hospitalization (Aubert et al., 2010). Another found that poorer adherence to medications to control blood pressure increased the odds of having an emergency department visit and being hospitalized (Pittman et al., 2010).

CHBRP found no studies that compared the effect of having a single deductible with having separate deductibles for prescription drugs and other covered benefits. However, there is a preponderance of evidence from studies of HDHPs that enrollment in a HDHP is associated with poorer adherence to drug therapy for certain chronic conditions, particularly high cholesterol. Findings regarding effects on numbers of prescriptions filled are ambiguous.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

CHBRP's analysis of the benefit coverage, utilization, and cost impacts of AB 1800 solely focuses on the annual out-of-pocket maximum requirement. In 2013, AB 1800 would require an annual out-of-pocket maximum for all covered benefits, including prescription drugs if covered, to be no more than \$6,050 for self-only coverage and \$12,100 for family coverage. This change applies to all DMHC-regulated plans and to CDI-regulated policies that provide outpatient prescription drug coverage.

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.

The impacts modeled in this section rely on some key assumptions. 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. For the enrollees in plans and policies subject to the annual out-of-pocket maximum requirement in AB 1800, CHBRP assumed no other changes in benefit structure, such as changes to deductibles, copayments, or coinsurance.

The following evidence supports CHBRP assumptions used for calculating the impact of AB 1800 on benefit coverage, utilization, and costs:

- CHBRP recognizes the fact that with the imposition of annual out-of-pocket maximums, some patients may initiate more spending on prescription drugs or other health services in response to new out-of-pocket limits.
- Cost-sharing substitution and health care services utilization effects derived from the introduction of an annual out-of-pocket maximum is more likely to occur among those who exceed or are expected to reach the annual out-of-pocket maximum of \$6,050 for individual coverage and \$12,100 for family coverage for all covered benefits.

This section will first present the current (or baseline) costs and coverage related to an annual out-of-pocket maximum and will then present the estimates of impacts on costs, coverage, and utilization if AB 1800 were enacted. For further details on the underlying data sources and methods, please see Appendix D at the end of this document.

Current (Baseline) Benefit Coverage, Utilization, and Cost

Current Coverage of the Mandated Benefit

CHBRP estimates that there are 21.7 million Californians with health insurance subject to AB 1800, of whom 7.8 million (36.1%) are enrolled in plans or policies that are compliant with the annual out-of-pocket maximum requirement of AB 1800. CHBRP assumes that plans with annual out-of-pocket maximums currently below the thresholds specified by AB 1800 would not change.

CHBRP estimates there are:

- 13.2 million Californians that currently have an annual out-of-pocket maximum for their plan or policy, but prescription drugs are not included in the annual out-of-pocket maximum;
- 511,000 Californians that currently have an annual out-of-pocket maximum for their plan or policy that includes prescription drugs, but the annual out-of-pocket maximum is greater than the annual out-of-pocket maximum AB 1800 would require; and
- 106,000 Californians in DMHC-regulated plans without coverage for outpatient prescription drugs, with an annual out-of-pocket maximum greater than the annual out-of-pocket maximum AB 1800 would require.

CHBRP conducted a bill-specific coverage survey of seven of California's largest health plans and insurers to estimate the current levels of annual out-of-pocket maximums. Responses to this survey represent 68.3% of enrollees in the privately funded CDI-regulated market, and 82.1% of enrollees in the privately funded DMHC-regulated market. Combined, responses to this survey represent 79.3% of enrollees in the privately funded markets subject to state mandates.

CHBRP reviewed the impact the mandate would have on the Medi-Cal Managed Care enrollees, the Healthy Families Program (HFP), the Major Risk Medical Insurance Program (MRMIP), and the Access for Infants and Mothers (AIM) program beneficiaries. CHBRP concludes that the foregoing plans are already in compliance with AB 1800 and thus estimates no impact to these public programs.

Current Utilization Levels

CHBRP estimates there are 19.8 million users of health care services prior to the mandate being enacted (see Table 1). CHBRP estimates the total medical costs per user paid by the plan or policy prior to the mandate being enacted is \$345.59, and the total medical costs per user paid by users is \$34.67 per month.

Current (Baseline) Premiums and Expenditures

Table 4 summarizes per member per month (PMPM) premiums and expenditures for DMHC-regulated plans and CDI-regulated policies prior to the implementation of the mandate. The final column in Table 4 shows the total annual PMPM premiums and expenditures for all DMHC-regulated plans and CDI-regulated policies.

Public Demand for Coverage

Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP: (1) considers the bargaining history of organized labor; and (2) compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and hence, are not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concludes that unions currently do not include cost-sharing arrangements for annual out-of-pocket maximums in their health insurance negotiations. In general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.⁵⁵

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by California Public Employees' Retirement System (CalPERS) currently have the largest number of enrollees. The CalPERS PPOs provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate. CalPERS PPOs generally have an annual out-of-pocket maximum, but prescription drugs are not included in the annual out-of-pocket maximum.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicate no substantive differences.

Given the lack of specificity in labor-negotiated benefits and the general match between health insurance that would be subject to the mandate and self-insured health insurance (not subject to state-level mandates), CHBRP concludes that public demand for coverage is essentially satisfied by the current state of the market.

Impact of the Mandate on Benefit Coverage, Utilization, and Cost

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.

⁵⁵ Personal communication, S Flocks, California Labor Federation, March 2012.

How Would Utilization Change as a Result of the Mandate?

CHBRP assumes that annual out-of-pocket maximums have minimal impact on the decision of the majority of enrollees considering their first medical encounter of the plan year. Hence, CHBRP assumes that there would be no change in the number of users of health care services. CHBRP estimates 19.8 million users of health care services prior to and after the mandate being enacted (see Table 1).

As presented in the *Medical Effectiveness* section, there is evidence from studies of cost sharing for health care services that indicates that persons who face higher cost sharing use fewer treatments than persons with lower cost sharing. The RAND Health Insurance Experiment (HIE) study found that persons enrolled in fee-for-service health insurance plans who paid a larger share of costs were less likely to be hospitalized, had fewer outpatient visits, and filled fewer prescriptions than persons with more generous coverage. Thus, although CHBRP assumes there is not an increase in the number of users of health care services, CHBRP estimates an increase in utilization by these users. This is a result of the decrease in cost sharing for enrollees who exceed the annual out-of-pocket maximum required by AB 1800.

CHBRP estimates that this increase in utilization by enrollees would result in an increase in total medical cost per user paid by the plan or policy, and a decrease in total medical cost per user paid by the enrollee (see Table 1). Thus, the annual out-of-pocket maximum required by AB 1800 would shift costs from enrollees to affected plans and policies.

Projected changes in per user costs as a result of an increase in utilization are:

- The total medical cost per user paid by the plan is estimated to be \$345.59 before the mandate is enacted. After the mandate is enacted, the total medical cost per user paid by the plan is estimated to be \$347.45, an increase of 1% per month.
- The total medical cost per user paid by the enrollee is estimated to be \$34.67 before the mandate is enacted. After the mandate is enacted the total medical costs per user paid by the enrollee is estimated to be \$33.51, a decrease of 3%.

Therefore, although the number of users will not change after the mandate is enacted, projected cost-sharing shifts from enrollees to plans and policies will include a projected increase in utilization of health care services.

To What Extent Does the Mandate Affect Administrative and Other Expenses?

Health care policies and plans include a component of administrative costs and profits in their premiums. CHBRP actuarial analysis assumes that health plans and policies apply their existing administration and profit loads to the increases in costs associated with the mandate. Therefore, administrative cost as a portion of the premium is not expected to change.

Compliance with the mandate would require plans and policies to inform the employers as well as current and potential enrollees on the changes to their policies. They would also need to change their information systems to comply with the mandated changes. These administrative costs would be reflected in the overall cost increases.

Content experts indicate that including prescription drug coverage in a plan or policy's annual out-of-pocket maximum would require significant systems changes since health benefit and drug benefit systems are separately maintained. Merging these systems would be necessary to estimate annual out-of-pocket spending per user. In addition, claims systems reorganization corresponding to these changes could significantly increase administrative costs.

Impact of the Mandate on Total Health Care Costs

CHBRP estimates that total net expenditures (including total premiums and out-of-pocket expenditures) would increase by \$246.5 million (or by 0.24%) as a result of AB 1800.

- Enrollee out-of-pocket expenditure is expected to decrease by \$275.5 million, or 3.23%.
- Total premium expenditure by private employers for group insurance is expected to increase by \$361.1 million, or 0.60%.
- Total premium expenditure for individually purchased insurance is expected to increase by \$72.8 million, or 0.96%.
- Total premium expenditures by enrollees with group insurance subject to AB1800 are expected to increase by \$88.1 million, or 0.60%.
- Average portion of the premium paid by the employers would increase by \$1.77 and \$5.54 PMPM in DMHC-regulated and CDI-regulated large-group markets, respectively. Average portion of the premium paid by employees in the same markets would increase by \$0.35 and \$1.56 PMPM, respectively. Enrollee out-of-pocket expenses for covered benefits would decrease in the same markets by \$1.00 and \$4.03 PMPM, respectively.
- Average portion of the premium paid by the employers would increase by \$0.96 and \$6.41 in DMHC-regulated and CDI-regulated small-group markets, respectively. Average portion of the premium paid by employees in the same markets would increase by \$0.31 and \$2.11 PMPM, respectively. Enrollee out-of-pocket expenses for covered benefits would decrease in the same markets by \$0.63 and \$5.11 PMPM, respectively.
- Average portion of the premium paid by enrollees in the DMHC- and CDI-regulated individual markets would increase by \$1.57 and \$3.45 PMPM, respectively. Enrollee out-of-pocket expenses for covered benefits would decrease in the same markets by \$0.84 and \$2.21 PMPM, respectively.
- Total premiums would increase by \$522.0 million, and total out-of-pocket expenses for the covered benefits paid by the enrollees would decrease by \$275.5 million.

The major impact of the mandate would be to shift some of the out-of-pocket expenses from enrollees to plans or policies and to the purchasers.

Impact on long-term costs

Long-term impacts of AB 1800 are uncertain. Plans and policies might respond to the change in the annual out-of-pocket maximum required by AB 1800 by implementing benefit design changes that could potentially offset all projected cost shifting from users to plans and policies. These may include increasing the total out-of-pocket maximum for plans and policies (up to the limit allowed by AB 1800), varying the cost-sharing structure so additional covered benefits are associated with higher copayments or coinsurance, or enforcing more stringent utilization controls.

Further, the annual out-of-pocket maximum will likely change in future years. The annual out-of-pocket maximum is defined by the maximum annual out-of-pocket expenses for HDHP, which can be adjusted annually by a cost-of-living adjustment. In 2015, this can be further modified, according to Section 1302(c) of the ACA, by a “premium adjustment percentage” set yearly by the Secretary of HHS. CHBRP cannot estimate the impact on long-term costs that may result from changes in the dollar value of the annual out-of-pocket maximum in future years.

Impacts for Each Category of Payer Resulting From the Benefit Mandate

The impact varies for CDI-regulated policies and DMHC-regulated plans, especially in the large-group, small-group, and individual markets, specifically as shown in Table 5.

AB 1800 is estimated to increase total expenditures by:

- 0.24% for the large-group DMHC-regulated plans;
- 0.54% for the large-group CDI-regulated policies;
- 0.15% for the small-group DMHC-regulated plans;
- 0.61% for the small-group CDI-regulated policies;
- 0.14% for the individual DMHC-regulated plans;
- 0.43% for the individual CDI-regulated policies.

For affected markets, insured premiums are expected to increase on average by 0.55%. The increases in premiums vary by market segment:

- \$2.12 PMPM in the large-group DMHC-regulated plans;
- \$7.11 PMPM in the large-group CDI-regulated policies;

- \$1.28 PMPM in the small-group DMHC-regulated plans;
- \$8.52 PMPM in the small-group CDI-regulated policies;
- \$1.57 PMPM in the individual DMHC-regulated plans;
- \$3.45 PMPM in the individual CDI-regulated policies.

As discussed earlier, CalPERS HMO, Medi-Cal Managed Care plans, and MRMIB plans are not impacted by AB 1800.

Impact on Access and Health Service Availability

CHBRP expects that there would be impacts on the access to and availability of health services and medication as a result of AB 1800 in the short run. To the extent that the annual out-of-pocket maximums are imposed on plans and policies, there would be an increased access for the small number of enrollees who seek health care services and who exceed their out-of-pocket maximums. Nonetheless, possible implementation of prior authorization requirements and formularies by the health plans and insurers are expected to mediate the possible increase in demand. For example, higher cost oral and injectable drugs may be dropped from formularies or may require prior authorization. CHBRP is unable to quantitatively estimate such effects.

Impact on the Uninsured and Public Programs as a Result of the Cost Impacts of the Mandate

CHBRP estimates the impact on the number of uninsured if there is at least a 1% increase in the PMPM premiums for any of the subgroups (Appendix D). Premiums for the CDI-regulated large-group, small-group, and individual market are expected to increase by 1.42%, 2.06%, and 1.55%, respectively. Using CHBRP's standard methods, premium changes associated with AB 1800 are projected to lead to a net *increase* of approximately 5,151 uninsured Californians from the CDI-regulated market. Implementation of the ACA in 2014 could alter this estimate. The counterbalanced effect on utilization and cost shifts from individuals to plans as a consequence of a potential increase in the number of uninsured was not included in the modeling assumptions since we cannot project a priori who the uninsured would be.

Table 4. Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2012

	DMHC-Regulated							CDI-Regulated			Total
	Privately Funded Plans (by Market)			CalPERS HMO (b)	Medi-Cal Managed Care Plans		MRMIB Plans (d)	Privately Funded Policies (by Market)			
	Large Group	Small Group	Individual		65 and Over (c)	Under 65		Large Group	Small Group	Individual	
Total Enrollees in Plans/Policies Subject to State Mandates (a)	10,538,000	2,231,000	695,000	854,000	201,000	3,539,000	888,000	389,000	1,108,000	1,439,000	21,882,000
Total Enrollees in Plans/Policies Subject to AB 1800	10,538,000	2,231,000	695,000	854,000	201,000	3,539,000	888,000	341,000	1,030,000	1,343,000	21,660,000
Average portion of premium paid by employer	\$367.66	\$292.19	\$0.00	\$356.28	\$279.00	\$164.00	\$98.18	\$390.79	\$311.39	\$0.00	\$72,614,883,000
Average portion of premium paid by employee	\$72.69	\$95.87	\$442.61	\$89.07	\$0.00	\$0.00	\$15.00	\$110.30	\$102.25	\$223.11	\$22,250,196,000
Total Premium	\$440.36	\$388.06	\$442.61	\$445.35	\$279.00	\$164.00	\$113.19	\$501.09	\$413.64	\$223.11	\$94,865,079,000
Enrollee expenses for covered benefits (deductibles, copays, etc.)	\$24.33	\$38.10	\$86.98	\$22.97	\$0.00	\$0.00	\$4.36	\$67.45	\$148.54	\$65.27	\$8,521,470,000
Total Expenditures	\$464.69	\$426.16	\$529.59	\$468.31	\$279.00	\$164.00	\$117.55	\$568.54	\$562.18	\$288.38	\$103,386,549,000

Source: California Health Benefits Review Program, 2012.

Note: (a) This population includes persons insured with private funds (group and individual) and insured with public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care plans, Healthy Families Program, AIM, MRMIP) enrolled in health plans or policies 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) Of these CalPERS HMO members, about 58%, or 495,000, are state employees or their dependents.

(c) Medi-Cal Managed Care state expenditures for members over 65 years of age include those who also have Medicare coverage.

(d) MRMIB plan state 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.

Table 5. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2012

	DMHC-Regulated							CDI-Regulated			Total
	Privately Funded Plans (by Market)			CalPERS HMO (b)	Medi-Cal Managed Care Plans		MRMIB Plans (d)	Privately Funded Policies (by Market)			
	Large Group	Small Group	Individual		65 and Over (c)	Under 65		Large Group	Small Group	Individual	
Total Enrollees in Plans/Policies Subject to State Mandates (a)	10,538,000	2,231,000	695,000	854,000	201,000	3,539,000	888,000	389,000	1,108,000	1,439,000	21,882,000
Total Enrollees in Plans/Policies Subject to AB 1800	10,538,000	2,231,000	695,000	854,000	201,000	3,539,000	888,000	341,000	1,030,000	1,343,000	21,660,000
Average portion of premium paid by employer	\$1.7732	\$0.9633	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$5.5422	\$6.4115	\$0.0000	\$361,144,000
Average portion of premium paid by employee	\$0.3506	\$0.3161	\$1.5742	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$1.5643	\$2.1053	\$3.4533	\$160,854,000
Total Premium	\$2.1238	\$1.2794	\$1.5742	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$7.1065	\$8.5168	\$3.4533	\$521,997,000
Enrollee expenses for covered benefits (deductibles, copays, etc.)	-\$1.0027	-\$0.6268	-\$0.8405	\$0.0000	\$0.0000	\$0.0000	\$0.0000	-\$4.0270	-\$5.1101	-\$2.2101	-\$275,495,000
Total Expenditures	\$1.1211	\$0.6526	\$0.7336	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$3.0795	\$3.4067	\$1.2432	\$246,502,000
Percentage Impact of Mandate											
Insured premiums	0.4823%	0.3297%	0.3557%	0.0000%	0.0000%	0.0000%	0.0000%	1.4182%	2.0590%	1.5479%	0.5503%
Total expenditures	0.2413%	0.1531%	0.1385%	0.0000%	0.0000%	0.0000%	0.0000%	0.5416%	0.6060%	0.4311%	0.2384%

Source: California Health Benefits Review Program, 2012.

Note: (a) This population includes persons insured with private funds (group and individual) and insured with public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care plans, Healthy Families Program, AIM, MRMIP) enrolled in health plans or policies 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) Of these CalPERS HMO members, about 58%, or 495,000, are state employees or their dependents.

(c) Medi-Cal Managed Care state expenditures for members over 65 years of age include those who also have Medicare coverage.

(d) MRMIB plan state 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.

PUBLIC HEALTH IMPACTS

This section presents the overall public health impact of AB 1800, followed by an analysis examining the potential for reduction in gender and racial/ethnic disparities in health outcomes and the potential for the mandate to reduce premature death and societal economic losses. Because of limited published data or the likelihood that the public health impacts of some requirements of AB 1800 would be negligible, CHBRP's assessment of the public health impact is focused on the bill's following requirements: an annual out-of-pocket maximum for all covered benefits; and a prohibition on a separate deductible applied to prescription drugs.

Public Health Outcomes

An Annual Out-of-Pocket Maximum for All Covered Benefits

CHBRP's ability to estimate the public health impact of this requirement is limited due to lack of information in several important areas. As presented in the *Medical Effectiveness* section, there is insufficient evidence from the literature addressing the impact of an annual out-of-pocket maximum comparable to that proposed in AB 1800. However, there is a preponderance of evidence showing that cost sharing in general is associated with reduced utilization, treatment adherence, and poorer clinical outcomes (see the *Medical Effectiveness* section of this report). Thus, it is reasonable to suggest that a limit on cost sharing, which AB 1800 institutes through an annual out-of-pocket maximum for all covered benefits, could improve adherence and possibly improve health outcomes.

There are two countervailing public health effects from the requirement in AB 1800 for an annual out-of-pocket maximum for all covered benefits. First, persons with out-of-pocket expenses exceeding the AB 1800 maximum would benefit from its passage, as it would reduce their cost sharing and may lead to improved utilization, adherence, and clinical outcomes. As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP projects that approximately 3.3% of all enrollees in plans and policies subject to AB 1800 would have their cost sharing reduced as a result of the annual out-of-pocket maximum AB 1800 would require. In addition, CHBRP estimates that the total medical costs paid by each enrollee who uses the covered benefits will decrease by 3%, and enrollee out-of-pocket expenses overall are expected to decrease by \$275.5 million. Therefore, this requirement may have a public health impact by reducing the financial burden on enrollees that currently have an annual out-of-pocket maximum that exceeds the annual out-of-pocket maximum set by AB 1800. However, second, the increases in premiums for CDI-regulated large-group, small-group, and individual market are likely to result from this mandate (see Table 5), and will lead to loss of insurance for an estimated 5,151 individuals as indicated in the *Benefit Coverage, Utilization, and Cost Impacts* section.

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 individuals 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. Although there may be a reduction in financial burden for enrollees who use covered benefits, it appears that the increase in premiums likely to result from the mandate will lead to a loss of coverage for an estimated 5,151 covered Californians.

A Prohibition on a Separate Deductible Applied to Prescription Drugs

CHBRP lacks information addressing two areas necessary to assess public health impact of a prohibition on a separate deductible for prescription drugs. First, as presented in the *Medical Effectiveness* section, there are no studies addressing the impact of prohibiting separate deductibles for covered prescription drugs and other covered benefits. Second, CHBRP has no information to estimate the probable financial impact on the covered population. Accordingly, CHBRP is unable to assess the public health impact for this requirement.

AB 1800's prohibition on 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.

Impact on Gender and Racial Disparities

Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: *A health disparity/inequality is a particular type of difference in health or in the most important influences of health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or great health risks than more advantaged groups* (Braveman, 2006).

CHBRP investigated the effect that AB 1800 would have on health disparities by gender, race, and ethnicity. Evaluating the impact on racial and ethnic disparities is particularly important because racial and ethnic minorities report having poorer health status and worse health indicators than whites (KFF, 2007). Since AB 1800 would only affect the insured population, a literature review was conducted to determine whether there are gender, racial, or ethnic disparities associated with the impact of cost sharing apart from disparities attributable to differences between insured and uninsured populations.

Impact on Gender Disparities

Due to lack of evidence, CHBRP cannot assess the impact of AB 1800 on gender-related disparities.

Impact on Racial/Ethnic Disparities

One important contributor to racial and ethnic health disparities is differences in the prevalence of insurance, where minorities are more likely than whites to be uninsured. Moreover, coverage disparities exist even within the insured population and may contribute to gaps in access and/or utilization among those covered (Kirby et al., 2006; Lillie-Blanton and Hoffman, 2005; Rosenthal et al., 2008). To the extent that racial/ethnic groups are disproportionately distributed among policies with more or less coverage, a mandate bringing all policies to parity may impact an existing disparity.

According to 2009 California Health Interview Survey (CHIS) data, the racial/ethnic distribution varies among different health insurance market segments in California. For example, Whites represent 68% of the CDI-regulated small and individual market segments, and Latinos represent 66% of the Medi-Cal HMO market segment (CHIS, 2009). However, even with coverage parity among policies, racial/ethnic health disparities may continue due to social, cultural, and economic factors that can affect utilization among different groups of insured persons (Gaskin et al., 2009; Hall et al., 2008).

CHBRP analyses are limited to the insured population (as the uninsured would not be affected by a health benefits mandate). Therefore, to assess a mandate's possible effects on health disparities (assuming the covered intervention is medically effective), CHBRP must answer two questions:

1. Are there racial/ethnic disparities in need for medical care or access to treatment?
2. Are there racial/ethnic disparities in premandate benefit coverage?

The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, devotes one chapter to the impacts of cost sharing on racial and ethnic disparities (Rice, 2003). The report notes three primary mechanisms for potential disparities due to cost sharing in health care. First, in cases where racial and ethnic minorities continue to use services despite cost sharing, the out-of-pocket expenditures constitute a disproportionate burden. Census data show that African American and Hispanic individuals have significantly lower incomes than whites; therefore, the same level of cost sharing constitutes a significantly larger proportion of income for racial and ethnic minorities than for whites. Second, national data indicate that certain racial and ethnic minority groups experience poorer health than whites. To the extent that this influences need for services and an inability to forgo certain treatments, cost sharing places a disproportionate burden on these populations. Third, in cases where cost sharing reduces utilization of services, many racial and ethnic minorities forgo necessary services solely due to economic burden, much more so than whites, who on average have higher incomes.

CHBRP's search found limited evidence on racial and ethnic disparities in effects of prescription drug cost sharing. Two recent studies were identified that addressed racial disparities in the general population. A recent national study using Medical Expenditure Panel Survey data showed that Latinos were less likely to use prescription drugs and have higher out-of-pocket drug costs, compared to whites (Chen J et al., 2010). Not having a usual source of care and limited English proficiency were contributing factors to the observed disparity. A national study evaluating the initiation of new prescriptions found that African Americans had 22% to 33% less use than whites, and Hispanics had 5% to 16% less use (Wang et al., 2007).

Racial/ethnic disparities in the impact of cost sharing as it affects prescription drug utilization exist. However, due to lack of evidence, CHBRP cannot assess the impact of AB 1800 on race- and ethnicity-related disparities.

Impacts on Premature Death and Economic Loss

Premature death is often defined as death before the age of 75 years (Cox, 2006). The overall impact of premature death due to a particular disease can be measured as years of potential life lost prior to age 75 years (YPLL) and summed for the population (Cox, 2006; Gardner and Sanborn, 1990). In California, it is estimated that there are nearly 102,000 premature deaths each year from all causes, accounting for more than 2 million YPLL (CDPH, 2011; Cox, 2006). In cases where a reduction in mortality is projected, a literature review is conducted to determine whether the YPLL specific to a given condition has been established. Some diseases and conditions do not result in death, and therefore, a mortality outcome is not relevant. Economic loss associated with disease is generally presented in the literature as the estimated dollar value of lost income associated with YPLL.

Premature Death

Whereas AB 1800 may affect premature mortality, the magnitude of the potential impact is unknown because evidence is lacking for CHBRP to make a quantitative estimate of the effect on patient behavior and the associated health effects.

Economic Loss

Whereas AB 1800 may affect a covered individual's economic burden from health care expenses, the magnitude of the potential impact is unknown because evidence is lacking for CHBRP to make a quantitative estimate of the effect on patient behavior and the associated health effects.

Long-Term Public Health Impacts

As a result of AB 1800, premiums for the CDI-regulated large-group, small-group, and individual market are expected to increase by 1.42%, 2.06%, and 1.55%, respectively, thus increasing the number of uninsured by approximately 5,151 people (see Table 5).⁵⁶ A systematic review on the causal effect of health insurance on utilization and outcomes in adults found that those who are insured experience better access to physician and preventive care, and better health outcomes for both “average” persons and those newly diagnosed with a disease (Freeman et al., 2008). In addition to the issues of health and health care access, the loss of health insurance can also cause substantial financial instability (Rowland et al., 2009).

As presented in the *Medical Effectiveness* section, 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, which can lead to reduced utilization, reduced treatment adherence, and poorer clinical outcomes. Evidence shows that persons with chronic conditions are more likely than the overall population to experience high financial burden from drug costs (Gellad et al., 2012). Furthermore, persons whose chronic conditions are not well controlled have poorer health outcomes and often have more emergency department visits and hospitalizations.

Long-term public health impacts due to AB 1800 are unknown. To the extent that the financial burden from out-of-pocket expenses for covered benefits including prescription drugs are reduced under AB 1800, there is potential for beneficial long-term health impacts, especially for people of limited financial means with expensive and chronic conditions. However, it appears that the increase in premiums likely to result from the mandate will lead to a loss of coverage for an estimated 5,151 covered Californians.

⁵⁶ Implementation of the ACA in 2014 could alter this estimate.

APPENDICES

Appendix A: Text of Bill Analyzed

On February 27, 2012, the Assembly Committee on Health requested CHBRP analyze AB 1800, as introduced. On March 13, 2012, the Assembly Committee on Health requested CHBRP analyze AB 1800, as the bill will be amended as indicated by the Bill Author. (AB 1800 was amended in Assembly on March 20, 2012.)

Below is the bill language, as it was introduced on February 27, 2012. Immediately following is the bill language with suggested amendments. The Bill Author has indicated to CHBRP that the bill will be amended in these ways and CHBRP, with agreement from the requesting Health Committee, has analyzed the text as it will be amended.

ASSEMBLY BILL No. 1800 (AS INTRODUCED)

Introduced by Assembly Member Ma

FEBRUARY 21, 2012

An act to amend, repeal, and add Section 1342.7 of the Health and Safety Code, and to add Section 10123.197.5 to the Insurance Code, relating to health care coverage.

Legislative Counsel's Digest

AB 1800, as introduced, Ma. Prescription drugs. Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides that the willful violation of provisions regulating health care service plans is a crime. Existing law provides for the licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plans and health insurers to provide certain benefits, but generally does not require plans and insurers to cover prescription drugs. Existing law imposes various requirements on plans and insurers if they offer coverage for prescription drugs. Existing law, with respect to health care service plans, authorizes a plan to file information with the department to seek the approval of, among other things, a copayment, deductible, or exclusion to a plan's prescription drug benefit and specifies that an approved exclusion shall not be subject to review through the independent medical review process. Existing federal law, the Patient Protection and Affordable Care Act, commencing January 1, 2014, imposes an annual limitation on cost sharing incurred under a health plan that shall not exceed a specified amount and defines "essential health benefits" to include, among other things, prescription drugs.

This bill would, commencing January 1, 2013, require a health care service plan contract and a health insurance policy offering outpatient prescription drug coverage to provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit, except as specified. The would bill also specify that this limit shall not exceed that federal limit. The bill would also provide, commencing January 1, 2013, that these provisions shall not be construed to affect the reduction in cost sharing for eligible insureds described in federal law. The bill would, commencing January 1, 2014, with respect to health care service plans, delete the provision specifying that an approved exclusion shall not be subject to review through the independent medical review process. The bill would, commencing January 1, 2014, provide that any deductible for basic health care services or essential health benefits shall also apply to covered prescription drugs.

Because this bill would impose new requirements on health care service plans, the willful violation of which would be a crime, it would thereby impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1342.7 of the Health and Safety Code is amended to read:

1342.7. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent

medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit.

~~(f)~~

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(g) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

~~—(g)~~

(h) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

~~—(h)~~

(i) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.

~~—(i)~~

(j) (1) The department shall periodically review its regulations developed pursuant to this section.

(2) On or before July 1, 2004, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.

~~—(j)~~

(k) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.

(l) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute,

that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1342.47 is added to the Health and Safety Code, to read:

1342.47. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department, in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the

standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2014, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(g) Notwithstanding any other provision of law, any deductible for basic health care services as defined in subdivision (b) of Section 1345 shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and basic health care services.

(h) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

(i) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

(j) (1) The department shall periodically review its regulations developed pursuant to this section.

(2) On or before July 1, 2014, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.

(j) This section shall become operative on January 1, 2014.

SEC. 3. Section 10123.197.5 is added to the Insurance Code, to read:

10123.197.5. (a) (1) A health insurance policy that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the insured's out-of-pocket costs of covered prescription drugs in that limit.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013, and shall remain in effect thereafter.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(b) Notwithstanding any other provision of law, on and after January 1, 2014, any deductible for essential health benefits, as described in subsection (b) of Section 1302 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section, shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and essential health benefits.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

ASSEMBLY BILL No. 1800 (WITH SUGGESTED AMENDMENTS)

Introduced by Assembly Member Ma
FEBRUARY 21, 2012

An act to amend, repeal, and add Section 1342.7 of the Health and Safety Code, and to add Section 10123.197.5 to the Insurance Code, relating to health care coverage.

Legislative Counsel's Digest

AB 1800, as introduced, Ma. ~~Prescription drugs~~ *Health care coverage*.
Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1342.7 of the Health and Safety Code is amended to read:

1342.7. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. ~~If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.~~

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the

copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

~~—(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out of pocket expenses for outpatient prescription drug coverage and include the enrollee's out of pocket costs of covered prescription drugs in that limit.~~

~~—(f)~~

~~—(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.~~

~~—(3) This limit shall not exceed the limit described in Section 1302(e) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013.~~

~~—(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.~~

(g) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

~~—(g)~~

(h) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

~~—(h)~~

(i) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.

~~—(i)~~

(j) (1) The department shall periodically review its regulations developed pursuant to this section.

(2) On or before July 1, 2004, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.

~~—(j)~~

(k) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.

~~—(l) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.~~

~~—SEC. 2. Section 1342.47 is added to the Health and Safety Code, to read:~~

~~—1342.47. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.~~

~~—(b) (1) Nothing in this chapter shall preclude a plan from filing~~

relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

—(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

—(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

—(d) The department, in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

—(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

—(2) Different limitations, including caps on benefits.

—(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

—(4) Different packages negotiated between purchasers and plans.

—(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

—(6) Current and past practices.

—(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

—(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2014, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit.

—(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits,

including prescription drugs, if covered.

~~—(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section.~~

~~—(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.~~

~~—(g) Notwithstanding any other provision of law, any deductible for basic health care services as defined in subdivision (b) of Section 1345 shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and basic health care services.~~

~~—(h) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.~~

~~—(i) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.~~

~~—(j) (1) The department shall periodically review its regulations developed pursuant to this section.~~

~~—(2) On or before July 1, 2014, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.~~

~~—(j) This section shall become operative on January 1, 2014.~~

Section 1367 is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be

licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the

number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service **consistent with Section 1367.004** ~~or from setting forth, by contract, limitations on maximum coverage of basic health care services~~, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this ~~chapter section~~ shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

Section 1367.004 is added to read:

(a) (1) a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2013, shall provide for a limit on annual out-of-pocket expenses for all covered benefits.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for any covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act

of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(b) On and after January 1, 2014, a health care service plan contract that is issued, amended or renewed shall provide that any deductible for covered benefits shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and any other covered benefits.

SEC. 3. Section 10123.197.5 is added to the Insurance Code, to read:

10123.197.5. (a) (1) A health insurance policy that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for **covered benefits** ~~outpatient prescription drug coverage~~ and include the insured's out-of-pocket costs of covered prescription drugs in that limit.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for **any** covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013, and shall remain in effect thereafter.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(b) Notwithstanding any other provision of law, on and after January 1, 2014, any deductible for **covered benefits** ~~essential health benefits, as described in subsection (b) of Section 1302 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022)~~ and any subsequent rules, regulations, or guidance issued under that

~~section,~~ shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and **any other covered benefits.** ~~essential health benefits.~~

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Appendix B: Literature Review Methods

Appendix B describes methods used in the medical effectiveness literature review conducted for AB 1800. A discussion of CHBRP's system for grading evidence, as well as lists of MeSH Terms, Publication Types, and Keywords, follows.

The literature search was limited to studies published in English from March 2008 to present. For earlier studies, CHBRP relied on a literature search conducted in 2008 for its issue analysis for SB 1522, a bill that concerned standardization of cost sharing and other aspects of health plans and health insurance policies.

The following databases of peer-reviewed literature were searched: MEDLINE (PubMed), the Cochrane Database of Systematic Reviews, the Cochrane Register of Controlled Clinical Trials, Web of Science, and EconLit. In addition, websites maintained by the following organizations that index or publish systematic reviews and evidence-based guidelines were searched: Agency for Healthcare Research and Quality, International Network of Agencies for Health Technology Assessment, the National Cancer Institute's Physician Data Query, National Health Service Centre for Reviews and Dissemination, National Institute for Health and Clinical Excellence, and the Scottish Intercollegiate Guideline Network.

Owing to the large volume of literature that has been published on cost sharing for health care services (i.e., the portion of expenditures paid by enrollees), CHBRP relied on meta-analyses, systematic reviews, and narrative reviews to obtain information about the overall findings from this literature. For the specific forms of cost sharing addressed in AB 1800—annual out-of-pocket maximums and deductibles—CHBRP also reviewed randomized controlled trials (RCTs) and nonrandomized studies with comparison groups.

Two reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Abstracts for 136 articles were identified. Nineteen meta-analyses, systematic reviews, narrative reviews, RCTs, and nonrandomized studies with comparison groups were retrieved and reviewed.

Evidence Grading System

In making a “call” for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- research design,
- statistical significance,
- direction of effect,
- size of effect, and

- generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention’s effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- clear and convincing evidence,
- preponderance of evidence,
- ambiguous/conflicting evidence, and
- insufficient evidence.

The conclusion states that there is “clear and convincing” evidence that an intervention has a favorable effect on an outcome if most of the studies included in a review have strong research designs and report statistically significant and clinically meaningful findings that favor the intervention.

The conclusion characterizes the evidence as “preponderance of evidence” that an intervention has a favorable effect if most, but not all five, criteria are met. For example, for some interventions, the only evidence available is from nonrandomized studies. If most such studies that assess an outcome have statistically and clinically significant findings that are in a favorable direction and enroll populations similar to those covered by a mandate, the evidence would be classified as a “preponderance of evidence favoring the intervention.” In some cases, the preponderance of evidence may indicate that an intervention has no effect or an unfavorable effect.

The evidence is presented as “ambiguous/conflicting” if their findings vary widely with regard to the direction, statistical significance, and clinical significance/size of the effect.

The category “insufficient evidence” of an intervention’s effect is used when there is little if any evidence of an intervention’s effect. *Insufficient evidence of an effect is not evidence of no effect.* Instead, this term is used in cases in which very few studies have been published on an outcome and/or the studies are of very low quality.

Search Terms

The search terms used to locate studies relevant to **AB 1800** were as follows:

MeSH terms used to search PubMed and Cochrane Library

Cost-Benefit Analysis
 Cost Sharing
 Deductibles and Coinsurances
 Drug prescriptions/utilization
 Drug Utilization
 Emergency Service, Hospital/statistics and numerical data/utilization

Ethnic Groups
Female
Health Services/utilization
Insurance Coverage
Insurance, Pharmaceutical Services
Male
Medication Adherence
Office Visits
Outcome Assessment (Health Care)
Patient Compliance
Prescription Drugs
Prescription Fees
Treatment Outcome

Keywords used to search PubMed, Cochrane Library, Web of Science, EconLit, and other relevant websites

adherence to medication
annual limits on out of pocket
benefit cap*
chronic disease*
coinsurance
co-payment
consumer driven health plan OR consumer driven health plans
copay
copayment,
cost effective*
cost sharing
cost utility
CVS/CareMark
deductible*
demand
discontinuation of medication
drug cost*
drug utilization
economic burden
effect*
emergency department visit*
filling a prescription
gender
HDHP*
health outcome*
health saving account*
high deductible health plan*
hospital admissions
hospitalization

impact
income
Kaiser Family Foundation
max of out of pocket
medical bankruptcy
medical debt
medication adherence
number of prescriptions filled
number of refills
office visit*
out of pocket maximum
patient compliance
pharmaceutical spending
pharmacy spending
premature death
prescription drug*
prescription drug benefit*
prescription drug trend*
prescription medication
price elasticity of demand
price of treatment
racial/ethnic
socioeconomic difference
supply
tier copayment
unit cost of treatment

* indicates that the search term was truncated

Years covered

2011 to present:

- the impact of cost sharing in general (for earlier studies, CHBRP relied on literature searches conducted for previous reports on bills that addressed cost sharing);

2008 to present:

- the impact of high deductible health plans on use of prescription drugs;
- the impact of annual limits on out-of-pocket costs (i.e., annual out-of-pocket maximum) for any covered benefit and not just prescription drugs.

Language

English

Appendix C: Summary Findings on Medical Effectiveness

There are no Summary of Findings on Medical Effectiveness tables for AB 1800.

Appendix D: Cost Impact Analysis: Data Sources, Caveats, and Assumptions

This appendix describes data sources, as well as general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methods, please refer to the CHBRP website at

http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, San Diego, and the University of California, Los Angeles, as well as the contracted actuarial firm, Milliman, Inc. (Milliman). Milliman provides data and analyses per the provisions of CHBRP's authorizing legislation.

Data Sources

In preparing cost estimates, the cost team relies on a variety of data sources as described below.

Health insurance

1. The latest (2009) California Health Interview Survey (CHIS), which is used to estimate health insurance for California's population and distribution by payer (i.e., employment-based, individually purchased, or publicly financed). The biennial CHIS is the largest state health survey conducted in the United States, collecting information from approximately 50,000 households. More information on CHIS is available at www.chis.ucla.edu.
2. The latest (2011) California Employer Health Benefits Survey is used to estimate:
 - size of firm,
 - percentage of firms that are purchased/underwritten (versus self-insured),
 - premiums for health care service plans regulated by the Department of Managed Health Care (DMHC) (primarily health maintenance organizations [HMOs] and point of service plans [POS]),
 - premiums for health insurance policies regulated by the California Department of Insurance (CDI) (primarily preferred provider organizations [PPOs] and fee-for-service plans [FFS]), and
 - premiums for high deductible health plans (HDHPs) for the California population with employment-based health insurance.
 - This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. Information on the CHCF/NORC data is available at: www.chcf.org/publications/2010/12/california-employer-health-benefits-survey.
3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States. See

www.milliman.com/expertise/healthcare/products-tools/milliman-care-guidelines/index.php.

Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blues plans, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed health care plans, generally those characterized as preferred provider plans or PPOs. The HCGs currently include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP's utilization and cost estimates draw on other data, including the following:

- The MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
 - An annual survey of HMO and PPO pricing and claim experience. The most recent survey (2010 Group Health Insurance Survey) contains data from seven major California health plans regarding their 2010 experience.
 - Ingenix MDR Charge Payment System, which includes information about professional fees paid for healthcare services, based upon approximately 800 million claims from commercial insurance companies, HMOs, and self-insured health plans.
 - These data are reviewed for applicability by an extended group of experts within Milliman but are not audited externally.
4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual), type of plan (i.e., DMHC-regulated or CDI-regulated), cost-sharing arrangements with enrollees, and average premiums. Enrollment in plans or policies offered by these seven firms represents an estimated 94.3% of the persons with health insurance subject to state mandates. This figure represents an estimated 93.9% of enrollees in full-service (nonspecialty) DMHC-regulated health plans and an estimated 95.5% of enrollees in full-service (nonspecialty) CDI-regulated policies. CHBRP analysis of the share of enrollees included in CHBRP's bill-specific coverage survey of the major carriers in the state is based on "CDI Licenses with HMSR Covered Lives Greater than 100,000" as part of the Accident and Health Covered Lives Data Call September 30, 2010, by the California Department of Insurance, Statistical Analysis Division, data retrieved from the Department of Managed Health Care's interactive website "Health Plan Financial Summary Report, July–September 2011," and CHBRP's Annual Enrollment and Premium Survey.

Publicly funded insurance subject to state benefit mandates

5. Premiums and enrollment in DMHC-regulated health plans and CDI-regulated policies by self-insured status and firm size are obtained annually from California Public Employees' Retirement System (CalPERS) for active state and local government public employees and their dependents who receive their benefits through CalPERS. Enrollment information is provided for DMHC-regulated health care service plans covering non-Medicare

beneficiaries—about 74% of CalPERS total enrollment. CalPERS self-funded plans—approximately 26% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOCs) documents publicly available at www.calpers.ca.gov.

6. Enrollment in Medi-Cal Managed Care (beneficiaries enrolled in Two-Plan Model, Geographic Managed Care, and County Operated Health System plans) is estimated based on CHIS and data maintained by the Department of Health Care Services (DHCS). DHCS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts that summarize the current scope of benefits. CHBRP assesses enrollment information online at www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_General_Medi_Cal_Enrollment.aspx.
7. Enrollment data for other public programs—Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP)—are estimated based on CHIS and data maintained by the Managed Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating health plans under these programs must comply with all requirements for DMHC-regulated health plans, and thus these plans are affected by state-level benefit mandates. CHBRP does not include enrollment in the Post-MRMIP Guaranteed-Issue Coverage Products as these persons are already included in the enrollment for individual market health insurance offered by DMHC-regulated plans or CDI-regulated insurers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. Enrollment information is obtained online at www.mrmib.ca.gov/. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats and Assumptions

The projected cost estimates are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated benefits (and, therefore, the services covered by the benefit) before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for plans and policies subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed mandate.

- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for 1 year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts, please see: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php
- Several recent studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew et al., 2005; Glied and Jack, 2003; Hadley, 2006). Chernew et al. (2005) estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, whereas Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and 0.84 percentage point decrease in the number of insured, respectively. The price elasticity of demand for insurance can be calculated from these studies in the following way. First, take the average percentage point decrease in the number of insured reported in these studies in response to a 1% increase in premiums (about -0.088), divided by the average percentage of insured persons (about 80%), multiplied by 100%, i.e., $(\{-0.088/80\} \times 100) = -0.11$. This elasticity converts the *percentage point* decrease in the number of insured into a *percentage* decrease in the number of insured persons for every 1% increase in premiums. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. For more information on CHBRP's criteria for estimating impacts on the uninsured please see: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

There are other variables that may affect costs, which CHBRP did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance: If a mandate increases health insurance costs, some employer groups and individuals may elect to drop their health insurance. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans: To help offset the premium increase resulting from a mandate, subscribers/policyholders may elect to increase their overall plan deductibles or copayments. Such changes would have a direct impact on the distribution of costs between the health plan and policies and enrollees, and may also result in utilization reductions (i.e., high levels of patient cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.
- Adverse selection: Theoretically, individuals or employer groups who had previously foregone health insurance may now elect to enroll in a health plan or policy, postmandate, because they perceive that it is to their economic benefit to do so.

- Medical management: Health plans and insurers may react to the mandate by tightening medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan types that previously had the least effective medical management (i.e., PPO plans).
- Geographic and delivery systems variation: Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models: Even within the health insurance types CHBRP modeled (HMO—including HMO and point of service [POS] plans—and non-HMO—including PPO and fee-for-service [FFS] policies), there are likely variations in utilization and costs by type. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans or insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.
- Compliance with the mandate: For estimating the postmandate coverage levels, CHBRP typically assumes that plans and policies subject to the mandate will be in compliance with the coverage requirements of the bill. Therefore, the typical postmandate coverage rates for populations subject to the mandate are assumed to be 100%.

Potential Effects of the Federal Affordable Care Act

As discussed in the *Introduction*, there are a number of Affordable Care Act (ACA) provisions that have already gone into or will go into effect over the next 3 years. Some of these provisions affect the baseline or current enrollment, expenditures, and premiums. This subsection discusses adjustments made to the 2012 Cost and Coverage Model to account for the potential impacts of the provisions of ACA that have gone into effect by January 1, 2012. It is important to emphasize 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 the *Benefit Coverage, Utilization, and Cost Impacts* section of this report.

CHBRP reviewed the ACA provisions and determined whether and how these provisions might affect:

1. The number of covered lives in California, and specifically the makeup of the population with health insurance subject to state mandates
2. Baseline premiums and expenditures for health insurance subject to state mandates, and
3. Benefits required to be covered in various health insurance plans subject to state mandates

There are still a number of provisions that have gone into effect for which data are not yet available. Where data allows, CHBRP has made adjustments to the 2012 Cost and Coverage model to reflect changes in enrollment and/or baseline premiums and these are discussed here.

Coverage for adult children

ACA Section 2714, modified by HR 4872, Section 2301, requires coverage for adult children up to age 26 years as dependents to primary subscribers on all individual and group policies, effective September 23, 2010. California's recently enacted law, SB 1088 (2010) implements this provision. As a result of the ACA, many of these young adults have gained access to health insurance through a parent. This dynamic has both diminished the number of uninsured and also shifted some young adults from the individually purchased health insurance market into the group market. Responses to CHBRP's Annual Enrollment and Premium Survey have captured the effects of this provision.

Minimum medical loss ratio requirement

PPACA Section 2718 requires health plans offering health insurance in group and individual markets to report to the Secretary of Health and Human Services the amount of premium revenue spent on clinical services, activities to improve quality, and other non-claim costs. Beginning in 2011, large-group plans that spend less than 85% of premium revenue and small-group/individual market plans that spend less than 80% of premium revenue on clinical services and quality must provide rebates to enrollees. According to the Interim Final Rule, (45 CFR Part 158) "Issuers will provide rebates to enrollees when their spending for the benefit of policyholders on reimbursement for clinical services and quality improvement activities, in relation to the premiums charged, is less than the medical loss ratio (MLR) standards established pursuant to the statute."⁵⁷ The requirement to report medical loss ratio is effective for the 2010 plan year, whereas the requirement to provide rebates is effective January 1, 2011. The MLR requirement, along with the rebate payment requirement, will affect premiums for 2012, but the effects are unknown and data are not yet available. There is potential for substantial impact on markets with higher administrative costs, including the small- and individual-group markets. Responses to CHBRP's Annual Enrollment and Premiums Survey indicate that carriers intend to be in compliance with these requirements. For those that may not be in compliance, the requirement to pay rebates is intended to align the MLR retrospectively. Therefore, for modeling purposes, CHBRP has adjusted administrative and profit loads to reflect MLRs that would be in compliance with this provision.

Pre-existing Condition Insurance Plan

PPACA Section 1101 establishes a temporary high-risk pool for individuals with pre-existing medical conditions, effective 90 days following enactment until January 1, 2014. In 2010, California enacted AB 1887 and SB 227, providing for the establishment of the California Pre-existing Conditions Insurance Plan (PCIP) to be administered by the Managed Risk Medical Insurance Board (MRMIB) and federally funded per Section 1101. MRMIB has projected average enrollment of 23,100 until the end of 2013, when the program will expire. As of

⁵⁷ Department of Health and Human Services, *Interim Final Rule: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act*. 45 CFR Part 158. December 1, 2010.

December 2010, there were approximately 1,100 subscribers.⁵⁸ The California PCIP is not subject to state benefit mandates,⁵⁹ and therefore, this change does not directly affect CHBRP's Cost and Coverage Model. CHBRP has revised its annual update of *Estimates of the Sources of Health Insurance in California*.⁶⁰ to reflect that a slight increase in the number of those who are insured under other public programs that are not subject to state level mandates.

Prohibition of pre-existing condition exclusion for children

PPACA Sections 1201 & 10103(e): Prohibits pre-existing condition exclusions for children. This provision was effective upon enactment). California's recently enacted law, AB 2244 (2010) implements this provision. AB 2244 also prohibits carriers that sell individual plans or policies from refusing to sell or renew policies to children with pre-existing conditions. Carriers that do not offer new plans for children are prohibited from offering for sale new individual plans in California for 5 years.⁶¹ This provision could have had significant premium effects, especially for the DMHC-regulated and CDI-regulated individual markets. The premium information is included in the responses to CHBRP's Annual Enrollment and Premium Survey. Thus the underlying data used in CHBRP annual model updates captured the effects of this provision.

Prohibition of lifetime limits and annual benefit limit changes

PPACA Section 2711 prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage, effective September 23, 2010. Plans may only impose annual limits on coverage and these annual limits may be no less than \$750,000 for "essential health benefits." The minimum annual limit will increase to \$1.25 million on September 23, 2011, and to \$2 million September 23, 2012. Earlier in 2010, CHBRP conducted an analysis of SB 890 which sought to prohibit lifetime and annual limits for "basic health care services" covered by CDI-regulated policies. CHBRP's indicated that DMHC-regulated plans were generally prohibited from having annual or lifetime limits. The analysis also indicated that less than 1% of CDI-regulated policies in the state had annual benefit limits and of those, the average annual benefit limit was approximately \$70,000 for the group market and \$100,000 for the individual market. Almost all CDI-regulated policies had lifetime limits in place, and the average lifetime limits was \$5 million. After the effective date of the PPACA Section 2711, removal of these limits may have had an effect on premiums. As mentioned, premium information is included in the responses to CHBRP's Annual Enrollment and Premium Survey. Thus the underlying data used in CHBRP annual model updates captured the effects of this provision to remove lifetime limits and to increase annual limits for those limited number of policies that had annual limits that fell below \$750,000.

Medi-Cal Managed Care enrollment: seniors and persons with disabilities

Although the PPACA allows states the option to expand coverage to those not currently eligible for Medicaid (Medi-Cal in California), large-scale expansions are not expected to be seen during

⁵⁸ Enrollment report presented at the Managed Risk Medical Insurance Board Meeting, January 19, 2010. Available at: www.mrmib.ca.gov/MRMIB/Agenda_Minutes_011911/Agenda_Item_9.a_PCIP_Board_Report_for_Dec_2010_FI_NAL.pdf.

⁵⁹ Correspondence with John Symkowick, Legislative Coordinator, MRMIB, October 19, 2010.

⁶⁰ See: http://www.chbrp.org/other_publications/index.php.

⁶¹ See enacted language at: www.leginfo.ca.gov/pub/09-10/bill/asm/ab_2201-2250/ab_2244_bill_20100930_chaptered.pdf.

2012. However, as a result of the 2010–2011 California Budget Agreement, there are expected to be shifts in coverage for seniors and persons with disabilities. Specifically, “Seniors and persons with disabilities who reside in certain counties which have managed care plans, and who are not also eligible to enroll in Medicare, will be required to enroll in a managed care plan under a phased-in process.”⁶² The Medi-Cal Managed Care enrollment in CHBRP’s 2012 Cost and Coverage Model has been adjusted to reflect this change. Baseline premium rates have also been adjusted to reflect an increase in the number of seniors and persons with disabilities in Medi-Cal Managed Care. Information from DHCS indicated that by November 2011, an estimated 289,000 seniors and persons with disabilities had enrolled in Medi-Cal Managed Care.⁶³ CHBRP used data from DHCS to adjust enrollment in Medi-Cal Managed Care, and to adjust premiums to account for the change in acuity in the underlying populations.⁶⁴

Bill Analysis—Specific Caveats and Assumptions

1. Calculations do not consider different effects on individual compared to family out-of-pocket annual maximums. Information on family coverage is not available in the data systems used to project changes in costs and utilization. CHBRP compliance assumptions assume the same effects of annual out-of-pocket maximums observed among individuals would apply to families.
2. CHBRP pursued the following approach to estimate the potential share of enrollees in plans/policies who would see their out-of-pocket costs reduced after AB 1800:

The share of individuals reaching the annual out-of-pocket maximums mandated by AB 1800 would vary by type of plan, benefit design, and annual out-of-pocket maximum. CHBRP used typical plan designs (described below) for each private market segment. For plans and policies that currently have no annual out-of-pocket maximum, or an out-of-pocket maximum higher than would be allowable under AB 1800, CHBRP assumed that the postmandate annual out-of-pocket maximum would be equal to the mandated limit. For plans and policies with annual out-of-pocket maximums below the AB 1800 limit, CHBRP assumed there would be no postmandate change in those maximums even if they currently exclude outpatient prescription drug costs. CHBRP estimated that the following share of enrollees in plans or policies that are currently noncompliant with AB 1800 in each market would reach the annual out-of-pocket maximums mandated by AB 1800:

⁶² Taylor, M. Legislative Analyst, *The Budget Package 2010-11 California Spending Plan*. LAO: November, 2010. Available at:

www.lao.ca.gov/reports/2010/bud/spend_plan/spend_plan_110510.pdf.

⁶³ Department of Health Care Services, Managed Care Implementation for Seniors and Persons with Disabilities: Monitoring Dashboard: February 2012. Available at:

www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf.

⁶⁴ See the study conducted for DHCS by Mercer on this topic: Mercer, *Medi-Cal Acuity Study: Seniors and Persons with Disabilities*. September 28, 2010. Available at

www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SPD_Study_092810.pdf.

Large HMO	6.7%
Large PPO	3.7%
Small HMO	3.1%
Small PPO	2.9%
Individual HMO	3.2%
Individual PPO	3.9%

Due to limited or no cost sharing, CHBRP projects that 0% of enrollees in CalPERS, Medi-Cal Managed Care, and MRMIRB would be impacted by AB 1800.

An estimated 3.4 million Californians are in private health plans or policies that are already compliant with AB 1800 and would also not be impacted by the mandate.

When CHBRP weighted the number of enrollees in all categories it projected that approximately 3.3% of enrollees in plans/policies subject to the mandate would have reduced cost sharing under AB1800.

3. Of the three major components of AB 1800, which address, respectively, annual out-of-pocket maximums, deductibles, and independent medical review eligibility of pharmacy formularies, the cost analysis only considered the impact of the individual out-of-pocket maximum component of the bill. The annual out-of-pocket maximum and independent medical review elements become active on January 1, 2013. The portion of the legislation relating to deductibles would take effect on January 1, 2014, and was omitted from the analysis. The eligibility for medical review of pharmaceutical formularies may have a material impact but was not considered quantifiable.

AB 1800 would mandate that all DMHC-regulated plans and all CDI-regulated policies which include drug coverage would be subject to annual out-of-pocket limits for all covered benefits no greater than those specified by the ACA; in 2013, these limits are \$6,050 for individual coverage and \$12,100 for family coverage. A plan can fail to be compliant with the mandate in several ways:

- Have no annual out-of-pocket limits on covered benefits
- Have annual out-of-pocket maximums that exceed the specified limits
- Exclude covered prescription drugs from the out-of-pocket maximum
- Have a separate prescription drug out-of-pocket maximum

CHBRP modeled typical noncompliant plans for each market segment and for each specific compliance failure. Non-high deductible plans were included in the model, assuming that high deductible plans and non-high deductible plans would have a similar percentage of gross claims impacted by the mandate. These plan designs are:

Plan	Ded	Coinsurance		Copayments		
		IN	OON	OV	OP	IP
LG HMO	\$0	0%	0%	\$20	\$20	\$250
LG PPO	\$500	10%	30%	\$0	\$0	\$0
SG HMO	\$0	0%	0%	\$20	\$20	\$250
SG PPO	\$500	15%	35%	\$0	\$0	\$0
Ind HMO	\$0	0%	0%	\$25	\$25	\$500
Ind PPO	\$2,500	20%	40%	\$0	\$0	\$0

Key: Ded=deductibles; IN=in-network; Ind=individual; IP=inpatient; LG=large-group; OON=out-of-network; OP=outpatient; OV=office visit; SG=small-group.

Annual out-of-pocket maximums varied according to the modeled source of noncompliance.

AB 1800 mandates a shifting of costs from plan members to carriers in affected plans, but CHBRP assumed that there would be no change in the number of medical and prescription drug services users. Out-of-pocket maximums are assumed to have minimal impact on the decision of members considering their first medical encounter of the plan year.

CHBRP used the Milliman Managed Care Rating Model (MCRM) to estimate the cost of the different medical plans. The MCRM estimates the cost of benefit plans based on average cost and utilization.

CHBRP estimated the cost of typical benefit designs: representative of the large-group, small-group, and individual markets. The model was calibrated to the average premiums in the carrier survey by adjusting provider discounts and the Degree of Healthcare Management (DoHM). The DoHM reflects the health care system efficiency.

CHBRP estimated the annual out-of-pocket maximum (OOPM) PMPM cost as follows:

1. Estimate the total dollars spent on medical costs needed to hit the OOPM.
2. Using a claim probability distribution (CPD) to determine the PMPM cost of claims exceeding the estimate in (1). A CPD is a distribution of annual average claims by member.
3. Multiply the PMPM cost in (2) by the coinsurance. This is because the initial pricing assumes coinsurance applies to all claims. Once the OOPM is reached, no further coinsurance will be charged. Therefore, the expected member coinsurance above the point where the OOPM is reached is added to the premium.
4. Apply a 5% utilization response factor to the gross claims impacted by the mandate as calculated in (2). This amount represents additional utilization induced by the removal of cost sharing above the out-of-pocket limit. This amount is added the postmandate claims cost calculated in (3).

CHBRP priced the products premandate with the OOPM applying to medical claims only and postmandate with the OOPM applying to both medical and prescription drug claims. The difference in net medical claim cost is the expected increase in cost due to the mandate.

For DMHC products, we applied a dampening factor to the estimated OOPM PMPM cost. For these products, the typical benefit designs apply copayments to certain services. These copayments do not translate into a flat coinsurance percentage across service category. Some services may have no cost sharing, while other services may have a copayment that translates into 10% or 20% of the average discounted charges. Therefore, using a flat coinsurance percentage to determine the total dollars spent on medical costs creates a bias and overstates the OOPM PMPM cost estimate. CHBRP adjusted for this by multiplying the estimated OOPM PMPM cost estimate by a dampening factor of 0.15.

The dampening factor was determined by an analysis of claims by member for several plan designs. The actual value of the OOPM was determined using this seriatim approach. It was compared to the OOPM cost estimate derived using the CPD approach. The value of the OOPM using a seriatim claim approach was between 10% and 20% of the value of the OOPM using a CPD approach. Therefore, we applied a factor of 0.15 to adjust our OOPM cost estimate for DMHC products.

Appendix E: Information Submitted by Outside Parties

In accordance with CHBRP policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

No information was submitted by interested parties for this analysis.

For information on the processes for submitting information to CHBRP for review and consideration please visit: http://www.chbrp.org/recent_requests/index.php.

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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