

California Health Benefits Review Program

Executive Summary

Analysis of Assembly Bill 1917:
Outpatient Prescription Drugs: Cost Sharing

A Report to the 2013-2014 California Legislature

April 25, 2014



KEY FINDINGS

Analysis of California Assembly Bill (AB) 1917: Outpatient Prescription Drugs: Cost Sharing

SUMMARY TO THE 2013–14 CALIFORNIA LEGISLATURE • APRIL 25, 2014



AT A GLANCE

AB 1917 (as introduced February 25, 2014) would require nongrandfathered plans and policies, except for cost sharing reduction products (CSRs) sold in Covered California, to limit cost sharing for an outpatient prescription drug to no more than 1/24 of the annual out-of-pocket maximum mandated by the ACA (1/24 of \$6,350 in 2014), or \$265. For enrollees in high deductible health plans (HDHPs), this limit would only apply once the enrollee met their annual deductible. For enrollees in CSRs in Covered California, AB 1917 would require that cost sharing for all covered benefits in a month be limited to 1/24 of the annual out-of-pocket maximum of those products.

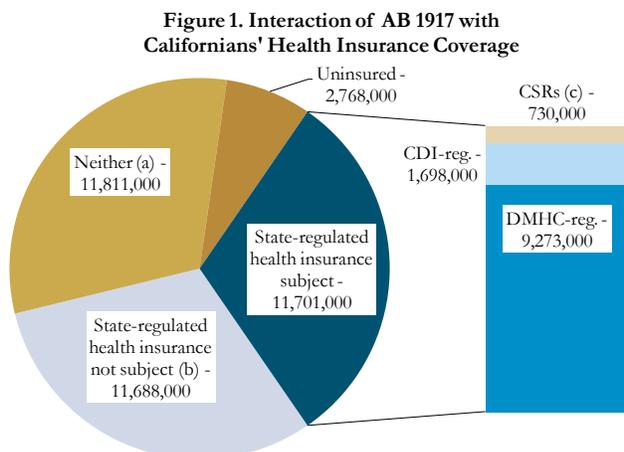
- **Enrollees covered.** CHBRP estimates that in 2015, 11.7 million of 23.4 million Californians with state-regulated health insurance would have coverage that would be subject to AB 1917. Medi-Cal Managed Care Plans are not subject to AB 1917 nor are grandfathered plans and policies.
 - **CSRs.** Enrollees eligible for cost sharing reductions under the ACA have incomes between 100% and 250% of the federal poverty level (FPL) and are enrolled in a silver metal-level qualified health plan (QHP) in Covered California. These products have reduced cost sharing, including a lower annual out-of-pocket maximum. CHBRP estimates there will be 730,000 enrollees in CSRs in California in 2015. The monthly cost-sharing limit on all covered benefits required by AB 1917 would change the benefit design of these products, bringing them out of compliance with Affordable Care Act (ACA) requirements. Therefore, CHBRP cannot estimate the impact of AB 1917 on benefit coverage, utilization, cost, and public health for CSRs.
- **Impact on expenditures.** AB 1917 would increase expenditures in California by an estimated \$106.1 million in the nongrandfathered group and individual market (excluding CSRs).
 - **Premiums.** Increases in per member per month (PMPM) premiums are estimated to range from an average of 0.047% (for DMHC-regulated large-group plans) to an average of 0.661% (for CDI-regulated individual market policies).
 - **Enrollee out-of-pocket expenses.** AB 1917 would shift costs from enrollees to health plans and insurers. Enrollee out-of-pocket expenses would be reduced by an estimated \$21.8 million.
- **Medical effectiveness.** Overall, there is strong evidence that persons who face higher cost sharing reduce use of both essential and nonessential services. For prescription drugs, there is evidence that as cost sharing increases for prescription drugs, including specialty prescription drugs, usage decreases.
- **Benefit coverage.** AB 1917 would apply to all outpatient prescription drugs; however, the mandate is estimated to have the greatest impact on high cost and/or specialty drugs. All enrollees subject to AB 1917 have coverage for outpatient prescription drugs, as broadly defined by AB 1917, and all have some form of cost sharing for these prescription drugs.
- **Utilization.** The limit on cost sharing would increase utilization of high cost and/or specialty drugs, both by enrollees using these prescription drugs premandate as well as by new users who will be using these drugs due to the lower cost sharing levels postmandate. Utilization would increase 2%, and there would be an estimated 947 new users (premandate, 45,410; postmandate, 46,357).
- **Public health.** CHBRP projects no measurable public health impact due to the small percentage of enrollees (0.42%) utilizing high cost and/or specialty prescription drugs with cost sharing that would be lowered as a result of AB 1917. However, CHBRP recognizes that on a case-by-case basis, AB 1917 may yield important health and quality of life improvements and could significantly impact disease progression and outcomes.
- **Essential Health Benefits (EHBs).** State rules related to cost sharing do not meet the definition of state benefit mandates that could exceed EHBs; therefore, AB 1917 would not exceed EHBs and would not require the state to defray the costs of this mandate for enrollees in QHPs.

BILL SUMMARY

AB 1917 would require:

- For a single covered outpatient prescription drug for a supply of up to 30 days, cost sharing cannot exceed 1/24 of the annual out-of-pocket maximum established by the ACA (1/24 of \$6,350 in 2014), or \$265.
- For plans and policies that meet the definition of a high deductible health plan (HDHP), this requirement would only apply once the deductible for the year has been met.
- For enrollees eligible for cost sharing reductions under the ACA, cost sharing in a single month cannot exceed 1/24 of the annual out-of-pocket maximum of the cost sharing reduction product.

State-regulated nongrandfathered group and individual market health insurance is subject to AB 1917. However, Medi-Cal Managed Care Plans are not subject to AB 1917. Therefore, the mandate would affect the health insurance of approximately 11.7 million enrollees (31% of all Californians). See Figure 1.



Source: California Health Benefit Review Program, 2014.

Notes: (a) Neither = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans. (b) State-regulated health insurance not subject = grandfathered plans and policies; Medi-Cal Managed Care Plans. (c) CSRs = cost sharing reduction products sold in Covered California.

CHBRP KEY FINDINGS: INCREMENTAL IMPACT OF AB 1917

Cost Sharing Reduction Products

Enrollees eligible for cost sharing reductions under the ACA are those with incomes between 100% and 250% of the federal poverty level (FPL) who enroll in a silver metal-level qualified health plan (QHP) sold in Covered California. These products have reduced cost sharing, including a lower annual out-of-pocket maximum. These products are referred to as “CSRs” (cost sharing reduction products). CHBRP estimates there will be 730,000 enrollees in CSRs in California in 2015 (see Figure 1).

AB 1917 would place a monthly out-of-pocket limit on cost sharing for all covered benefits for enrollees in

CSRs. This would halve the annual out-of-pocket maximum for these products, increasing their actuarial value – the portion of costs the health insurance carrier pays for covered benefits – bringing the products out of ACA compliance. It is not possible to meet both the requirements of AB 1917 and the requirements of the ACA; therefore, CHBRP cannot estimate the benefit coverage, utilization, cost, and public health impacts for CSRs.

Benefit Coverage, Utilization and Cost

The number of enrollees subject to AB 1917 and included in this analysis is approximately 10,971,000 (excluding enrollees in CSRs). AB 1917 would apply to all outpatient prescription drugs; however, the mandate is estimated to have the greatest impact on high cost and/or specialty drugs.

Benefit coverage: AB 1917 defines an outpatient prescription drug broadly, including all covered prescription drugs self-administered, administered by a licensed health care professional in an outpatient setting, or administered in a non-inpatient clinical setting. All enrollees subject to AB 1917 have coverage for outpatient prescription drugs, as defined by AB 1917, and all have some form of cost sharing for these prescription drugs. AB 1917 mandates changes in cost sharing and does not mandate coverage of specific treatments and services; therefore, CHBRP does not estimate changes in benefit coverage due to AB 1917.

Benefit utilization: The cost sharing limit on outpatient prescription drugs would increase the number of enrollees utilizing these high cost and/or specialty prescription drugs as well as increase the number of prescription drug claims. Premandate, CHBRP estimates 45,410 enrollees would have a prescription drug claim with cost sharing greater than \$265 (1/24 of the annual out-of-pocket maximum), whereas postmandate, an estimated 46,357 enrollees would have a claim with cost sharing that would have exceeded the limit of \$265 premandate. This is an increase of 947 enrollees who will begin using these drugs due to the lower cost sharing levels postmandate. The average number of prescription drug claims in a year for these enrollees would increase 2%.

The reduction in cost sharing for outpatient prescription drugs would result in enrollees facing additional cost sharing for other covered health care services before they reach their annual out-of-pocket maximum. This would decrease these enrollees use of other health care services by an estimated 0.31%.

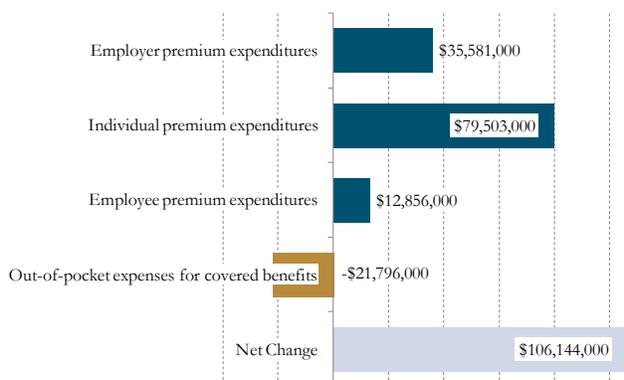
Benefit costs: See Figure 2 for a summary of changes in expenditures postmandate. In addition:

- The average cost sharing per outpatient prescription drug claim premandate is \$325. Average cost sharing

per claim postmandate will be reduced to \$189, a reduction of \$136 (42%).¹

- CalPERS total premiums are estimated to increase by \$7,581,000, or 0.18%.
- Increases in per member per month (PMPM) premiums are estimated to range from an average of 0.047% (for DMHC-regulated large-group plans) to an average of 0.661% (for CDI-regulated individual market policies) in the affected market segments.

Figure 2. Changes in Total and Aggregate Expenditures by Category Postmandate, AB 1917



Medical Effectiveness

Overall, there is strong evidence that persons who face higher cost sharing reduce use of both essential and nonessential services.

Prescription drug cost sharing: There is strong evidence that persons who face higher cost sharing for a prescription drug are less likely to maintain meaningful levels of prescription drug adherence than persons who face lower cost sharing. Furthermore, there is evidence that poorer adherence to prescription drug therapy for chronic conditions is associated with higher rates of hospitalization and emergency department visits and poorer health outcomes.

Specialty prescription drugs: There is a evidence that the effect of cost sharing on use of specialty drugs is similar to the effects for all kinds of prescription drugs — as cost sharing increases, usage decreases. However, there is some evidence that the effect of cost sharing may differ depending on the specific disease and specific specialty drug.

Public Health

Health impacts: CHBRP projects no measurable public health impact due to the small number of enrollees (46,357 of 10.97 million, 0.42%) with a reduction in cost sharing for prescriptions that would have exceeded the \$265 limit premandate. CHBRP

¹ The postmandate amount is lower than the limit of \$265 set by AB 1917 because some enrollees would reach their annual out-of-pocket maximum; these enrollees would have no cost sharing after reaching their annual out-of-pocket maximum.

recognizes that on a case-by-case basis, AB 1917 may yield important health and quality of life improvements for some persons.

Financial burden: To the extent that AB 1917 removes a cost barrier for some enrollees who would then initiate therapy earlier and maintain adherence, the health impact on disease progression and outcomes could be significant on a case-by-case basis.

Long-Term Impacts

Utilization and cost impacts: In the long-term, AB 1917 is likely to accelerate the use of high-cost prescription drugs due to reduced cost sharing and development of new high-cost specialty drugs. AB 1917 is likely to increase overall health expenditures most likely leading to increases in premiums.

Public health impacts: To the extent that cost barriers for high-cost and/or specialty prescription drugs are reduced, there are potentially beneficial long-term health impacts for people with chronic conditions such as multiple sclerosis and rheumatoid arthritis. However, CHBRP is unable to quantify the long-term public health impact of AB 1917 due to uncertainty in the market's response to the downward cost pressure of mandated reductions in enrollee cost sharing and the upward pressure of the increasing number and cost of specialty drugs.

Essential Health Benefits and the Affordable Care Act

AB 1917 modifies the cost sharing for outpatient prescription drugs, and, for enrollees in CSRs, for all covered benefits. As state rules related to cost sharing do not meet the definition of state benefit mandates that could exceed essential health benefits (EHBs), AB 1917 would not exceed EHBs and would not require the state to defray the costs of this mandate for enrollees in QHPs.

CONTEXT FOR BILL CONSIDERATION: COST SHARING AND SPECIALTY PRESCRIPTION DRUGS

What is cost sharing?: Payment for covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Specifically, the *patient* cost-share is the portion that enrollees are responsible for paying out-of-pocket directly to the provider for the health care service or treatment (including prescription drugs) covered by the plan or policy. Common cost-sharing mechanisms include: *deductibles* — a fixed dollar amount (lump sum for one or more services) an enrollee is required to pay out-of-pocket within a given time period (e.g., a year) before the health plan or insurer begins to pay, in part or in whole, for covered benefits; *copayments* — a flat dollar amount for a covered benefit; and *coinsurance* — a percentage of cost for a covered benefit. An *annual out-of-pocket maximum* is a limit on the

enrollee's total cost-sharing (copayments, coinsurance, and deductibles) obligations in a one-year period.

Cost sharing and outpatient prescription drugs:

Prescription drug benefits are a specific type of covered benefit usually subject to cost sharing as part of the medical benefit or a separate outpatient prescription drug benefit. The separate drug benefit designs can be characterized by the number of tiers (up to four) into which drug classes and specific medications are assigned. Each tier has a distinct cost-sharing level and/or form; the lower tiers are less costly to both the enrollee and to the health plan or insurer. Some payers use a four-tier system that includes life-style drugs and specialty drugs in the fourth tier; typically, these are the most costly drugs. The four-tier design frequently results in greater enrollee out-of-pocket expenses, thus the discussion of tiers is particularly relevant to the analysis of AB 1917.

Specialty prescription drugs: There is no standard industry definition of specialty prescription drugs, but it is generally recognized by many payers as prescription drugs with an average minimum monthly cost of \$1,150. Other criteria may include prescription drugs that treat a rare disease, require special handling, or have a limited distribution network.

Most of the conditions targeted by these specialty drugs tend to be chronic and progressive in nature and can impact quality of life, along with morbidity and mortality. Examples include growth hormone disorders, rheumatoid arthritis, asthma, multiple sclerosis, hepatitis C, hemophilia, cancer, and lupus.

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1917

The California Assembly Committee on Health requested on February 25, 2014, 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) 1917: Outpatient prescription drugs: cost sharing. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.¹

State benefit mandates apply to a subset of health insurance in California, those regulated by one of California's two health insurance regulators:² the California Department of Managed Health Care (DMHC)³ and the California Department of Insurance (CDI).⁴ In 2015, CHBRP estimates that approximately 23.4 million Californians (60%) will have health insurance that may be subject to any state health benefit mandate law or law effecting the terms and conditions of coverage.⁵ Of the rest of the state's population, a portion will be uninsured (and therefore will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

Nongrandfathered group and individual market DMHC-regulated plans and CDI-regulated policies are subject to AB 1917.⁶ However, Medi-Cal Managed Care is not subject to AB 1917. The regulator, DMHC, and the purchaser, the California Department of Health Care Services, have indicated that by referencing "group" plans, AB 1917 would not require compliance from plans enrolling Medi-Cal beneficiaries into Medi-Cal Managed Care.^{7,8} Therefore, the mandate would affect the health insurance of approximately 11.7 million enrollees (31% of all Californians).

¹ Available at: www.chbrp.org/docs/authorizing_statute.pdf.

² California has a bifurcated system of regulation for health insurance. The Department of Managed Health Care (DMHC) 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, which offer benefit coverage to their enrollees through health insurance policies.

³ DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) 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 (IC) Section 106(b) or Section 10198.6(a).

⁵ CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.

⁶ 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 ACA. 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/grandfathered-health-plan/). Grandfathered plans and policies are not subject to AB 1917; only nongrandfathered plans and policies are subject to AB 1917.

⁷ Personal communication, S. Lowenstein, DMHC, January 2014.

⁸ Personal communication, C. Robinson, Department of Health Care Services, citing Sec. 2791 of the federal Public Health Service Act, January 2014.

Specialized health care service plans and specialized health insurance policies are also subject to AB 1917.⁹ Enrollees in these plans and policies are not included in the above estimates of enrollees subject to AB 1917.

Developing Estimates for 2015 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)¹⁰ is substantially affecting health insurance and its regulatory environment in California. It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the incremental effects of the proposed bills — specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these incremental effects are presented in this report. In order to accommodate continuing changes in health insurance enrollment, CHBRP is relying on projections from the California Simulation of Insurance Markets (CalSIM) model¹¹ to help estimate baseline enrollment for 2015. From this projected baseline, CHBRP estimates the incremental impact of proposed benefit mandates that could be in effect after January 2015.

Bill-Specific Analysis of AB 1917

AB 1917 would require that:

- For a single covered outpatient prescription drug for a supply of up to 30 days, cost sharing cannot exceed 1/24 of the annual out-of-pocket maximum established by the ACA and codified in California statute.¹²
 - For DMHC-regulated plans and CDI-regulated policies that meet the definition of a high deductible health plan (HDHP), this requirement would only apply once the deductible for the year has been met.
- For enrollees eligible for cost sharing reductions under the ACA, cost sharing in a single month not exceed 1/24 of the annual out-of-pocket maximum of the cost sharing reduction product.

Cost sharing reductions: Enrollees eligible for cost sharing reductions under the ACA are enrollees with incomes between 100% and 250% of the federal poverty level (FPL) who enroll in a silver metal–level¹³ QHP in Covered California.¹⁴ These products have reduced cost sharing,

⁹ Specialized health care service plans and specialized health insurance policies include chiropractic-only, vision-only, dental-only, and behavioral health-only insurance plans and policies.

¹⁰ The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

¹¹ CalSIM was developed jointly and is operated by the University of California, Los Angeles Center for Health Policy Research and the University of California, Berkeley Center for Labor Research. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

¹² ACA Section 1302(c); H&SC Section 1367.006; and IC Section 19112.28.

¹³ Section 1302(d) of the ACA requires coverage within specified levels of coverage, or “precious metal” levels: bronze; silver; gold; and platinum. These precious metal levels correspond to an actuarial value for the plan or policy based on the cost-sharing features, not the benefits covered. The actuarial levels are as follows: 60% actuarial

including a lower annual out-of-pocket maximum. This report refers to these products as “CSRs” (cost sharing reduction products).

Cost sharing: Cost sharing would include copayments, coinsurance, and deductibles.

Prescription drug coverage: AB 1917 *does not* require DMHC-regulated plans or CDI-regulated policies to cover outpatient prescription drugs, nor does it require coverage of specific drugs or require changes be made to drug formularies. AB 1917 *does* use a broad definition of outpatient prescription drugs, which includes all covered prescription drugs self-administered, administered by a licensed health care professional in an outpatient setting, or administered in a non-inpatient clinical setting.

The cost-sharing limits required by AB 1917

Limit on outpatient prescription drugs. The ACA requires an annual out-of-pocket maximum for all nongrandfathered group and individual market plans and policies.^{15,16} The annual out-of-pocket maximum for 2015 has not been set yet; therefore, this report reflects estimates based on the annual out-of-pocket maximum in effect in 2014. In 2014, the annual out-of-pocket maximum is \$6,350 for self-only coverage and \$12,700 for family coverage.

For enrollees in nongrandfathered group and individual market plans and policies, excluding enrollees in CSRs, AB 1917 would require cost sharing for a single covered outpatient prescription drug for up to a 30-day supply not exceed \$265 (1/24 of the annual out-of-pocket maximum of \$6,350).¹⁷

Limit for enrollees in CSRs. AB 1917 would require enrollees in CSRs in Covered California “...not be required to pay in a single month more than 1/24 of the annual out-of-pocket limit for the cost sharing reduction product.” This provision of AB 1917:

1. References the annual out-of-pocket maximum for CSRs that, as a result of the reduced cost sharing for these products, is lower than the annual out-of-pocket maximum allowed for other nongrandfathered plans and policies under the ACA; and

value for bronze-level plans; 70% actuarial value for silver-level plans; 80% actuarial value for gold-level plans; and 90% actuarial value for platinum-level plans.

¹⁴ ACA Section 1402.

¹⁵ ACA Section 1302(c). ACA Section 1302(c) 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). Section 223(c)(2)(A)(ii) 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]. Further, as established in Section 1302(c) of the ACA, for plan and policy years beginning after 2014, the limitation is that just described increased by a premium adjustment percentage, which is defined as “the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).”

¹⁶ The annual out-of-pocket maximum is inclusive of copayments, coinsurance, deductibles, and any other form of cost sharing, but not premiums. Cost sharing is generally understood to not include premiums, and premium payments would not accrue towards the annual out-of-pocket maximum.

¹⁷ This report assumes that, because a prescription drug is prescribed for one enrollee, the cost sharing limit is 1/24 of the annual out-of-pocket maximum for self-only coverage, not family coverage.

2. Limits what is paid in a month to 1/24 of the annual out-of-pocket maximum for all covered benefits, not just for an outpatient prescription drug.¹⁸

AB 1917's monthly limit on cost sharing for enrollees in CSRs would halve the annual out-of-pocket maximum for these products (see Table a). This would change the actuarial value of the products — the portion of costs the health insurance carrier pays for covered benefits — increasing the percentage of costs for which the health insurance carrier is responsible and decreasing the percentage of costs for which the enrollee is responsible.

The ACA sets the actuarial values of CSR products.¹⁹ The halving of the annual out-of-pocket maximum for CSRs would increase the actuarial value of the products, bringing them out of compliance with the actuarial value requirements set by the ACA.

Table a summarizes the provisions of AB 1917 and the cost-sharing limits AB 1917 would require.

¹⁸ The language for this provision of the bill uses the term “pay” rather than “cost sharing.” However, as only cost sharing (e.g., copayments, coinsurance, deductibles) accrue to an enrollee’s annual out-of-pocket maximum, CHBRP assumes that it is cost sharing that is being limited and that the monthly cost of premiums are not included in the monthly limit of AB 1917.

¹⁹ ACA Section 1402(c)(2).

Table a. AB 1917's Three Provisions and the Cost Sharing Limits

Product (a)	AB 1917 Provision	Cost Sharing Limit by Provision
Non-HDHP	Cost sharing cannot exceed 1/24 of the annual OOP max for a <i>single outpatient prescription drug</i> for up to a 30-day supply	<ul style="list-style-type: none"> • Annual OOP max (2014) = \$6,350 (self-only) (b) • 1/24 of annual OOP max = \$265 limit for an outpatient prescription drug for up to a 30-day supply
HDHP	<u>After an enrollee's deductible is met</u> , cost sharing cannot exceed 1/24 of the annual OOP max for a <i>single outpatient prescription drug</i> for up to a 30-day supply	<ul style="list-style-type: none"> • Annual OOP max (2014) = \$6,350 (self-only) (b) • 1/24 of annual OOP max = \$265 limit for an outpatient prescription drug for up to a 30-day supply, <u>after deductible is met</u>
CSRs (c)	Cost sharing in a single month cannot exceed 1/24 of the annual OOP max for a CSR product in Covered California <i>for all covered benefits</i>	<p>Enrollees with incomes between 100% and 200% FPL:</p> <ul style="list-style-type: none"> • Annual OOP max (2014) = \$2,250 self-only/\$4,500 family • 1/24 of annual OOP max = \$93.75 self-only/\$187.50 family monthly cost-sharing limit • AB 1917 halves the ACA annual OOP max — \$1,125 self-only/\$2,250 family — <u>bringing the products out of compliance with the actuarial value requirements set by the ACA</u> (d) <hr/> <p>Enrollees with incomes between 200% and 250% FPL:</p> <ul style="list-style-type: none"> • Annual OOP max (2014) = \$5,200 self-only/\$10,400 family • 1/24 of annual OOP max = \$216.67 self-only/\$433.33 family monthly cost-sharing limit • AB 1917 halves the ACA annual OOP max — \$2,600 self-only/\$5,200 family — <u>bringing the products out of compliance with the actuarial value requirements set by the ACA</u> (d)

Source: California Health Benefits Review Program, 2014.

Notes: (a) These are all nongrandfathered plans and policies; only nongrandfathered group and individual market plans and policies are subject to AB 1917.

(b) As a single prescription drug is prescribed for one enrollee, CHBRP assumes the cost-sharing limit is 1/24 of the annual out-of-pocket maximum for self-only coverage, not family coverage.

(c) A CSR product is a silver metal-level qualified health plan sold in Covered California to enrollees with incomes between 100% and 250% FPL. These products have reduced cost sharing, including a lower annual out-of-pocket maximum.

(d) AB 1917 would limit the amount an enrollee could pay in a month for all covered benefits to 1/24 of the annual out-of-pocket maximum. This halves the products' annual out-of-pocket maximum. For example, \$93.75 × 12 months = \$1,125, which is half of the set annual out-of-pocket maximum of \$2,250.

Key: CSRs=cost sharing reduction products; FPL=federal poverty level; HDHP=high deductible health plan; max=maximum; OOP=out-of-pocket.

Outpatient prescription drugs

AB 1917 defines outpatient prescription drugs as any covered outpatient prescription drug not administered in an inpatient setting, and would therefore include prescription drugs covered under both the outpatient prescription drug benefit and the medical benefit (e.g., injectable

drugs). The definition of outpatient prescription drugs in AB 1917 is broader than that currently defined in the California Code of Regulations and used by both DMHC and CDI.²⁰ Were AB 1917 to be enacted, plans and policies in both regulated markets would be subject to the broader definition included in AB 1917 when meeting the requirements of the mandate.

Analytic Approach and Key Assumptions

AB 1917 would affect the terms and conditions of coverage; 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 cost sharing requirements relevant to this bill.

CSRs

AB 1917 would limit the amount an enrollee could pay out-of-pocket in a month for all covered benefits to 1/24 of the annual out-of-pocket maximum of the CSR product, thus halving the yearly annual out-of-pocket maximum (see Table a). This would increase the actuarial value of the product, bringing it out of compliance with the actuarial value requirements set by the ACA.

Were AB 1917 to be enacted, CSRs would need to comply both with the cost sharing requirements of AB 1917 and with the actuarial value requirements of the ACA. Federal regulations require that first the annual out-of-pocket maximum is adjusted to meet actuarial value requirements.²¹ However, the annual out-of-pocket maximums for CSRs are set by CMS (see the annual out-of-pocket maximums in Table a) and thus cannot be adjusted upwards to bring the products into compliance with the actuarial value requirements.

It is not possible to meet both the requirements of AB 1917 and the requirements of the ACA. AB 1917 renders the CSR products out of ACA compliance; therefore, the impact of AB 1917 on benefit coverage, utilization, cost, and public health for CSRs cannot be estimated.

Specialized health care service plans and specialized health insurance policies

AB 1917 would apply to specialized health care service plans and policies (specialized health plans and policies). Specialized health plans and policies include chiropractic-only, vision-only, dental-only, and behavioral health-only plans and policies. Often these types of plans and policies are exempted from benefit mandates. Prescription drug coverage in some specialized health plans and policies may be minimal, whereas others, such as behavioral-health only plans and policies, may have more extensive coverage of prescriptions drugs for which enrollee cost sharing could exceed the limit AB 1917 would place on a covered outpatient prescription drug. The scope of enrollee coverage and outpatient prescription drug coverage in specialized health plans and policies in 2015 is not known to CHBRP; therefore, the benefit coverage, utilization, cost, and public health impacts on these products is not analyzed.

²⁰ The California Code of Regulations defines outpatient prescription drugs as “self-administered drugs approved by the FDA for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an inpatient basis.” California Code of Regulations, Section 1300.67.24(a)(1).

²¹ Department of Health and Human Services. Actuarial Value and Cost-Sharing Reductions Bulletin. February 24, 2012. Available at: www.pnhp.org/news/2012/february/cms-on-actuarial-value-and-cost-sharing-reductions.

Interaction With Other California Requirements

Affordable Care Act requirements codified in California statute

Nongrandfathered small-group and individual market plans and policies are required to cover essential health benefits (EHBs); 1 of the 10 categories of EHBs is prescription drugs.²² In addition, as previously discussed, the ACA places an annual out-of-pocket maximum on EHBs for all nongrandfathered group and individual market plans and policies,²³ and enrollees with incomes between 100% and 250% FPL in silver metal-level QHPs in Covered California (e.g., CSRs) receive cost sharing reductions.²⁴

Orally administered anticancer medications

In 2013, AB 219 (Perea) Health care coverage: cancer treatment was enacted, taking effect in 2015.²⁵ AB 219 will limit cost sharing for prescribed, orally administered anticancer medications to no more than \$200 for up to a 30-day supply. This report assumes, as a result of the passage of AB 219, that cost sharing for these prescription drugs would not be impacted by the provisions of AB 1917.

Additional DMHC and CDI prescription drug coverage requirements

In addition to AB 219, DMHC-regulated plans are subject to specific limitations regarding prescription drug cost sharing,²⁶ including:

- Copayments, deductibles, and other limitations cannot render the benefit illusory.²⁷
- The copayment cannot exceed the retail price of the drug.
- A copayment or coinsurance shall not exceed 50% of the “cost to the plan.”²⁸
- If a plan uses coinsurance, it must either: (1) have a maximum dollar amount cap on the coinsurance that will be charged for a single prescription; (2) have the coinsurance apply towards an annual out-of-pocket maximum for the plan; or (3) have the coinsurance apply towards an annual out-of-pocket maximum for the prescription drug benefit.

CDI limits expenses paid by the insured, requiring all policies to be economically sound.²⁹ Individual policies must provide “real economic value” to the insured.³⁰

²² ACA Section 1302; H&SC Section 1367.005; and IC Section 10112.27.

²³ ACA Section 1302(c); H&SC Section 1367.006; and IC Section 10112.28.

²⁴ ACA Section 1402.

²⁵ H&SC Section 1367.656; IC Section 10123.206.

²⁶ California Code of Regulations, Section 1300.67.24.

²⁷ H&SC Section 1367; California Code of Regulations Title 28, Section 1300.67.4.

²⁸ The “cost to the plan” means the actual cost incurred by the plan or its contracting pharmacy benefit manager.

²⁹ IC Section 10291.5(a)(1).

³⁰ IC Section 10291.5(b)(7)(A) and 10270.95.

Requirements in Other States

Some states have recently passed or are considering legislation aimed at addressing the high cost sharing some enrollees may have for prescription drugs. Most recently, Delaware enacted legislation that required copayments or coinsurance on a specialty tier drug not exceed \$100 per month for up to a 30-day supply of any single drug nor exceed, in the aggregate for specialty tier covered drugs, \$200 per month per enrollee. In Virginia, a bill was introduced at the end of last year (2013) that would require copayments or coinsurance not exceed \$150 per month for a prescription drug covered in a specialty drug tier for to a 30-day supply of any single drug. In addition, in Indiana, a bill was introduced this year (2014) that would, among other requirements, not allow copayments or coinsurance to exceed \$200 for a 1-month supply of a single prescription drug or \$500 for a 1-month supply of more than one prescription drug.

Background on Cost Sharing and Specialty Prescription Drugs

CHBRP presents the following background information about two concepts important to the analysis of AB 1917: cost sharing and the role of specialty prescription drugs. This information is general in nature and provides context for the consideration of this bill.

What Is Cost Sharing?

Payment for covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Specifically, the *patient* cost-share is the portion that enrollees are responsible for paying out-of-pocket directly to the provider for the health care service or treatment (including prescription drugs) covered by the plan or policy. Noncovered services or treatments are always paid in full by the enrollee.

Common cost-sharing mechanisms include: *deductibles* — a fixed dollar amount (lump sum for one or more services) an enrollee is required to pay out-of-pocket within a given time period (e.g., a year) before the health plan or insurer begins to pay, in part or in whole, for covered health care services; *copayments* — a flat dollar amount for a covered benefit; and *coinsurance* — a percentage of cost for a covered benefit. An *annual out-of-pocket maximum* is a limit on the enrollee's total cost-sharing (copayments, coinsurance, and deductibles) obligations in a 1-year period. Once the annual limit is met, the enrollee pays no more cost sharing for the year. Premium payments are not considered part of cost sharing.

Cost sharing and outpatient prescription drug benefits

Prescription drug benefits are a specific type of covered benefit usually subject to cost sharing as part of the medical benefit or a separate outpatient prescription drug benefit. The separate drug benefit designs can be characterized by the number of tiers (up to four) into which drug classes and specific medications are assigned. Each tier has a distinct cost-sharing level and/or form; the lower tiers are less costly to both the enrollee and to the health plan or insurer. Some payers use a three- or four-tier system, which includes life-style drugs and specialty drugs in the fourth tier; typically, these are the most costly drugs. *The four-tier design frequently results in greater enrollee out-of-pocket expenses, thus the discussion of tiers is particularly relevant to the analysis of AB 1917, which would limit cost sharing for an outpatient prescription drug to \$265 (1/24 of the annual out-of-pocket maximum) for up to a 30-day supply.*

Specialty Prescription Drugs

There is no standard industry definition of specialty prescription drugs, but it is generally recognized by many payers as prescription drugs with an average minimum monthly cost of \$1,150. Other criteria may include prescription drugs that treat a rare disease, require special handling, or have a limited distribution network.

The number and cost of specialty prescription drugs continues to increase and payers are managing these high-cost drugs with different cost-sharing methods. For example, a 2011 national survey reported that 49% of plans place specialty drugs in tier 4 and 51% distribute specialty drugs among tiers 2 and 3 depending on their preferred status. Of the commercial plan respondents, 25% reported an average copayment of \$120 and 72% reported an average coinsurance of 22% for specialty drugs. Specialty drug copayments among all tiers ranged from \$10 to \$250 per prescription and coinsurance ranged from 10% to 50%.

Most of the conditions targeted by these specialty drugs tend to be chronic and progressive in nature and can impact quality of life, along with morbidity and mortality. Examples include growth hormone disorders, rheumatoid arthritis, asthma, multiple sclerosis, hepatitis C, hemophilia, cancer, and lupus.

Medical Effectiveness

CHBRP's medical effectiveness analysis for AB 1917 focuses on the impact of cost sharing on use of prescription drugs and, for those below specific income levels, on use of all health care services, including prescription drugs. CHBRP chose this analytic approach because AB 1917 would not increase the number of Californians who have health insurance coverage for prescription drugs in general, or, for those enrolled in CSRs in Covered California, for all health care services. Instead, AB 1917 would affect the terms and conditions of cost sharing for prescription drug coverage and all health care services. The analysis does not address the effectiveness of specific treatments because AB 1917 would not mandate coverage for any specific treatments, but instead, as indicated, would affect the terms and conditions of coverage.

CHBRP could find no studies of cost sharing that analyzed cost-sharing provisions as specific as those outlined in AB 1917. Instead, CHBRP presents reviews of literature whose findings approximate those in AB 1917. For the first provision, we review studies of the effect of cost sharing on prescription drug use, including specialty drugs; for the second, we review studies of the impact of cost sharing on prescription drugs use among those in HDHPs; and for the third, we review the impact of cost sharing on use of all health care services by low-income enrollees.

The only randomized controlled trial, the RAND Health Insurance Experiment (HIE), was conducted in the 1970s. That study established that cost sharing affects utilization, that the poor and elderly are more affected by cost sharing, and that use of essential and nonessential services are both affected by cost sharing. As discussed further, the results of more recent studies which were not randomized trials are broadly consistent with the results of the RAND HIE.

Study Findings

There is a preponderance of evidence from studies with strong research designs that persons who face higher cost sharing reduce use of both essential and nonessential health care services

Prescription drug cost sharing

- A large number of studies have been published on the effects of cost sharing on the use of prescription drugs by persons with health insurance.
- Studies of the effects of cost sharing on the population to which AB 1917 applies indicate:
 - There is a preponderance of evidence from studies with strong research designs that persons who face higher cost sharing for a prescription drug are less likely to maintain meaningful levels of adherence than persons who face lower cost sharing.
 - There is a preponderance of evidence from studies with moderate research designs that poorer adherence to prescription drug therapy for chronic conditions is associated with higher rates of hospitalization and emergency department visits and poorer health outcomes.
 - There is a preponderance of evidence from studies with moderate research designs that the effect of cost sharing on use of specialty drugs is similar to the effects for all kinds of prescription drugs, that is, as cost sharing increases, usage decreases. However, there is some evidence that the effect of cost sharing may differ depending on the specific disease and specific specialty drug.

Prescription drug cost sharing and high deductible health plans

- Most of the recent literature on the impact of deductibles has addressed HDHPs. Studies of HDHPs have compared persons in these plans to persons enrolled in health maintenance organizations or preferred provider organizations (PPOs).
- Studies of HDHPs in which prescription drugs were subject to the deductible had the following findings:
 - There is ambiguous evidence that persons enrolled in HDHPs were as likely to fill any prescriptions as persons enrolled in PPOs because CHBRP found only one well-designed study.
 - There is ambiguous evidence regarding effects of HDHPs on the number of prescriptions filled because findings vary widely across studies.
 - The preponderance of evidence from two studies with strong designs 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 with strong designs 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.

Cost sharing among low-income persons

- There is a preponderance of evidence from the RAND HIE and many subsequent observational studies that cost sharing has stronger effects on use of health care services by low-income persons than high-income persons. However, a recent well-done observational study of this issue in Massachusetts after its health reform indicates otherwise.

Benefit Coverage, Utilization, and Cost Impacts

Key Assumptions

CHBRP estimates the impact of AB 1917 on cost sharing for outpatient prescription drugs, but excludes enrollees in CSRs from those estimates. CHBRP does not estimate the impact of limiting cost sharing for all covered benefits for enrollees in CSRs. This exclusion is because the AB 1917 limit on cost sharing for these products would effectively reduce the annual out-of-pocket maximums, increasing the actuarial value of these products. If AB 1917 is enacted, the resulting change would render these products out of compliance with actuarial value requirements set by the ACA.

AB 1917 would apply to all outpatient prescription drugs; however, the mandate is estimated to have the greatest impact on high cost and/or specialty drugs, which most frequently have coinsurance requirements that could exceed the cost-sharing limit of AB 1917. CHBRP assumes that a reduction in cost sharing would lead to an increase in use of these prescription drugs (a price elasticity of 0.1 for private insurers). For CalPERS plans, an increase in use of infertility drugs was estimated (a price elasticity of 0.34).

A reduction in cost sharing for prescription drugs would lead to fewer enrollees reaching their annual out-of-pocket maximums. These enrollees would continue to have cost sharing for other covered health care services. CHBRP assumes a decline in use of other health care services for these enrollees due to the increase in cost sharing.

CHBRP assumes that 88% of large- and small-group plans and policies have a maximum dollar amount cap on cost sharing for a prescription drug that is set lower than \$265 (1/24 of the annual out-of-pocket maximum) for a 30-day supply; 12% do not have a prescription drug cap on cost sharing and could have cost sharing that would exceed the limit AB 1917 would require. In the absence of specific data on plans and policies in the individual market, CHBRP assumes that these plans and policies do not have maximum dollar amount caps on cost sharing for a prescription drug.

Table 1 summarizes the estimated benefit coverage, utilization, and cost impacts of AB 1917.

Coverage Impacts

CHBRP estimates 23,389,000 enrollees are insured in DMHC-regulated plans and CDI-regulated policies in California in 2015, 11,701,000 of which (50%) are subject to AB 1917. Of these enrollees, an estimated 730,000 are enrolled in CSRs in Covered California and are excluded

from the following analysis. Therefore, the number of enrollees subject to AB 1917 and included in this analysis is approximately 10,971,000.

- All enrollees subject to AB 1917 have coverage for outpatient prescription drugs, as defined by AB 1917, and all have some form of cost sharing for these drugs. The number of enrollees with coverage for outpatient prescription drugs will remain the same postmandate.
- Premandate, about 45,410 (0.41%) enrollees are estimated to have a prescription drug claim in a year with cost sharing that would exceed 1/24 of the annual out-of-pocket maximum (\$265) for a 30-day supply.

Utilization Impacts

- If AB 1917 is enacted, cost sharing for prescription drugs cannot exceed 1/24 of the annual out-of-pocket maximum for a 30-day supply, or \$265. Postmandate, an estimated 46,357 enrollees will have a prescription drug claim in a year with cost sharing that would have exceeded \$265 premandate, but no longer would. This is an increase of 947 (2.09%) enrollees who will begin using these drugs due to the lower cost sharing levels postmandate.
- The cost-sharing limit required by AB 1917 will also lead to an increase in the number of prescription drug claims with cost sharing that would have exceeded \$265 for up to a 30-day supply premandate. The increase in filled prescription drugs is from 6.09 premandate to 6.25 postmandate (2.72%).
- The average cost sharing per prescription drug claim premandate is \$324.83. Average cost sharing per prescription drug claim postmandate will be reduced to \$188.92, a reduction of \$135.91 (41.84%).³¹
- Enrollees who have reduced cost sharing for prescription drugs due to AB 1917 would continue to have cost sharing for other covered health care services before they reach their annual out-of-pocket maximum. Subsequently, these enrollees would decrease their use of other health care services by an estimated 0.31%. The average cost sharing pre claim for other health care services would increase from \$15.82 to \$17.56 (10.97%).

Cost Impacts

- AB 1917 would increase total net expenditures in 2015 by \$106,114,000, or 0.08%, in the nongrandfathered group and individual market.
- Total premiums for private employers are estimated to increase by \$28,000,000, or 0.05%.

³¹ The postmandate amount is lower than the limit of \$265 set by AB 1917 because some enrollees would reach their annual out-of-pocket maximum; these enrollees have no cost sharing after reaching their annual out-of-pocket maximum.

- Total premiums for those with individually purchased insurance are estimated to increase by \$79,503,000, or 0.47%.
- CalPERS total premiums are estimated to increase by \$7,581,000, or 0.18%.
- AB 1917 would reduce enrollee out-of-pocket expenses (cost sharing) by an estimated \$21,796,000, or 0.17%.
- Total premiums for enrollees with group and CalPERS coverage are estimated to increase by \$12,856,000, or 0.06%.

Public Health Impacts

- *Health impacts:* CHBRP estimates that 46,357 enrollees, including 947 new users, would fill an additional 13,184³² high-cost prescription drugs were AB 1917 enacted. However, CHBRP projects no measurable public health impact due to the small number of enrollees (46,357 of 10.97 million, 0.42%) with a reduction in cost sharing for prescriptions that would have exceeded the \$265/prescription limit premandate. CHBRP recognizes that on a case-by-case basis, AB 1917 may yield important health and quality of life improvements for some persons.
- *Financial burden:* In the first year postmandate, CHBRP estimates that AB 1917 would reduce out-of-pocket expenses by \$21.8 million for 46,357 of the 10.97 million enrollees whose cost sharing would no longer exceed the AB 1917 limit of \$265/prescription. This translates to a 42% reduction (\$132/prescription) in the average cost sharing for an enrollee's high-cost prescription drug. To the extent that AB 1917 removes a cost barrier for some enrollees who would then initiate therapy earlier and maintain adherence, the health impact on disease progression and outcomes could be significant on a case-by-case basis.
- *Disparities:* Although there are gender and racial/ethnic disparities in prevalence of certain diseases and conditions, and evidence that, in general, lower cost sharing can improve adherence, CHBRP estimates AB 1917 would have no measureable impact on disparities due to the small number of enrollees with prescriptions that would no longer exceed the cost-sharing limit of \$265/prescription. This magnitude is too small to measure a change in disparities within the California population.

Long-Term Impacts

Cost and Utilization

- In the long-term, AB 1917 is likely to accelerate the use of high-cost prescription drugs due to reduced cost sharing and development of new high-cost specialty drugs.
- AB 1917 is likely to increase overall health expenditures with use of existing and new high-cost prescription drugs. Increases in these expenditures will most likely lead to increases in premiums.

³² Calculated as pre-/postmandate enrollees (avg. number of prescriptions): $46,357(6.25) - 45,410(6.09) = 13,184$.

Public Health

- *Health impacts:* To the extent that more people have access to high-cost and/or specialty prescription drugs due to reduced cost sharing, there is the potential for beneficial long-term health impacts for those with chronic conditions such as multiple sclerosis and rheumatoid arthritis. However, CHBRP is unable to estimate the long-term public health impact of AB 1917 due to uncertainty in the market's response to the downward cost pressure of mandated reductions in enrollee cost sharing and the upward pressure of the increasing number and cost of specialty drugs.
- *Premature mortality:* AB 1917 may decrease premature death resulting from a variety of conditions treated with high-cost, life-saving, or life-sustaining prescription drugs, but there is a lack of evidence to inform estimates of the marginal effect on all the possible health outcomes of the 46,357 enrollees who would change behavior due to the reduced cost sharing. Therefore, the magnitude of AB 1917's prescription drug cost-sharing limit on premature death is unknown.
- *Economic loss:* Although AB 1917 may affect economic loss resulting from a variety of conditions treated with high-cost prescription drugs, there is a lack of evidence to inform changes in future utilization. Therefore, the impact of AB 1917's prescription drug cost-sharing limit on economic loss is unknown.

Interaction With Essential Health Benefits

AB 1917 modifies the cost sharing for outpatient prescription drugs, and for enrollees in CSRs, for all covered benefits. As state rules related to cost sharing do not meet the definition of state benefit mandates that could exceed EHBs, AB 1917 would not exceed EHBs and would not require the state to defray the costs of this mandate for enrollees in QHPs.

Table 1. AB 1917's Impacts on Benefit Coverage, Utilization, and Cost, 2015

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	23,389,000	23,389,000	—	0.00%
Total enrollees with health insurance subject to AB 1917	11,701,000	11,701,000	—	0.00%
Total enrollees with health insurance subject to AB 1917 enrolled in CSRs in Covered California and <u>excluded</u> from the following analysis	730,000	730,000	—	0.00%
Total enrollees with health insurance subject to AB 1917 and included in the following analysis	10,971,000	10,971,000	—	0.00%
Utilization and cost				
Number of enrollees with high cost/specialty prescription drug claims greater than the AB 1917 limit on cost sharing	45,410	0	-45,410	100%
Number of enrollees with prescription drug claims impacted by the AB 1917 limit on cost sharing	45,410	46,357	947	2.09%
Percent of enrollees with prescription drug claims impacted by the AB 1917 limit on cost sharing	0.41%	0.42%	0.01%	2.09%
Average number of prescription drug claims impacted by the AB 1917 limit on cost sharing	6.09	6.25	0.17	2.72%
Average cost sharing per prescription drugs claim impacted by the AB 1917 limit on cost sharing	\$324.83	\$188.92	-\$135.91	-41.84%
Average number of other medical services received by enrollees with at least one prescription drug claim impacted by the AB 1917 limit on cost sharing	147.98	147.52	(0.46)	-0.31%
Average per-claim cost sharing of other medical services exceeding AB 1917 limit on cost sharing	\$15.82	\$17.56	\$1.74	10.97%
Expenditures (b)				
<i>Premium expenditures by payer</i>				
Private employers for group insurance	\$54,590,722,000	\$54,618,722,000	\$28,000,000	0.05%

Table 1. AB 1917's Impacts on Benefit Coverage, Utilization, and Cost, 2015 (Cont'd)

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Expenditures (b) (Cont'd)				
CalPERS HMO employer expenditures (c)	\$4,297,494,000	\$4,305,075,000	\$7,581,000	0.18%
Medi-Cal Managed Care Plan expenditures	\$17,504,711,000	\$17,504,711,000	\$0	0.00%
Enrollees for individually purchased insurance	\$16,930,080,000	\$17,009,583,000	\$79,503,000	0.47%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (d)	\$22,232,708,000	\$22,245,564,000	\$12,856,000	0.06%
<i>Enrollee expenses</i>				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$12,867,143,000	\$12,845,347,000	-\$21,796,000	-0.17%
Total expenditures	\$128,422,858,000	\$128,529,002,000	\$106,144,000	0.08%

Source: California Health Benefits Review Program, 2014.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed care Plans, Healthy Families Program) 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) Expenditures do not include estimates for Covered California enrollees in CSRs.

(c) Of the increase in CalPERS employer expenditures, about 57% or \$4,321,000 would be state expenditures for CalPERS members who are state employees or their dependents.

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

Key: CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; CSRs=cost sharing reduction products; DMHC=Department of Managed Health.

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Edward Yelin, PhD, and Margaret Fix, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Dominique Ritley, MPH, and Ronald Fong, MD, MPH, of the University of California, Davis, prepared the public health impact analysis. Nadereh Pourat, PhD, and AJ Scheitler, MEd, PhD, of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, and Dan Henry, ASA, MAAA, of Milliman, provided actuarial analysis. Debbie Stern, Rxperts, provided technical assistance with the literature review and expert input on the analytic approach. Laura Grossmann, MPH, 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, Theodore Ganiats, MD, of the University of California, San Diego, 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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A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct 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 manages all external communications, including those with the California Legislature. 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.

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 of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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