Resource
Deductibles in State-Regulated Health Insurance for 2023

November 7, 2022

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California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2022). Resource: Deductibles in State-Regulated Health Insurance for 2023. Berkeley, CA*

OVERVIEW

At the request of the California State Legislature, the California Health Benefits Review Program (CHBRP) provides prompt, independent, and rigorous evidence-based analyses of proposed health insurance benefit laws that would impact Californians enrolled in health plans regulated by the California Department of Managed Care (DMHC) and health policies regulated by the California Department of Insurance (CDI). These are enrollees whose benefits are subject to state regulation and can be influenced by the proposed state-level legislation. CHBRP estimates the presence of various kinds of deductibles, a form of cost sharing, among these enrollees because the bills CHBRP analyzes sometimes directly address application of a deductible.[1]

This resource discusses deductibles and their interaction with other forms of cost sharing, as well as estimates regarding their presence among state-regulated health insurance, potential impacts of new prohibitions on their application, and related state and federal law.

Approximately 46% of commercial and CalPERS[2] associated enrollees in plans and policies regulated by DMHC or CDI have a medical deductible and approximately 26% of enrollees have a pharmacy benefit regulated by DMHC or CDI that includes a deductible. Deductible amounts vary, as does their presence by market segment. For example, no CalPERS associated enrollees have any deductible, but in the individual market, 56% of enrollees have a high (≥ $1,400) medical deductible and 28% have a high pharmacy deductible.

When considering a bill that proposes state-level deductible prohibitions (which would be enforced by DMHC and/or CDI), it is important to consider how other forms of cost-sharing, as well as out-of-pocket maximums would impact enrollees' total cost sharing for a plan or policy year.

Deductibles – One Form of Cost Sharing

When present, a deductible is the amount an enrollee is generally required to pay out-of-pocket (OOP) before the health plan or policy begins to reimburse medically necessary use of covered benefits. However, there are some benefits for which application of a deductible may be prohibited.[3] When applicable, once this amount is paid, other forms of cost sharing (such as coinsurance[4] or copayments[5]) may still be applicable to the use of covered benefits. Premiums do not count towards a deductible. The presence of deductibles varies depending on the enrollee's plan or policy design and relevant laws and regulations.

For the majority of enrollees in plans and policies regulated by DMHC or CDI, there are no deductibles.[6] However, as previously noted, deductibles are present for a substantial minority. When deductibles are present, their amount typically varies from $500 per year to the Internal Revenue Service (IRS)-specified "high deductible threshold" of $1,400 per year, to perhaps as much as $8,550 per year, which is the current annual OOP spending threshold set by the federal government (HealthCare.gov Glossary, n.d.). Enrollees may have annual cost sharing limits that are lower than the OOP spending threshold. Lower

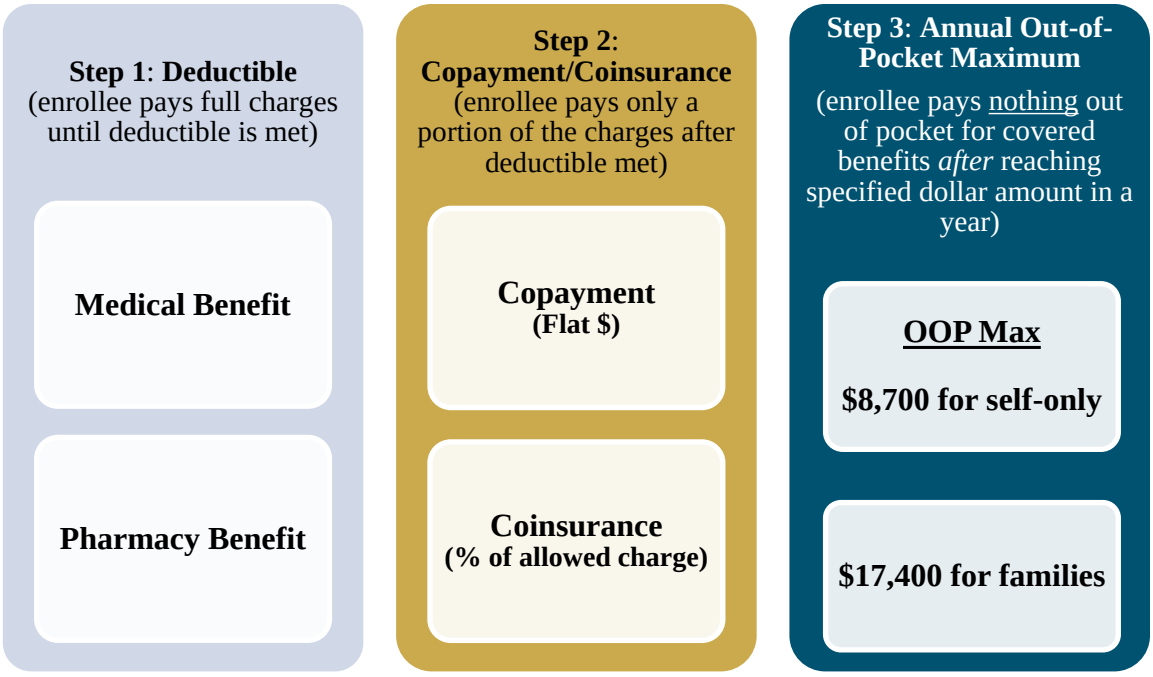
[1] Recent examples include CHBRP's analyses of SB 568 (2021) and AB 97 (2021), both available at: http://chbrp.com/completed_analyses/index.php.
[2] California Public Employees' Retirement System
[3] For example, federal and California state law states that non-grandfathered group and individual health insurance plans and policies must cover certain preventive services without cost-sharing (including deductibles) when delivered by in-network providers. For more information, see CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at: www.chbrp.org/other_publications/index.php.
[4] Coinsurance is a form of cost sharing in which an enrollee pays a percentage of covered health care costs, such as 20% of a hospital stay.
[5] Copayments are a form of cost sharing in which an enrollee pays a predetermined, flat dollar amount out-of-pocket at the time of receiving a health care service, such as a $20 copayment for a physician office visit.
[6] This includes all CalPERS enrollees and all Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

income individuals and families may qualify for reduced OOP maximums through cost sharing reduction discounts (HealthCare.gov Cost-sharing Reductions, n.d.). OOP maximums limit deductibles as well as other forms of cost sharing.

The number of deductibles applicable for an enrollee also varies. Deductibles applicable to a medical benefit (which covers hospitalization and office visits) are somewhat more common than deductibles applicable to an outpatient pharmacy benefit (which generally covers self-administered medications accessed at a pharmacy). Among enrollees with a medical deductible, most also have a pharmacy deductible. Additionally, deductibles can be designed to be applicable to both the medical and pharmacy benefit, as is the case for most enrollees in Health Savings Account (HSA)-qualified High Deductible Health Plans (HDHPs).

To better understand how plans and policies with a deductible work on a yearly basis, it is useful to think of stages before and after the deductible is met (see Figure 1).

Figure 1. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2021; CMS, 2021.

Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2). The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2021).
Key: OOP Max = annual out-of-pocket maximum.

The beginning of Step 1 is marked by the first day of the plan or policy year. During Step 1, an enrollee pays the full price of most covered benefits until they meet their deductible. However, in some plans and policies,[7] certain services are exempted from the deductible and allow for "first dollar" coverage.[8] The beginning of Step 2 is marked by the date the enrollee meets their deductible. During Step 2, an enrollee pays any applicable coinsurance and/or copayments, and insurers reimburse the rest of the price of

[7] Several such plans and policies are available through Covered California, the state's ACA marketplace. For example, see https://www.coveredca.com/support/getting-started/gold-most-services-covered/. Accessed on August 31, 2021.
[8] "First dollar" coverage is when plans or policies have no deductible and the insurer reimburses the price of covered benefits for the first dollar spent

covered benefits. The beginning of Step 3 is marked by the date an enrollee meets their out-of-pocket (OOP) maximum.[9] During Step 3, the enrollee pays nothing OOP for covered benefits for the remainder of the plan or policy year. The duration of each step depends on an enrollee's use of covered benefits. For example, an enrollee could have an inpatient procedure early in the plan or policy year[10] and meet their deductible in the first month. Then, through copayments and coinsurance for additional covered benefits throughout the next two months, the enrollee meets their OOP maximum. This enrollee would spend one month in Step 1, the following two months in Step 2, and the rest of the plan or policy year in Step 3. Conversely, an enrollee could never meet their deductible in a plan or policy year because the enrollee used no covered benefits that were subject to a deductible for that plan or policy year. This enrollee spends the entire year in Step 1.

There are situations where the application of a deductible is not as straightforward as described above. For enrollees in Preferred Provider Organization (PPO) plans and policies, where out-of-network coverage is expected to be regularly used, only the cost sharing associated with a "reasonable" price can count towards any applicable deductible. The remainder of the price that might be "balance billed" is not subject to the deductible limits and does not accrue to the enrollee's ability to meet the deductible.

Estimates of Deductibles for Californians Enrolled in State-Regulated Health Insurance

Approximately 22.8 million (57.9% of all) Californians[11] are enrolled in plans or policies regulated by DMHC or CDI and so have health insurance that can be subject to the benefit bills CHBRP is asked to analyze. Tables 1 and 2 display CHBRP's estimates regarding the presence of deductibles for these Californians. These estimates do not differentiate between self-only and family deductibles and, for analytic purposes, treat combined deductibles (medical and pharmacy) as separate. See Appendix A for further detail on the approach used to generate these estimates.

Among this group, no deductibles are present for the Medi-Cal beneficiaries. Among the 14.7 million commercial or CalPERS enrollees, approximately 46% have a medical deductible and 26% of those with a pharmacy benefit regulated by DMHC or CDI[12] have a pharmacy deductible. Tables 1 and 2 note the variation in presence of deductibles for California's commercial market segments: the individual market, the small group market, and the large group market. Table 1 notes the presence of medical deductibles and Table 2 notes the presence of pharmacy deductibles among enrollees with state-regulated health insurance.

[9] Out-of-pocket (OOP) maximum is the most an enrollee could pay for cost-sharing (copayments, coinsurance, and deductibles) towards covered benefits in a 1-year period.
[10] Deductibles are applicable to each plan year. For example, if a plan year aligns with the calendar year, the deductible will be applicable from January through December and will reset in January of the following year.
[11] See CHBRP's *Sources of Health Insurance in California*, available as a resource at http://chbrp.org/other_publications/index.php.
[12] See CHBRP's *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available as a resource at http://chbrp.org/other_publications/index.php.

Table 2. Medical Deductibles among Commercial and CalPERS Enrollees in State-Regulated Plans and Policies, 2023

Market Segment	Enrollment	Any Deductible Present	Low Deductible ($1 - $1,399)	High Deductible (a) (≥ $1,400)	HSA-Qualified HDHP
DMHC/CDI Individual	2,924,000	83%	27%	47%	9%
DMHC/CDI Small Group	2,169,000	72%	37%	27%	8%
DMHC/CDI Large Group	8,802,000	32%	22%	4%	5%
DMHC CalPERS (b)	881,000	0%	0%	0%	0%
Total	**14,776,000**	**46%**	**24%**	**16%**	**6%**

Source: California Health Benefits Review Program, 2022.
Notes: (a) Does not include enrollees in HSA-qualified plans or policies. (b) CalPERS enrollees in DMHC-regulated plans do not have deductibles.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

Table 3. Pharmacy Deductibles among Commercial and CalPERS Enrollees in State-Regulated Plans and Policies with a State-Regulated Pharmacy Benefit, 2023

Market Segment (a)	Enrollment	Any Deductible Present	Low Deductible ($1 - $1,399)	High Deductible (b) (≥ $1,400)	HSA-Qualified HDHP
DMHC/CDI Individual	2,905,000	56%	29%	19%	9%
DMHC/CDI Small Group	2,169,000	38%	26%	5%	8%
DMHC/CDI Large Group	8,346,000	15%	10%	0%	6%
DMHC CalPERS (c)	662,000	0%	0%	0%	0%
Total	**14,082,000**	**26%**	**16%**	**5%**	**6%**

Source: California Health Benefits Review Program, 2022.
Notes: (a) approximately 95.1% of enrollees in DMHC or CDI regulated plans and policy have a pharmacy benefit also regulated by DMHC or CDI.[13] (b) Does not include enrollees in HSA-qualified plans or policies. (c) CalPERS enrollees in DMHC-regulated plans do not have deductibles.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

[13] See CHBRP's *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available as a resource at http://chbrp.org/other_publications/index.php

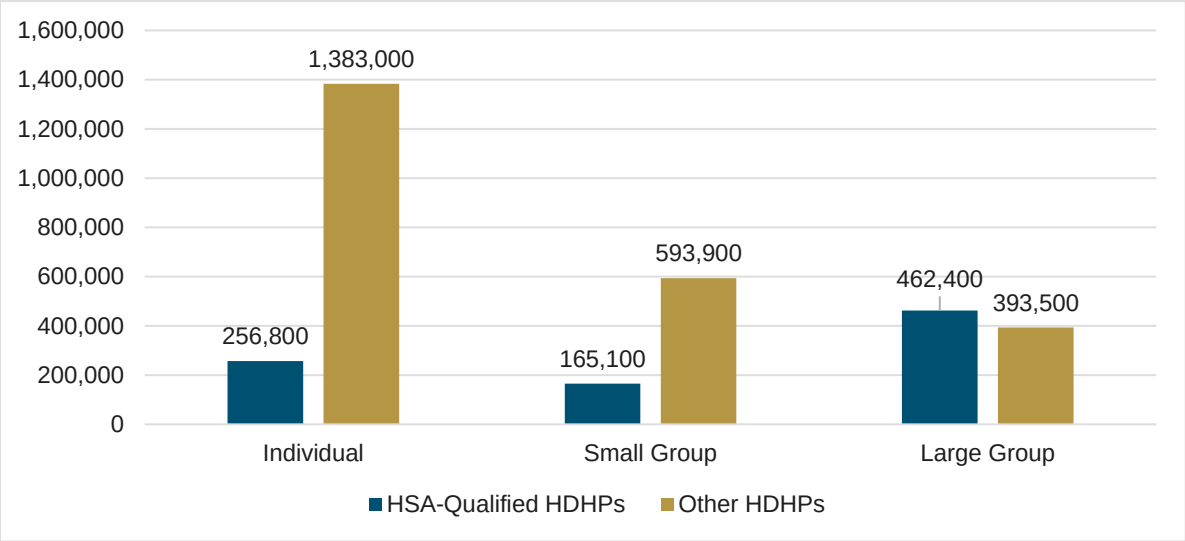
Health Savings Account-Qualified and Other High Deductible Health Plans and Policies

High deductible health plans and policies (HDHPs) have a higher deductible than a traditional health insurance plan and are subject to requirements set by federal regulation (HealthCare.gov Glossary, n.d.). For the 2021 plan year, the IRS defines a HDHP as any plan with a deductible of at least $1,400 for an individual and $2,800 for a family.

HDHPs can be paired with health savings accounts (HSAs), which are pre-tax instruments that allow enrollees (generally without the involvement of any employer (SHRM, 2018))[14] to put aside money for qualified healthcare expenses, including any healthcare services subject to a deductible (HealthCare.gov Glossary, n.d.). HSA-qualified HDHPs are not allowed to have separate medical and pharmacy deductibles.[15] To be eligible to establish an HSA for taxable years beginning after December 31, 2003, a person must be enrolled in an HSA-qualified HDHP. In order for a HDHP to be HSA-qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS.

Although the phrase “high deductible health plan” is frequently used to reference HSA-qualified plans and policies, in California there are many more commercial enrollees in non-HSA plans and policies that also have a “high” ($1,400 or greater) deductible (see Figure 2).[16] Approximately 2.6 million enrollees in state-regulated non-HSA health insurance plans and policies have a medical deductible that exceeds $1,400. As seen in Figure 2, HDHPs are most common among enrollees in the Individual Market.

Figure 2. Enrollment in State-Regulated High Deductible Health Plans and Policies, 2022*



Source: California Health Benefits Review Program, 2022.
Notes: *This figure uses enrollment in plans and policies with a medical deductible. All of the enrollees in HSA-qualified HDHPs would have a single deductible applicable to both their medical and pharmacy benefits. Enrollees in other HDHPs may have a deductible applicable to their pharmacy benefit.
Key: HDHP = high deductible health plan; HSA = health savings account.

[14] HSAs may have employer involvement as employers can contribute to the HSA in addition to employees. For other pre-tax instruments, such as a health reimbursement arrangement (HRA), employers must be involved. HRAs, for example are funded solely by employers.
[15] HSA-qualified HDHPs have a combined medical and pharmacy deductible generally ranging from $1400 to $7000.
[16] Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) are other pre-tax strategies for covering health costs. HRAs are established and funded solely by employers. Enrollees in HDHPs that are not HSA-qualified may have HRAs, FSAs, or no account specific to paying medical expenses.

As is the case for most plans and polices, the Affordable Care Act (ACA) also requires HDHPs to cover select preventive services at no cost to enrollees on a pre-deductible basis.[17] For example, for an enrollee who is 12 to 16 weeks pregnant, a urine culture to test for bacteriuria is covered on a pre-deductible basis (and is not subject to other cost sharing). Federal guidance does allow, but does not require, HDHPs to cover select additional preventive care benefits without applying a deductible.[18] For example, for an enrollee who is pregnant or has a new child, routine prenatal and well-child care can be covered on a pre-deductible basis (but would still be subject to any other cost sharing). Federal guidance also allows, but does not require, HDHPs to cover certain additional medical services and purchased items, including prescription drugs, for certain chronic conditions that are classified as preventive care on a pre-deductible basis.[19] For example, for enrollees diagnosed with hypertension, a blood pressure monitor would be considered preventive care and could be covered on a pre-deductible basis (but would still be subject to any other cost sharing).

Potential Impacts of New Prohibitions on the Application of Deductibles

CHBRP has recently analyzed bills that would prohibit or limit application of a deductible. There are two primary ways a bill prohibits or limits a deductible. The first way is to prohibit all forms of cost sharing (copayments, coinsurance, and deductibles). For example, CHBRP analyzed Senate Bill 473 (2021), which proposed to limit all cost sharing for insulin. The second way is to prohibit only deductibles and still allow other forms of cost sharing such as copayments and coinsurance. For example, CHBRP analyzed Assembly Bill 97 (2021), which proposed to prohibit the application of a deductible for insulin, but permitted application of copayments and coinsurance.

There are many ways prohibition of a deductible can impact enrollees in plans or policies regulated by DMHC or CDI. Factors influencing this variation include cost of the service used, size of enrollee's deductible, application of OOP maximum, and an enrollee's use of services not subject to the prohibition. An enrollee who meets their deductible through the use of services not impacted by the prohibition will see no annual cost sharing impact, but may see a change in how quickly they meet their deductible, depending on when they use the other services. An enrollee who only uses services impacted by the prohibition, and does not meet their deductible, will see a decrease in total annual cost sharing. Enrollees in this group will still experience cost sharing in the form of copayments and coinsurance.

When prohibitions only apply to a deductible, but not other cost sharing, the other cost sharing amounts enrollees have to pay may still represent substantial costs. Among enrollees in HDHPs, high coinsurance and copayments are common. Therefore, while a bill may prohibit a deductible for some services, enrollees with a HDHP will still need to pay high coinsurance or copayments for those services. Some enrollees would have to pay high coinsurance and copayments on a monthly basis for some benefits, such as a medication that is prescribed for indefinite use. This is why prohibition of a deductible alone may not produce a substantial change in annual cost sharing (or in adherence to prescribed use) for some enrollees.

Examples

Example A illustrates annual cost sharing at baseline and postmandate for an enrollee who uses a single high-cost drug (and no other medical services). This enrollee would experience a decrease in total annual cost sharing as a result of a deductible prohibition. Example B illustrates annual cost sharing at baseline

[17] For more information, see CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at www.chbrp.org/other_publications/index.php.
[18] IRS Notice 2004-23 provides a safe harbor that lets HSA-qualified HDHPs waive the deductible for preventive care benefits. More information available at: https://www.irs.gov/pub/irs-drop/n-04-23.pdf.
[19] IRS Notice 2019-45 expands the list of preventive care benefits permitted to be provided by a HDHP under section 223(c)(2) of Internal Revenue Code without a deductible, or with a deductible below the applicable minimum deductible for an HDHP. More information available at: https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

and postmandate for an enrollee who would reach their deductible within a plan year, regardless of the prohibition, and would see no change in total annual cost sharing.

Example A: The enrollee example in Table 3 has a pharmacy deductible of $300 per year and a $1200 monthly drug cost. Coverage for the high-cost drug is subject to 30% coinsurance ($250 per prescription) once the deductible is met. At baseline, during month 1 of the plan or policy year, the enrollee pays $300 towards the total drug cost to meet their deductible, plus the $250 coinsurance since the deductible has been met. For the remainder of the months of the year, the enrollee pays $250 per month in coinsurance for the drug. The annual cost sharing at baseline is $3,300. Postmandate, the enrollee no longer has to meet the $300 deductible for this drug but still has to pay coinsurance. Therefore, the enrollee pays the $250 coinsurance all 12 months of the plan or policy year, starting at month 1, resulting in a total annual cost sharing postmandate of $3,000. Postmandate, annual cost sharing for the high-cost drug decreases by $300 (9%) as a result of the first month's filled prescription not being subject to the deductible.

Table 4. High-Cost Drug Example – Enrollee Cost Sharing Per Prescription By Month*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Baseline Enrollee Cost Sharing	$550	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$3,300
Postmandate Enrollee Cost Sharing	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$3,000

Source: California Health Benefits Review Program, 2022

Notes: *Example assumes the plan or policy year is on a calendar year basis.

Example B: The enrollee example in Table 4 has an HSA-qualified HDHP (and therefore a combined medical and pharmacy deductible) with a $1400 deductible and a $500 monthly insulin drug cost. Coverage for insulin is subject to a $25 copayment per prescription. The enrollee has additional medical costs for other medical care not subject to the deductible. At baseline, the enrollee meets the deductible through cost sharing for prescription insulin and other medical care. Postmandate, the enrollee meets the deductible through other medical care subject to the deductible. There is no change in annual cost sharing.

Table 4. Insulin Prescription Example – Enrollee Cost Sharing Per Prescription by Month*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Baseline Enrollee Cost Sharing	$25 $500 insulin $200 other	$25 $500 insulin $200 other	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$1,700
Postmandate Enrollee Cost Sharing	$25 $200 other	$25 $450 other	$25	$25	$25 $200 other	$25	$25	$25 $100 other	$25	$25	$25 $50 other	$25 $400 other	$1,700

Source: California Health Benefits Review Program, 2022

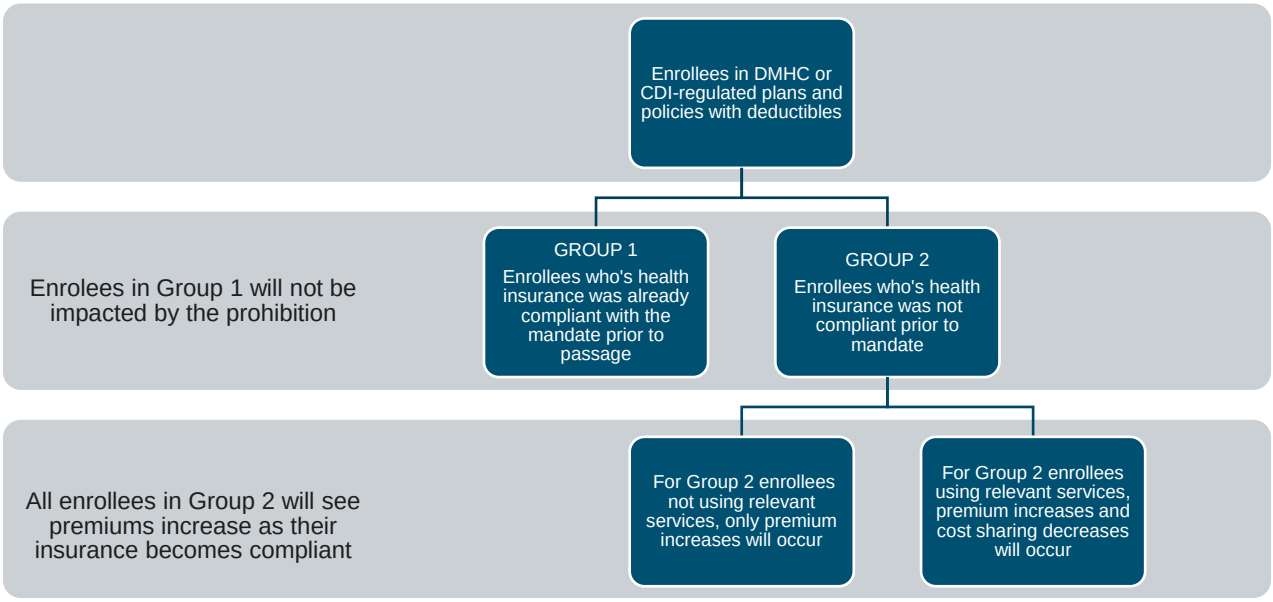
Notes: *Example assumes the plan or policy year is on a calendar year basis.

Impact of Prohibition Depends on Plan or Policy Compliance Prior to Mandate

Enrollees in DMHC-regulated plans or CDI-regulated policies with deductibles may fall into two groups (see Figure 3). Enrollees in Group 1 will not see an immediate impact as a result of these types of

mandates because the plans or policies are already compliant with the prohibition. Enrollees in Group 2 will be impacted as a result of the prohibition because the plans or policies are not already compliant. The impact to enrollees in Group 2 varies. All enrollees in Group 2 will see premiums increase. However, while some of these enrollees will additionally see changes in cost sharing, others will see no change because they will meet their deductible through the use of other medical care services, services still subject to the deductible.

Figure 3. Flow Chart of Impact to Enrollees when State-Regulated Plan or Policy is Subject to Deductible Prohibition



Source: California Health Benefit Review Program, 2021

State and Federal Laws Related to Deductibles

A number of state and federal health insurance laws place requirements regarding deductibles and all cost sharing (including deductibles) on plans and policies regulated by DMHC or CDI.

- **Federal Requirement of Presence of Deductible for HSA-Qualified Plans/Policies:** As previously discussed in the HDHP section, for HSA-qualified plans and policies, federal law requires the presence of a deductible but prohibits application of the deductible for selected preventive care – see IRS specifications,[20] which reference the Social Security Act[21] as well as IRS Notice 2019-45.[22]
- **Federally Selected Preventive Service Coverage Requirement:** The ACA requires that non-grandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing (including deductibles) when delivered by in-network providers and as soon as 12 months after a recommendation for such services appears in any of a number of federal lists (CCIIO, 2010).[23]
- **Federally Declared Public Health Emergency COVID-19 Testing and Vaccination Coverage Requirement:** For the duration of the federally declared public health emergency,

[20] Section 223(c)(2)(C) of Title 26 of the United States Code.
[21] Section 1861 of the Social Security Act.
[22] The IRS notice is available at: https://www.irs.gov/pub/irs-drop/n-19-45.pdf.
[23] For more information: CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at: www.chbrp.org/other_publications/index.php.

FDA-approved COVID-19 testing and vaccinations must be covered without cost sharing (including deductibles)[24] when delivered by in-network or out-of-network providers.[25]

- **State of California Prescription Drug Coverage Requirement:** The annual deductible for outpatient prescription drugs, if any, shall not exceed $500.[26] However, this statute has different terms for enrollees in plans/policies with an actuarial value at or equivalent to bronze level.[27]

Conclusion

Approximately 6.8 million Californians are enrolled in plans and policies regulated by DMHC or CDI that include a deductible. Depending on a number of factors, including other forms of applicable cost-sharing and OOP maximums, the impact of a state-level deductible prohibition on enrollee's total cost-sharing for the plan or policy year would vary, and could have little or no impact for some enrollees.

[24] 2020 Families First Coronavirus Response Act (FFCRA).
[25] 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act
[26] H&SC 1342.73; IC 10123.1932. These laws have a scheduled expiration date of January 1, 2024. The cost sharing limit is relevant to non-grandfathered plans/policies issued, amended, or renewed on or after January 1, 2015.
[27] For plans and policies with an actuarial value at or equivalent to bronze level, the pharmacy benefit deductible shall not exceed $1000.

APPENDIX A

Below is a brief description of the approach and key assumptions used to estimate the presence of deductibles among enrollees in plans and policies regulated by DMHC and CDI.

Estimates were based on the results of surveys of California's largest (by enrollment) plans and insurers regulated by DMHC or CDI.

For both Tables 1 and 2, non-HSA plan/policy in-network medical deductible information was summarized by regulator, line of business, and deductible or metal tier levels.

For Table 1, assumptions include:

- For large group and grandfathered[28] plans/policies, ranges of deductibles exist. For plans in the $1 to $1,399 deductible range, a medical deductible of $750 was assumed. For plans with a deductible of $1,400 or greater, a $2,000 medical deductible was assumed.
- For small group plans/policies, the 2022 Covered California plan offerings (Covered CA, 2021) were reviewed. The average medical deductible for the Silver tier plans was assumed to be applicable to all plans in that tier. For all other tiers, the mode was assumed applicable to all.
- For individual plans/policies, the 2022 Covered California plan offerings (Covered CA, 2021) were reviewed. The non-HSA plan medical deductible at each tier was assumed to be applicable.

For Table 2, assumptions include:

- 14% of large group plans were assumed to have a pharmacy deductible based on the large group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
- Large group plans with a pharmacy deductible were assumed to have a pharmacy deductible of $190 based on the average large group pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
- 10% of the small group and individual grandfathered plans were assumed to have a pharmacy deductible based on the small group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KFF, 2015).
- The small group and individual grandfathered plans with a pharmacy deductible were assumed have a pharmacy deductible of $160 based on the average small group pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KFF, 2015). The 2015 report was used because grandfathered plans are allowed to offer benefits they had before the Affordable Care Act was signed in 2010 and are not allowed to significantly reduce coverage. The information needed was not available in more recent reports.
- For all nongrandfathered small group plans, the 2022 Covered California plan offerings were reviewed (Covered CA, 2021). Platinum and Gold plans were assumed to have no pharmacy deductible. Silver plans were assumed to have a "low" pharmacy deductible and Bronze plans were assumed to have a $500 pharmacy deductible.

[28] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." See http://www.healthcare.gov/glossary/grandfathered-health-plan. Accessed on December 7, 2021.

- For all nongrandfathered individual plans, the 2022 Covered California plan offerings were reviewed (Covered CA, 2021). The non-HSA plan pharmacy deductible was assumed for each tier.

For Tables 1 and 2, assumptions include:

- HSA-qualified plan/policy medical and pharmacy in-network deductibles were summarized using the 2021 individual and 2020 small group Covered California plans for individual and small group nongrandfathered plans (Covered CA, 2021). Large group and grandfathered plans were assumed to have a $2,500 deductible, based on the Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).

APPENDIX B

CHBRP is aware of some other estimates of enrollees in high deductible health plans (HDHPs) in California as well as some estimates of national HDHP enrollment trends. Although it can be difficult to compare different estimates, due to variations in how the estimates are generated and/or the group or groups addressed by the estimates, these other estimates are broadly congruent with CHBRP's estimates of enrollees in HDHPs.

Besides the results from CHBRP's own survey of the largest (by enrollment) California plans and insurers, which are presented in this document, CHBRP is aware of two other recent California-specific sets of estimates of enrollees in HDHPs.

One of the estimates sets is from a 2020 analysis of data from the California Health Interview Survey (CHIS) (Planalp and Hartman, 2020). The analysis was completed by the State Health Access Data Assistance Center (SHADAC). The SHADAC and CHBRP estimates agree that enrollment in HDHPs is higher in the individual market than in the group market. The SHADAC and CBHRP estimates of HDHP enrollment in the individual market are comparable, 44% and 56%, respectively. The difference in the SHADAC and CHBRP estimates of enrollment in HDHPs in the group market is more marked, 32% and 13%, respectively. Variations in approach between the two surveys are the likely reason for the difference. These variations include the following:

- CHIS surveys a sample of California residents, whereas CHBRP surveys plans and insurers.
- The SHADAC estimates include self-insured plan enrollees, whereas the CHBRP estimates include only enrollment in plans and policies regulated by DMHC or CDI.
- SHADAC defined a high deductible as $2,000+, whereas CHBRP defined it as $1,400+.

The other set of California-specific estimates of enrollment in HDHPs is from the 2020 California Employer Health Benefits Survey (CEHBS) (Whitmore and Satorius, 2021). The CEHBS survey was completed by the California Health Care Foundation (CHCF) and NORC at the University of Chicago. The CEHBS and CHBRP estimates agree that enrollment in HDHPs is higher in the small group market than in the large group market. Although the CEHBS estimates (72% of small group enrollees and 48% of large group enrollees) are greater than the CHBRP estimates (35% of small group enrollees and 9% of large group enrollees), variations in approach between the two surveys are the likely reason for the differences. These variations include the following:

- The CEHBS survey asked employers about plans and policies available to employees, whereas CHBRP's survey of plans and insurers asked about enrollment.
- The CEHBS estimates include self-insured plan enrollees, whereas the CHBRP estimates include only enrollment in plans and policies regulated by DMHC or CDI.
- CEBHS defined large groups as 200+ enrollees, whereas CHBRP defined them as 100+ enrollees.
- CEBHS defined a high deductible as $1000+, whereas CHBRP defined it as $1,400+.

In terms of trends in deductibles over time, the SHADAC analysis estimates that the percentage of Californians enrolled in HDHPs is growing. The SHADAC analysis estimates that between 2013 and 2018 there was an overall increase in enrollees in HDHPs from 16% to 31% (Planalp and Hartman, 2020). Several national estimates also indicate increasing enrollment in HDHPs over time (Claxton et al., 2021; Miller and Keenan, 2021; Collins et al., 2022).

The national estimates of enrollment in HDHPs are higher than the CHBRP and SHADAC estimates for California. Estimates from the 2021 Kaiser Family Foundation Employer Health Benefits Survey, the 2018 National Compensation Survey, and the 2017 National Health Interview Survey all estimate, with varying definitions and methodology, that in recent years enrollment in HDHPs is higher nationally than in California (57%, 45%, and 43.4% enrollment in HDHPs nationally, respectively) (Claxton et al., 2021; BLS, 2020; Cohen and Zammitti, 2018). This is congruent with a 2017 estimate from SHADAC showing that California had the 5th lowest percent of employees in HDHPs out of all states (SHADAC, 2018). Some reasons for California's lower enrollment in HDHPs include:

- California's relatively greater market penetration of managed care.
- California's history of relatively more stringent regulation of health insurance markets.

The several California-specific estimates of HDHP enrollment, all of which are based on surveys, agree directionally on many points. Differences between them are likely due to substantial differences in survey methodology and the definitions used in making the estimates. All of the California specific estimates as well as national estimates suggests that California has relatively fewer enrollees in HDHPs than the national average, but California's trends in increasing presence and size of deductibles align with national trends.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at http://www.chbrp.org/.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, in the Office of the Vice Chancellor for Research.

Acknowledgements

The 2021 version of this issue brief was prepared by John Lewis, MPA, of CHBRP staff, and Katie Patrick, MPH candidate, a CHBRP Summer 2021 Intern. Drafts were reviewed by Garen Corbett, MS, and Adara Citron, MPH, both of CHBRP staff, and Dylan Roby, PhD of the University of California, Irvine.

The 2022 version was updated by Adara Citron, MPH, Sabrina Woll, John Lewis, MPA, all of CHBRP staff, and Madison Olmsted, MPP candidate.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.