

Deductibles in State-Regulated Health Insurance for 2026

JUNE 2025



California Health Benefits Review Program (CHBRP)
University of California

At the request of the California State Legislature, the California Health Benefits Review Program (CHBRP)¹ provides independent and rigorous evidence-based analyses of proposed health insurance benefit legislation 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 proposed state-level legislation.

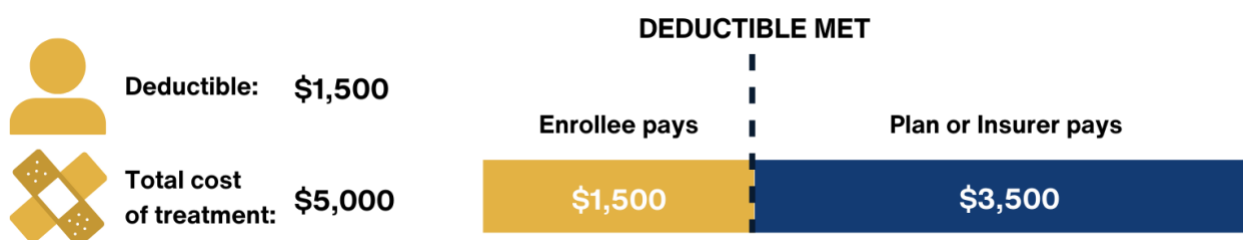
This resource takes a closer look at deductibles – one type of cost sharing² – for enrollees of commercial DMHC-regulated health plans and CDI-regulated policies. These plans and policies are subject to state regulation and can be influenced by the proposed state-level legislation CHBRP is asked to analyze. CHBRP considers the presence or absence of deductibles because the bills analyzed sometimes address application of a deductible.³

In 2026, no deductibles are expected to be present for California Public Employees' Retirement System (CalPERS) enrollees or Medi-Cal beneficiaries in DMHC-regulated plans. Therefore, this resource focuses only on the commercial state-regulated health insurance markets.

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 insurer begins to reimburse medically necessary use of covered benefits (see Figure 1).

Figure 1. Deductible Examples



Source: California Health Benefits Review Program, 2025.

¹ See CHBRP's [authorizing statute](#).

² Cost sharing is the portion of health insurance for which enrollees are responsible for paying out-of-pocket, directly to the provider of a covered health care service or treatment. For more information, see CHBRP's [explainer](#), *What is Cost Sharing in Health Insurance?*

³ Examples include CHBRP's [analyses](#) of SB 568 (2021) and AB 97 (2021).

A deductible is a one-time annual cost. When applicable, once the deductible amount is paid, other forms of cost sharing (such as coinsurance⁴ or copayments⁵) may still be applicable to the use of covered benefits. Premiums do not count towards a deductible. The presence of deductibles and their sizes vary depending on the enrollee's plan or policy design and relevant laws and regulations.

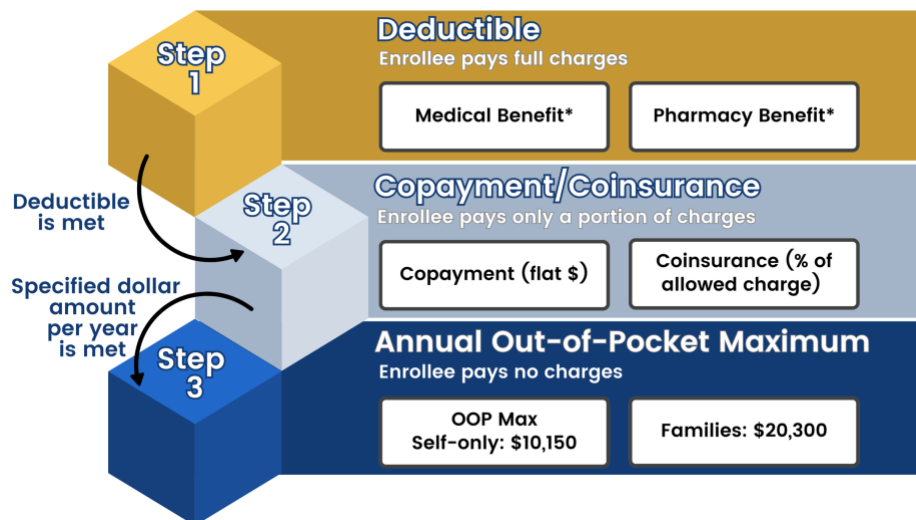
Deductibles are present for many commercial enrollees in DMHC-regulated plans and CDI-regulated policies. When deductibles are present, their amount typically varies from \$500 per year to the Internal Revenue Service (IRS)-specified "high deductible threshold" for 2026 of \$1,700 per year, to perhaps as much as the current OOP maximums. The OOP maximum is the most an enrollee could pay for cost sharing towards covered benefits in a one-year period.⁶ In 2026, OOP maximums are expected to be \$10,150 for self-only plans and \$20,300 for families.⁷

Enrollees may have annual cost-sharing limits that are lower than the OOP limit. For example, lower income individuals and families with health insurance from Covered California may qualify for reduced OOP maximums through Enhanced Silver plans with cost-sharing reductions (CSR) subsidies (Covered CA, n.d.). OOP maximums can 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 2).

Figure 2. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2025; CMS, 2024.

Note: (a) 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.

(b) The annual OOP maximums listed are for the 2026 benefit year, as determined by CMS. OOP Max differs for enrollees in HSA-qualified HDHPs. Lower income individuals and families may qualify for reduced OOP maximums through Enhanced Silver plans with CSRs (Covered CA, n.d.).

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 OOP at the time of receiving a health care service, such as a \$20 copay for a physician office visit.

⁶ See [Revenue Procedure 2025-19](#) for more information on IRS high-deductible threshold for 2026.

⁷ See CMS' [publication](#) on maximum annual limitations on cost sharing for 2026.

Key: CSR = cost sharing reduction subsidy; HDHP = high deductible health plan; HSA = health savings account; OOP Max = annual out-of-pocket maximum.

The beginning of Step 1 is marked by the first day of the plan or policy year. As discussed in detail below, for some enrollees in some plans and policies, service-specific deductible prohibitions or waivers may allow for “first dollar” coverage for some covered benefits.⁸ However, during Step 1, an enrollee generally pays the full price of most covered benefits until they meet their deductible. The beginning of Step 2 is marked by the enrollee meeting their deductible. During Step 2, an enrollee pays any applicable coinsurance and/or copayments, and plans or insurers reimburse the rest of the price of covered benefits. The beginning of Step 3 is marked by the date an enrollee meets their OOP maximum. 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 year⁹ and meet their deductible in the first month. Then, through copayments and coinsurance for additional covered benefits throughout the next two months, the enrollee could meet 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, for that plan or policy year, used no covered benefits to which a deductible would have been applicable. This enrollee spends the entire year in Step 1.

Note that Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive care), enrollees may pay coinsurance or copayments prior to their deductible being met. Copayments and coinsurance may also be applied against the deductible in some circumstances.

There are situations where the application of a deductible is not as straightforward as described above. For example, enrollees in Preferred Provider Organization (PPO) plans and policies, where out-of-network coverage is expected to be regularly used, only the copayments and coinsurance 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 deductible.¹⁰

There are some covered benefits for which application of a deductible (or even all cost sharing) may be prohibited or waived for some enrollees. In such cases, enrollees could receive first dollar coverage for those covered benefits. Examples of service-specific deductible prohibitions and waivers include:

- For some enrollees in nongrandfathered group and individual health insurance plans and policies, federal and California state laws prohibit all cost sharing (including any applicable deductibles) for certain preventive services when delivered by in-network providers.¹¹ For example, recommended biennial screening mammograms for women aged 40-74 years must be covered without any cost sharing for enrollees.
- For some enrollees with health insurance through Covered California, plans and insurers may be obligated to not apply a deductible for certain tests, treatments or services (see Appendix A).
- For some enrollees, in the absence of a service-specific deductible prohibition or obligation (see the two preceding bullets), plans and insurers may waive an otherwise applicable deductible for a particular covered benefit. For example, although there is no service-specific deductible prohibition for diagnostic mammograms (which may follow a screening mammogram should those results cause concern), for some enrollees in state-regulated plans and policies, applicable deductibles are waived for that particular service.¹²

⁸ “First dollar” coverage is when plans or policies have no applicable deductible and the plan or insurer reimburses the price of covered benefits for the first dollar spent. Other forms of cost sharing, including copayments and coinsurance may still apply.

⁹ 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.

¹⁰ For more information about balance billing, see CHBRP’s [issue brief](#), *Balance Billing Prohibitions and the No Surprises Act*.

¹¹ See CHBRP’s [resource](#), *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*, available as a resource at: .

¹² See CHBRP’s [analysis](#) of SB 974 (2022).

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

In 2026, approximately 22.2 million (58.4% of all) Californians¹³ will be commercial enrollees 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. Approximately 17.9 million Californians are enrolled in commercial state-regulated plans and policies that include a deductible. Tables 1 and 2 note the variation in presence of deductibles for those Californians. Table 1 notes the presence of medical deductibles and Table 2 notes the presence of pharmacy deductibles¹⁴ among commercial enrollees (whose health insurance is state-regulated). These estimates are based on the results of surveys of California's largest (by enrollment) plans and insurers regulated by DMHC or CDI and do not differentiate between self-only and family deductibles.

In 2026, approximately 26% of enrollees in commercial health plans and policies regulated by DMHC or CDI will have a medical deductible and approximately 27% of these enrollees will have a pharmacy deductible. Another 1% of these enrollees will have a combined medical and pharmacy deductible.¹⁵

Table 1. Medical Deductibles among Commercial Enrollees in State-Regulated Plans and Policies, 2026

Market Segment	Enrollment	Any Deductible Present	Low Deductible	High Deductible (a)		HSA-Qualified HDHP	
			\$1-1,399	\$1,400-\$3,999	≥\$4,000	\$1,600 - \$3,999	≥\$4,000
DMHC/CDI Large Group	8,298,000	37%	12%	13%	4%	6%	1%
DMHC/CDI Small Group	2,141,000	71%	37%	21%	4%	7%	3%
DMHC/CDI Individual	2,217,000	52%	0%	1%	43%	1%	7%
Total	12,656,000	45%	14%	12%	11%	5%	3%

Source: California Health Benefits Review Program, 2025.

Notes: (a) Does not include enrollees in HSA-qualified plans or policies.

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

¹³ See CHBRP's [resource](#), *Sources of Health Insurance in California*.

¹⁵ Estimates based on the results of surveys of California's largest (by enrollment) plans and insurers regulated by DMHC or CDI.

Table 2. Pharmacy Deductibles among Commercial Enrollees in State-Regulated Plans and Policies with a State-Regulated Pharmacy Benefit, 2026

Market Segment	Enrollment	No Deductible	Combined Medical and Pharmacy Deductible	Low Deductible (<\$500)	High Deductible (b) (≥\$500)	HSA-Qualified HDHPs
DMHC/CDI Large Group	7,869,000	82%	1%	8%	2%	7%
DMHC/CDI Small Group	2,141,000	53%	0%	33%	4%	10%
DMHC/CDI Individual	2,213,000	45%	0%	29%	18%	8%
Total	12,656,000	70%	1%	16%	5%	8%

Source: California Health Benefits Review Program, 2025.

Notes: (a) Approximately 96.6% of commercial enrollees in DMHC or CDI regulated plans and policies have a pharmacy benefit also regulated by DMHC or CDI.¹⁶ (b) Does not include enrollees in HSA-qualified plans or policies.

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

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 or policy and are subject to requirements set by federal regulation (HealthCare.gov Glossary, n.d.). For the 2026 plan year, the IRS defines a HDHP as any plan with a deductible of at least \$1,700 for an individual and \$3,400 for a family.¹⁷

HDHPs can be paired with health savings accounts (HSAs), which are pre-tax instruments that allow enrollees to put aside money for qualified healthcare expenses, including any healthcare services subject to a deductible (HealthCare.gov Glossary, n.d.). HSAs are generally funded by enrollee contributions.¹⁸ HSA-qualified HDHPs are not allowed to have separate medical and pharmacy deductibles.¹⁹ 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. For example, Silver plans available through Covered California are not HSA-qualified even though some have a high deductible because they offer numerous service-specific deductible waivers (Covered CA, n.d.).

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” (\$1,700 or greater) deductible (see Figure 3).²⁰

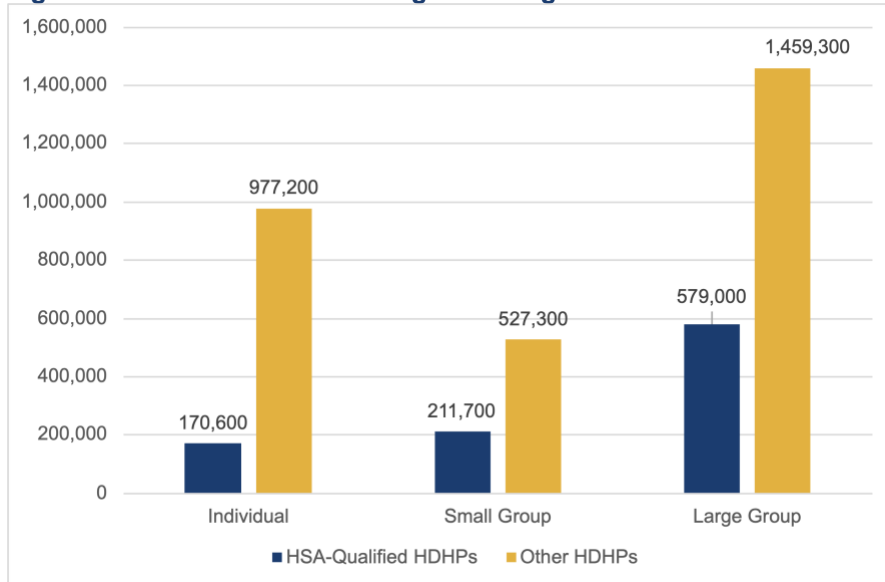
¹⁶ See CHBRP’s [resource](#), *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

¹⁷ See [IRS Revenue Procedure 2025-19](#).

¹⁸ 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.

¹⁹ HSA-qualified HDHPs have a combined medical and pharmacy deductible generally ranging from \$1650 to \$8,300.

²⁰ 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.

Figure 3. Enrollment in State-Regulated High Deductible Health Plans and Policies, 2026*

Source: California Health Benefits Review Program, 2025.

Notes: *This figure uses enrollment in plans and policies with a medical deductible. All of the enrollees in HSA-qualified HDHPs have a single deductible applicable to both 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.

As is the case for most plans and policies, the California and the Federal Preventive Services Mandates require HDHPs to cover select preventive services at no cost to enrollees on a pre-deductible basis.²¹ This means that preventive services must be covered regardless of whether the enrollee has met their deductible. 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, HSA-qualified HDHPs to cover select additional preventive care benefits without applying a deductible.²² 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, HSA-qualified 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.²³ 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 Service-Specific Deductible Prohibitions

CHBRP has analyzed bills that would prohibit or limit application of a deductible. The bills' approaches have varied. Senate Bill (SB) 473 (2021) proposed to limit all cost sharing for insulin (copayments, coinsurance, and deductibles).²⁴ SB 568 (2021) proposed to prohibit the application of a deductible for some drugs, but permitted application of copayments and coinsurance.²⁵

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. High coinsurance and copayments are common in HDHPs. Therefore, while a bill may prohibit a deductible for some services, enrollees with a HDHP may still need to pay high coinsurance or

²¹ See CHBRP's [resource](#), *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.

²² [IRS Notice 2004-23](#) provides a safe harbor that lets HSA-qualified HDHPs waive the deductible for preventive care benefits.

²³ [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.

²⁴ See CHBRP's [analysis](#) of SB 473 (2021).

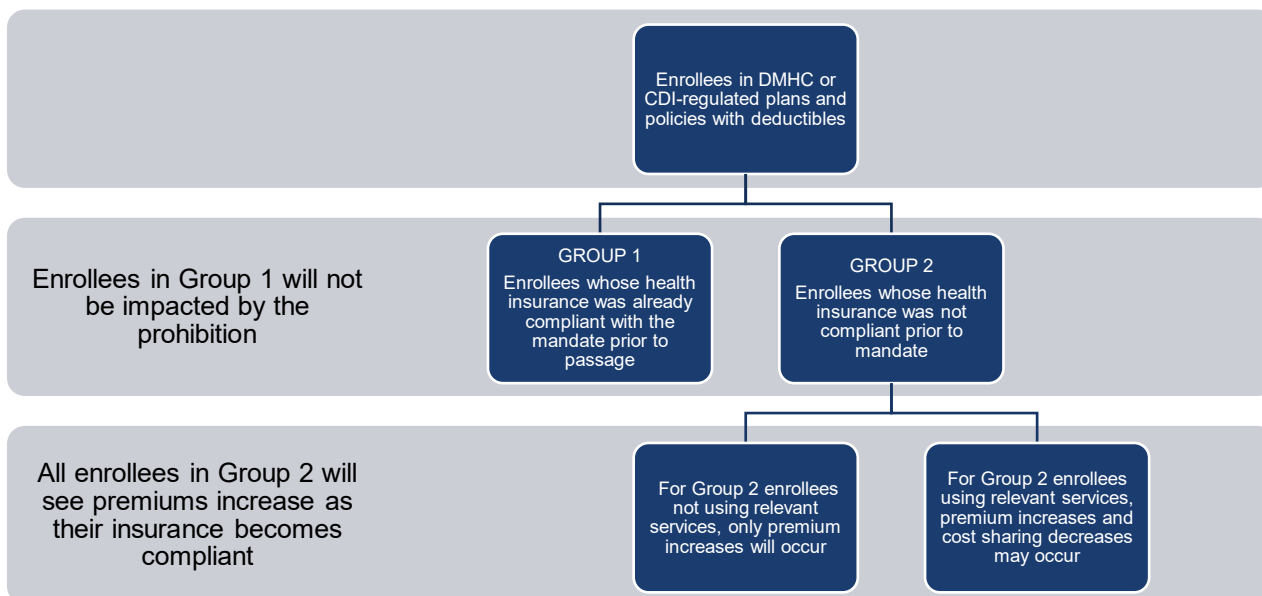
²⁵ See CHBRP's [analysis](#) of SB 568 (2021).

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 for some enrollees.

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 4). Enrollees in Group 1 will not see an immediate impact as a result of a service-specific deductible prohibition because the plans or policies are already compliant with the prohibition. Enrollees in Group 2 will be impacted because the plans or policies are not already compliant. The impact on 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 that remain subject to the deductible.

Figure 4. Flow Chart of Impact to Enrollees when State-Regulated Plan or Policy is Subject to a Service-Specific Deductible Prohibition



Source: California Health Benefit Review Program, 2025

State and Federal Laws Related to Deductibles

Several state and federal health insurance laws place requirements regarding deductibles and other cost sharing on plans and policies regulated by DMHC or CDI. Examples include:

- **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,²⁶ which reference the Social Security Act²⁷ as well as IRS Notice 2025-19.²⁸
- **Federally Selected Preventive Service Coverage Requirement:** The Federal Preventive Services Mandate requires nongrandfathered group and individual health insurance plans and policies to cover certain

²⁶ Section 223(c)(2)(C) of Title 26 of the United States Code.

²⁷ Section 1861 of the Social Security Act.

²⁸ See the [IRS Notice 2025-19](#) for more information.

preventive services for some enrollees 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).²⁹ The California Preventive Services Mandate does the same.³⁰

- **Federally Mandated Cost Sharing Reduction Subsidies.** The Affordable Care Act establishes a requirement for insurers to offer plans with cost sharing reduction subsidies for persons and families who earn an income below 250% of the federal poverty level (HealthCare.gov, n.d.; Norris, 2022; Levitt et al., 2017). These are Enhanced Silver plans that have lower deductibles, lower OOP maximums, and service-specific deductible waivers.
- **State of California Prescription Drug Coverage Requirement:** California law prohibits the annual deductible for outpatient prescription drugs, if any, from exceeding \$500.³¹ However, this statute has different terms for enrollees in plans/policies with an actuarial value at or equivalent to bronze level.³²

Conclusion

Approximately 17.9 million Californians are enrolled in commercial plans and policies regulated by DMHC or CDI that include a deductible. Depending on several 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.

²⁹ See CHBRP's [resource](#), *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.

³⁰ See CHBRP's [resource](#), *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.

³¹ HSC 1342.73; INS 10123.1932. The cost sharing limit is relevant to nongrandfathered plans/policies issued, amended, or renewed on or after January 1, 2015.

³² For plans and policies with an actuarial value at or equivalent to bronze level, the pharmacy benefit deductible shall not exceed \$1000.

APPENDIX A

As noted in the table below,³³ for some enrollees with health insurance through Covered California, plans and insurers may be obligated to not apply a deductible for certain tests, treatments or services.



2025 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Silver 73 CA Enhanced CSR	Silver 87 CA Enhanced CSR	Silver 94 CA Enhanced CSR	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	>\$30,120 (Above 200% FPL)	\$22,591 to \$30,120 (>150% to ≤200% FPL)	up to \$22,590 (100% to ≤150% FPL)	N/A	N/A
Free Preventive Care Visit	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	\$60	\$50	\$35	\$15	\$5	\$35	\$15
Urgent Care		\$60	\$50	\$35	\$15	\$5	\$35	\$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$95*	\$90	\$85	\$25	\$8	\$65	\$30
Emergency Room Facility		40% after deductible is met	\$400	\$350	\$150	\$50	\$330	\$150
Laboratory Tests		\$40	\$50	\$50	\$20	\$8	\$40	\$15
X-Rays and Diagnostics		40% after deductible is met	\$95	\$95	\$40	\$8	\$75	\$30
Imaging	Full cost per script until out-of-pocket maximum is met		\$325	\$325	\$100	\$50	\$75 copay or 25% coinsurance***	\$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)		\$19	\$18	\$15	\$5	\$3	\$15	\$7
Tier 2 (Preferred Drugs)		40% up to \$500 per script after drug deductible is met	\$60**	\$55	\$25	\$10	\$60	\$16
Tier 3 (Non-preferred Drugs)			\$90**	\$85	\$45	\$15	\$85	\$25
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250 per script	15% up to \$150 per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible - The amount you pay before the plan pays	N/A	Individual: \$5,800 Family: \$11,600	Individual: \$5,400 Family: \$10,800	N/A	N/A	N/A	N/A	N/A
Pharmacy Deductible - The amount you pay before the plan pays	N/A	Individual: \$450 Family: \$900	Individual: \$50 Family: \$100	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$9,200 individual \$18,400 family	\$8,850 individual \$17,700 family	\$8,700 individual \$17,400 family	\$6,100 individual \$12,200 family	\$3,000 individual \$6,000 family	\$1,150 individual \$2,300 family	\$8,700 individual \$17,400 family	\$4,500 individual \$9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (specialist) for the first three visits.

After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

Source: Covered California, 2025

³³ Available on Covered California's [website](https://www.coveredca.com).

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 reports 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, under the Office of the Vice Chancellor for Research.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2025). Resource: Deductibles in State-Regulated Health Insurance. Berkeley, CA