California Health Benefits Review Program

Analysis of California Assembly Bill AB 1305
Limitations on Cost-Sharing: Family Coverage

A Report to the 2015–2016 California State Legislature

April 22, 2015

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Key Findings:

Analysis of California Assembly Bill AB 1305 Limitations on Cost-Sharing: Family Coverage

Summary to the 2015–2016 California State Legislature, April 2015

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

Assembly Bill AB 1305 (introduced February 27, 2015) would limit cost sharing for enrollees with family coverage by requiring health insurers to standardize the per-person deductible and out-of-pocket (OOP) limits across self-only and family health insurance of the same contract.

- **Enrollees covered.** CHBRP estimates that in 2015, 506,722 enrollees (1.3% of all Californians) have health insurance that would be affected by AB 1305.
- **Impact on expenditures.** AB 1305 would decrease total net annual expenditures by $37,754,000, or 0.028%.
  - The majority of the cost savings ($20,767,000) will come from a decrease in premiums paid by enrollees purchasing insurance in the individual market.
- **EHBs.** AB 1305 does not require coverage of specific health benefits and therefore would not exceed essential health benefits.
- **Benefit coverage.** Currently, 97.937% of enrollees subject to AB 1305 are covered by DMHC-regulated plans or CDI-regulated policies that have no deductible or an embedded deductible, therefore already compliant with AB 1305. CHBRP found that 506,722, or 2.063%, of enrollees had health insurance with an aggregated deductible.
  - Postmandate, 100% of enrollees would have mandate-compliant coverage.
- **Utilization.** The premandate average PMPM covered benefits paid for by the plan or policy equaled a total average of covered health services of $399.81.
  - As deductibles increase under the 2:1 family to per-person deductible ratio, individuals may reduce their overall service use, which leads to a reduction in overall expenditures. CHBRP estimates a decrease of $0.11 (-0.027%) in overall expenditures.
- **Long-term impacts.** Recent growth trends suggest that the number of Californians enrolled in state-regulated HDHPs will increase. Such an increase could result in a proportional increase in total cost savings.

BILL SUMMARY

AB 1305 requires state-regulated family insurance plans or policies to use the same per-person deductible and per-person annual OOP limit as the corresponding self-only health insurance contract.

AB 1305 addresses the disparity in some health insurance products where cost-sharing for enrollees with family coverage exceeds that of enrollees who purchase insurance for themselves only.

For example, assume a product has a $1,500 deductible for single coverage and a $3,000 deductible for family coverage. If the health insurance "aggregates" the deductible, then the family would collectively need to meet the $3,000 deductible before insurance begins to pay. That $3,000 deductible would need to be met whether one family member or several family members were receiving care.

AB 1305 would mandate the lower per-person limit on deductibles, even when the enrollee purchases family coverage. AB 1305 requires the same for OOP limits.

CONTEXT FOR BILL CONSIDERATION

CHBRP's survey of California's seven largest health insurance carriers found that high-deductible health plans (HDHPs), which can be paired with tax-advantaged Health Savings Accounts or Health Reimbursement Accounts, would be the only health insurance products affected by AB 1305. Health insurers reported that HDHPs were the only products that had aggregated deductibles or OOPs.

HDHP deductibles and OOP limits are set by the Internal Revenue Service if health insurers want their HDHPs to be HSA-qualified, meaning enrollees could save money for health expenses in tax-advantaged savings accounts. IRS regulations dictate that HDHP deductibles:

- For single coverage, cannot be less than $1,300 (in 2015);

- For a family, cannot be less than $2,600 (in 2015), whether paid for a one member in the family or multiple family members.

TYPES OF DEDUCTIBLES

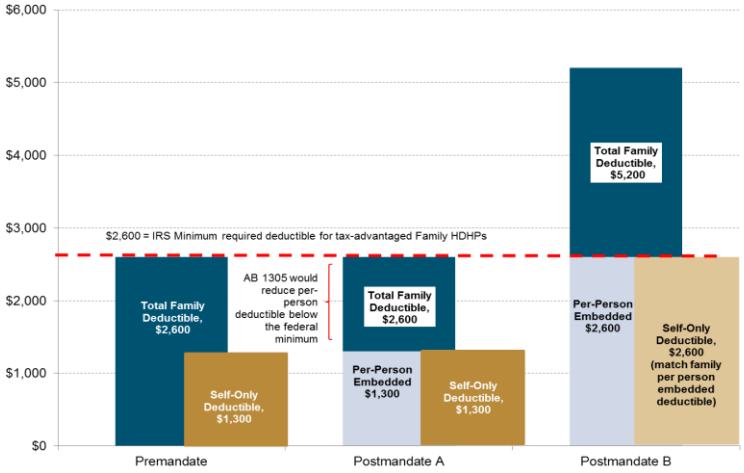
- **Aggregated family deductibles**: These types of HDHPs count all of a family's cost sharing to the deductible limit, whether the deductible is met by one family member or multiple family members.
  - Example: for a family plan with the minimum deductible amount, $2,600, the plan would not pay for an enrollee's expenses until the entire family had at least $2,600 in expenditures. That $2,600 could be paid by one member or more than one member in the family.
- **Per-person (embedded) deductibles**: These types of HDHPs have deductibles for the family as a whole, in addition to per-person deductibles for one family member. If an enrollee meets the per person deductible for one family member, they would not have to meet the higher annual deductible amount for the whole family. This type of deductible is generally seen in non-HDHP insurance coverage. The IRS stipulates, however, that HDHP deductibles in this type of arrangement, whether for one family member or the family as a whole, cannot fall below the minimum deductible for a family ($2,600 in 2015).
  - Example: Using the minimum required deductible for HDHPs, in this situation, the plan would begin to pay for services for an enrollee when he or she had expenditures of $2,600, regardless of whether the entire family has reached $5,200. Other family members would need to continue to pay toward the $5,200 before insurance begins to pay for their health care, but the first family member who had already reached his or her per-person deductible would have services covered.

INCREMENTAL IMPACT OF ASSEMBLY BILL AB 1305

Market Impact

AB 1305 would disallow "aggregated family deductibles" and require all family health insurance products in California to fall into the per-person category of deductibles. For those HDHPs that are at the minimum allowable deductible ($2,600), CHBRP finds that AB 1305 could result in two separate reactions (Figure 1).

Figure 1. Effect of AB 1305 on Deductibles



Postmandate A: Health insurers could continue to offer HSA-compatible HDHPs for self-only enrollees, with deductibles at $1,300. However, family HDHP deductibles, also limited to $1,300, would not be HSA-compatible because, as previously mentioned, the IRS requires family HDHP deductibles to be at least $2,600. Families could continue to use these plans, but would not be able to use the plan/policy with an HSA with it because it would no longer be HSA-compatible for families.

Postmandate B: Under this scenario, CHBRP assumes that health insurers would set deductible levels for both self-only and families at the minimum level required for *family* HDHPs: $2,600. Because AB 1305 requires the per-person embedded deductible to be equivalent to the self-only deductible, the self-only deductible would also be $2,600. Any enrollee with a plan depicted by Postmandate B could use an HSA. Enrollees purchasing single coverage may opt for either Postmandate B, or Postmandate A, which has a lower deductible and is also HSA-compatible.

Cost Impacts

AB 1305 would decrease total net annual expenditures by $37,754,000, or 0.028%. This is due to a $25,319,000 decrease in total health insurance premiums paid by employers and enrollees for newly covered benefits, added to a decrease in enrollee expenditures for covered

benefits ($12,435,000). The majority of the cost savings ($20,767,000) will come from a decrease in premiums paid by enrollees for individually purchased insurance.

CHBRP may overstate the effect of coverage for enrollees purchasing self-only HDHPs. Due to data constraints, CHBRP's model estimates that all enrollees in self-only plans migrate to the higher deductible of $2,600 as illustrated by the Postmandate B scenario discussed in the Policy Context. Because it is unlikely that all self-only enrollees would choose a higher $2,600 deductible, when another HDHP, at $1,300 is IRS-complaint for single coverage, CHBRP's estimates may overstate the premium expenditure reductions. The reductions in premiums illustrated in Table 5 would likely be less.

Long-Term Impacts

In later years, the recent growth of HDHPs as a proportion of health insurance coverage in the overall market will likely continue, and the negative impact on utilization that has been identified in many studies will also grow proportionally. The literature suggests that the expected expansion of HDHP plans would increase the cost savings that could be expected after the 12-month CHBRP timeframe ends. However, any savings that may accrue to enrollees will be in the form of reduced premiums in some markets, and they will likely defer both needed and unnecessary care to decrease their own higher out-of-pocket costs (CHCF, 2012). On the other hand, families with HDHPs could potentially increase utilization in the long term because AB 1305 limits their cost sharing.

Essential Health Benefits and the Affordable Care Act

Because AB 1305 would not mandate the coverage of any specific services, it would not exceed federally and state-mandated EHBs, and therefore, would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs) in Covered California.

Public Health

Because a Public Health Impacts analysis was not requested by the Legislature, estimating how these long-term effects could potentially impact public health (including economic loss, increased mortality, racial and ethnic disparities, and gender disparities) is beyond the scope of this report. However, in previous reports, CHBRP has identified literature that clearly show cost-sharing barriers can have the unintended impact of delaying necessary care (CHBRP, 2012, 2014). Additionally, CHBRP also identified literature noting that disparities in utilization among racial and ethnic groups already exist (CHBRP, 2012, 2014) and that these consequences could be further magnified over time, although they cannot be quantified here.

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California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510.287.3876
Fax: 510.763.4253
www.chbrp.org

ABOUT CHBRP

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

An analytic staff in the University of California's Office of the President supports a task force of faculty and research staff from several campuses of the University of California 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, and content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, as well as all CHBRP reports and publications are available at www.chbrp.org.

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Table 1. AB 1305 Impacts on Benefit Coverage, Utilization, and Cost, 2015

	Premandate	Postmandate	Increase/ Decrease	Change Post-mandate
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	24,557,000	24,557,000	0%	0%
Total enrollees with health insurance subject to AB 1305	24,557,000	24,557,000	—	0%
Number of enrollees with either no deductible or an embedded deductible deductibles	24,050,278	24,557,000	506,722	2.107%
Number of enrollees with an aggregated deductible at or above $5,200 (b)	358,832	—	(358,832)	−100.000%
Number of enrollees with an aggregated deductible below $5,200	147,890	—	(147,890)	−100.000%
Percentage of enrollees with either no deductible or an embedded deductible	97.937%	100.000%	2.063%	2.107%
Percentage of enrollees with an aggregated deductible at or above $5,200	1.461%	0.000%	−1.461%	−100.000%
Percentage of enrollees with an aggregated deductible below $5,200	0.602%	0.000%	−0.602%	−100.000%
Utilization and cost				
Covered benefits paid by plan, PMPM	$347.18	$347.11	−$0.06	−0.019%
Covered benefits paid by member, PMPM	$52.63	$52.59	−$0.04	−0.080%
Covered benefits total, PMPM	$399.81	$399.70	−$0.11	−0.027%
Expenditures				
Premium expenditures by payer				
Private employers for group insurance	$58,393,205,000	$58,391,632,000	−$1,573,000	−0.003%
CalPERS HMO employer expenditures	$4,391,552,000	$4,391,552,000	$0	0.000%
Medi-Cal Managed Care Plan expenditures (c)	$17,667,731,000	$17,667,731,000	$0	0.000%
Premium expenditures for individually purchased insurance	$21,319,735,000	$21,298,968,000	−$20,767,000	−0.097%
Individually purchased – outside Covered California	$8,581,274,000	$8,560,507,000	−$20,767,000	−0.242%
Individually purchased – Covered California	$12,738,461,000	$12,738,461,000	$0	0.000%

Premium expenditures for enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (d)	$18,703,917,000	$18,700,938,000	−$2,979,000	−0.016%
Enrollee expenses				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	$15,510,004,000	$15,497,569,000	−$12,435,000	−0.080%
Total expenditures	$135,986,144,000	$135,948,390,000	−$37,754,000	−0.028%

Source: California Health Benefits Review Program, 2015.

Notes*:* (a) This population includes persons with privately funded (including Covered California) and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employer-sponsored health insurance.

(b) CHBRP found that health insurance carriers only reported aggregated deductibles in high-deductible health insurance plans (HDHPs). To comply with both AB 1305 and federal tax laws, CHBRP made the simplifying assumption that family HDHPs would need to be at least $5,200. Please see Policy Context, Analytic Approach and Key Assumptions for more details.

(c) Enrollee premium expenditures include contributions to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) Of the increase in CalPERS employer expenditures, about 57.5% or $0.00, would be state expenditures for CalPERS members who are state employees, state retirees, or their dependents. This percentage reflects the share of enrollees in CalPERS HMOs as of September 30, 2013. CHBRP assumes the same ratio in 2015.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

POLICY CONTEXT

The California Assembly Committee on Health has requested[1] that the California Health Benefits Review Program (CHBRP)[2] conduct an evidence-based assessment of AB 1305, which would limit cost sharing for enrollees with family coverage. Specifically, those Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies, in which the family's total cost sharing is "aggregated," or counted toward the family's deductible and out-of-pocket (OOP) limit, would be subject to AB 1305.

If enacted, AB 1305 would affect the health insurance of approximately 506,722 enrollees (1.3% of all Californians). This represents 2.1% of the 24.6 million Californians who will have health insurance regulated by the state[3] that may be subject to any state health benefit mandate law.[4,5]

Bill-Specific Analysis of AB 1305, Limitations on Cost Sharing

Bill Language

AB 1305 requires state-regulated family insurance plans or policies to use the same per-person deductible and per-person annual OOP limit as the corresponding self-only health insurance contract.

AB 1305 addresses the disparity in some health insurance products where cost sharing for enrollees with family coverage exceeds that of enrollees who purchase insurance for themselves only. For example, assume a product has a $1,500 deductible for single coverage and a $3,000 deductible for family coverage. If the health insurance "aggregates" the deductible, then the family would collectively need to meet the $3,000 deductible before insurance begins to pay. That $3,000 deductible would need to be met whether one family member, or several family members, were receiving care. AB 1305 would mandate the lower per-person limit on deductibles, even when the enrollee purchases family coverage. AB 1305 requires the same for OOP limits.

The full text of AB 1305 can be found in Appendix A.

Analytic Approach and Key Assumptions

CHBRP's analysis focuses on high-deductible health plans (HDHPs), which health insurance carriers reported are the only types of health insurance product that contain aggregated deductibles and out-of-pocket maximums.[6]

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[1] March 3, 2015, available at www.chbrp.org/.
[2] CHBRP is authorized to review legislation affecting health insurance regulated by the state. CHBRP's authorizing statute is available at www.chbrp.org/docs/authorizing_statute.pdf.
[3] State benefit mandates apply to a subset of health insurance in California, those regulated by one of California's two health insurance regulators: the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).
[4] CHBRP's estimates of the source of health insurance available at: www.chbrp.org/other_publications/index.php.
[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.
[6] CHBRP survey of the seventh largest health insurance carriers in California. See the *Benefit Coverage, Utilization, and Cost Impacts* section.

Further, CHBRP's analysis focuses on the provisions of AB 1305 that limit *deductibles* for each family enrollee to the per-person amount, but does not focus on the OOP limits set by AB 1305 for each family enrollee. CHBRP assumes HDHPs would maximize out-of-pocket limits allowable under federal law.[7] Under this assumption, AB 1305's provisions limiting OOP payments paid by a single family member would duplicate federal regulations, which when effective in 2016, will limit OOP payments for a single family member to the per-person OOP limit.[8] Federal regulations are silent on family deductibles.[9]

Additionally, CHBRP makes the following assumptions in its analysis:

- Ratio of family deductible to-per-person deductible: Family deductibles are often defined as a multiple of the per-person deductible. This analysis assumed all family deductibles are twice the deductible of a per-person deductible. Although AB 1305 does not specify a specific ratio between per-person and family deductibles, health insurance carriers reported that the typical ratio between family and per-person contracts is 2:1. And although federal regulations do not explicitly require the 2:1 ratio, they use that ratio when setting limits per person and for families (Table 2).
- Cost sharing is the only modification: CHBRP makes the simplifying assumption that health insurers only adjust cost sharing in reaction to the enactment of AB 1305. CHBRP is aware that health insurers may use any number of methods to adjust the structures of their health insurance products in reaction to AB 1305, such as the scope of benefit coverage,[10] or scope of provider networks in their products.
- Tax-advantaged status: Health insurers would want to continue to provide HDHPs because of their tax-advantaged status for employers and/or enrollees.

Interaction With Existing Requirements

Federal Requirements

Internal Revenue Service

The Internal Revenue Service (IRS) sets cost-sharing minimum and maximum limits for HDHPs (Table 2). The IRS also allows for the aggregation of cost sharing paid by all members of a family toward the higher deductible and out-of-pocket limits. Deductibles for family HDHPs cannot be less than $2,600 (in 2015), whether paid for a single member of the family or multiple family members persons in the family.

[7] IRS regulations limit maximum OOPs to $6,450 per person for HDHPs in 2015. Internal Revenue Service. Publication 969.
[8] The per-person federal OOP limit under Affordable Care Act (ACA) regulations is $6,600 in 2015. The OOP per-person for HDHPs specifically is $150 lower at $6,450.
[9] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. *Federal Register*, Vol. 80, No. 39. February 27, 2015. Available at: www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf. Accessed March 14, 2015.
[10] Benefit coverage for nongrandfathered health insurance would need to meet ACA parameters, which require coverage of 10 essential health benefits (EHBs).

Table 2. Federal Cost-Sharing Limits for High-Deductible Health Plans

	Self Only	Family (a)
Minimum deductible (b)	$1,300	$2,600 (c)
Maximum out-of-pocket (HDHP) per IRS (b)	$6,450	$12,900
Maximum out-of-pocket (all insurance) per ACA (d)	$6,600	$13,200

Source: California Health Benefits Review Program, 2015.
Notes: (a) Family cost sharing may be aggregated to reach the cost-sharing limit, or a separate cost-sharing amount may be applied to each family member.
(b) Internal Revenue Service, Publication 969 (IRS, 2015).
(c) Under ACA, Family HDHPs must meet a minimum deductible of $2,600, whether that amount is met by all members of a family or a single member of the family.
(d) Federal Register, Vol. 80, No. 39. February 27, 2015.

Family HDHPs can have two types of deductibles:

- Aggregated family deductibles: These types of HDHPs count all of a family's cost sharing to the deductible limit, whether the deductible is met by one family member or multiple family members. For example, for a family plan with the minimum deductible amount, $2,600, the plan would not pay for an enrollee's expenses until the entire family had at least $2,600 in expenditures. That $2,600 could be paid by one member, or more than one member in the family.
- Per-person (embedded) deductibles: These types of HDHPs have deductibles for the family as a whole, in addition to per-person deductibles for one family member. If an enrollee meets the per person deductible for one family member, they would not have to meet the higher annual deductible amount for the whole family. This type of deductible is generally seen in non-HDHP insurance coverage. The IRS stipulates, however, that HDHP deductibles in this type of arrangement, whether for one family member or the family as a whole, cannot fall below the minimum deductible for a family ($2,600 in 2015). Again, using the minimum required deductible for HDHPs, in this situation, the plan would begin to pay for services for an enrollee when he or she had expenditures of $2,600 regardless of whether the entire family has reached $5,200.[11] Other family members would need to continue to pay toward the $5,200 before insurance begins to pay for their health care, but the first family member who had already reached his or her per-person deductible would have services covered.

Effect of AB 1305

AB 1305 would disallow the "aggregated family deductibles" and require all family HDHPs in California to fall into the per-person category of deductibles. As shown in Figure 2 (below), for those HDHPs that are at the minimum allowable deductible ($2,600), CHBRP finds that AB 1305 could result in two separate reactions as depicted in Table 3 and Figure 1.

Postmandate A. Health insurers could continue to offer HSA-compatible HDHPs for self-only enrollees in Postmandate A, however AB 1305's requirement that the embedded per-person deductible for families be equivalent to the self-only deductible would mean family HDHPs would be out of compliance with IRS regulations. Therefore, families who have HDHPs such as those represented by Postmandate A would not be permitted to use an HSA because the plan is not HSA-compliant.

[11] Recall that CHBRP assumes that family deductibles are twice the per-person/self-only deductible levels as is reported by both health insurance carriers and the ratio used by the federal government in setting limits.

Postmandate B. In addition, health insurers could introduce a second HDHP product, Postmandate B. In Postmandate B, per-person deductibles for family plans would be IRS-compliant, with the minimum deductible set at $2,600. Because AB 1305 requires the per-person embedded deductible to be equivalent to the self-only deductible, the self-only deductible would increase to $2,600. Any enrollee with a plan depicted by Postmandate B could use an HSA. Enrollees who want self-only plans would be selecting a higher deductible (and possibly lower premiums) with Postmandate B coverage.

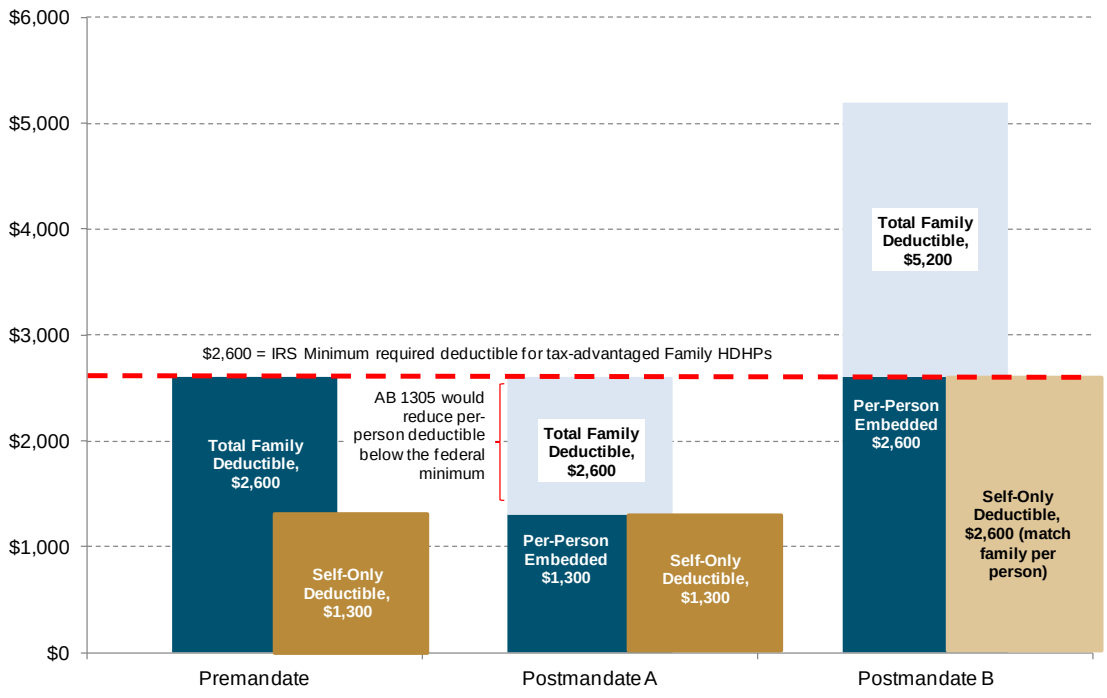
It is important to note that AB 1305 does not require a 2:1 ratio of family deductible to per-person deductible, and health insurers could also react by setting both family and per-person deductibles at the federal minimum of $2,600, though that is less likely, or use a different ratio (e.g. 3:1, 1:1). As previously mentioned, CHBRP assumes a 2:1 ratio because it is the common ratio used among carriers to differentiate between self-only and family health insurance, and the federal government uses the same ratio when setting per-person versus family cost-sharing limits (Table 2).

For more about the different types of cost sharing in health insurance contracts, please see Appendix C.

Table 3. Potential Effects of AB 1305 on Deductibles

	Self-Only Deductible	Per-Person Embedded Deductible	Total Family Deductible	Explanation
Premandate	$1,300	n/a	$2,600	Minimum deductible to be IRS-compliant
Postmandate A	$1,300	$1,300	$2,600	Self-only is still IRS-compliant. Per-person embedded would be IRS-noncompliant. Families who want an HSA-compliant product would not select this plan.
Postmandate B	$2,600	$2,600	$5,200	All are IRS-compliant. Self-only enrollees who want an HSA-compliant plan with a lower deductible would not select this plan.

Figure 2. AB 1305 Effect on Deductibles



Notes:
*Beginning in 2016, ACA limits annual out-of-pocket costs per-person in all plans, whether an enrollee has self-only or family coverage.

Cost-sharing limits in the Affordable Care Act

The Affordable Care Act (ACA) has profoundly changed health insurance benefit structure, its financing, and regulation in California. The ACA sets the following policies on cost sharing:

- Annual out-of-pocket maximums: The ACA specifically restricts annual out-of-pocket costs to $6,600 for self-only coverage and $13,200 for families, in 2015 (Table 2):

- Per-person cost-sharing limits: The ACA's final regulations[12] specifies that the annual limit on cost sharing for self-only coverage ($6,600) applies whether an enrollee has self-only coverage or a family coverage. The annual per-person cost-sharing limits for HDHPs are lower ($6,450 in 2015) than the ACA's specified annual limit, and therefore remain unchanged by this provision.

- Exception for HDHP deductibles. The ACA regulations specifically relate to annual out-of-pocket limits, not deductibles. The final rules state that "the deductible limit is not regulated in the same manner as the annual limit [on OOP costs.] Therefore, family high deductible plans that count the family's cost-sharing to the deductible … can continue to be offered under this policy."

[12] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. Federal Register, Vol. 80, No. 39. February 27, 2015. Available at: www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf. Accessed March 14, 2015.

AB 1305 and essential health benefits (EHBs)

Because AB 1305 would not mandate the coverage of any specific services, it would not exceed federally and state-mandated EHBs[13], and therefore would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs)[14] in Covered California.

It is important to note that both state and federal cost-sharing limits, in addition to those specified in AB 1305, apply only to those expenses incurred for EHBs.

State Requirements

California law and regulations

California's law already aligns with many of the ACA's restrictions on cost sharing and out-of-pocket costs. Specifically:

- OOP payments and EHBs: California law requires non-grandfathered state-regulated individual and small group health plans and policies to limit OOP payments for EHBs;[15]
- Annual OOP limits: California law also aligns the maximum OOP payments for all covered EHBs to the federal limits, as defined by federal regulations.[16]

Similar requirements in other states

CHBRP is unaware of similar existing or pending legislation in other states.

General Caveat for All CHBRP Analyses

It is important to note that CHBRP's analysis of proposal benefit mandate bills typically address the incremental effects of the proposed bills – specifically, how the proposed legislation would impact benefit coverage, utilization, costs, and public health. CHBRP's estimates of these incremental effects are presented in this report.[17]

[13] The ACA requires non-grandfathered small-group and individual market health insurance – including, but not limited to, QHPs sold in Covered California – to cover 10 specified categories of EHBs. Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[14] In California, QHPs are non-grandfathered small-group and individual market DMHC-regulated plans and CDI-regulated policies sold in Covered California, the state's online marketplace.
[15] Health and Safety Code (HSC) 1367.005.
[16] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. Federal Register, Vol. 80, No. 39. February 27, 2015. Available at: www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf. Accessed March 14, 2015.
[17] For CHBRP's technical approach to developing estimates, please see Appendix D.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

AB 1305 would require DMHC-regulated health plans and CDI-regulated policies to standardize deductibles across all family and single coverage product lines. Currently, family DMHC-regulated plans and CDI-regulated policies may have a family-level deductible and are not required to include an embedded per-person deductible. AB 1305 would require that all family-level plans and policies be modified to include an embedded per-person deductible. Additionally, AB 1305 requires that the embedded per-person deductible in a family plans or policies must be less than or equal to the deductible attached to equivalent self-only plans or policies from within the same product lines. AB 1305 further requires that out-of-pocket (OOP) costs also follow this same cost-sharing structure. Because the OOP requirements overlap with federal regulations, CHBRP focuses this analysis on the impact of AB 1305 on the change in the embedded per-person deductible.

By mandating this change, AB 1305 would have the effect of potentially moving DMHC-regulated plans and CDI-regulated family policies out of compliance with federal tax law,[18] if they are high deductible health plans (HDHP), and if they currently have an aggregate family-level deductible that is $2,600 (see Figure 2 in the Policy Context section of this report).[19] Therefore, for this segment of the market, AB 1305 has the potential to impact the benefit design of these plans and policies, as health insurance companies will likely change their family HDHP plans and policies to be compliant with AB 1305 and remain qualified for federal tax savings to the consumers or employers.[20]

To conduct this analysis, CHBRP assumes that health insurance companies would maintain the ratio of 2:1 for the total family deductible compared to the embedded single-person deductible, as is the customary practice reported to CHBRP in the carrier surveys and is the assumption of federal regulations. CHBRP also assumes that health insurers would set premiums for these new products based on accepted actuarial guidelines that account for expected utilization. CHBRP further assumes that the health insurance carriers will keep their product lines compliant with IRS regulations, although it is possible that they could create new noncompliant health insurance products, which would lessen the estimated impact of AB 1305 discussed in this report. Finally, CHBRP assumes that the risk pools, provider networks, and other aspects of insurance products would remain the same for the one year following enactment, the timeframe of this analysis.

This section reports the potential incremental impact of AB 1305 on estimated baseline benefit coverage, utilization, and overall cost. After surveying health insurance carriers and using data from CHBRP's actuary, Milliman, in the CHBRP Cost Model, CHBRP finds that whereas premiums and enrollee expenses for covered benefits will increase for some markets, total health care expenditures on average will go down postmandate. For further details on the underlying data sources and methods, please see Appendix D.

[18] HDHPs (or health plans) for single coverage would still be compliant because the IRS limit for one person's plan is $1,300.
[19] These regulation pertain specifically to HDHPs with an HSA attached, which is assumed to be the majority of HDHP plans given the preferential tax treatment.
[20] Personal communication with Assistant law professor David Gamage, UC Berkeley, March 25, 2015.

Benefit Coverage

Premandate (Baseline) Benefit Coverage

Currently, 97.937% of enrollees subject to AB 1305 are covered by DMHC-regulated plans or CDI-regulated policies that are already complaint with the proposed mandate, either because the plan or policy does not have a deductible, the per-person deductible is already mandate compliant, or an embedded per-person deductible with a family deductible already exists. Using the 2014 California Employer Health Benefits Survey[21] data reporting aggregate family deductible levels among employer-based plans that did not include an embedded per-person deductible, CHBRP found that 1.461% (358,832) of enrollees have coverage with aggregate family deductibles higher than or equal to $5,200,[22] and 0.602% (147,890) had aggregate family deductibles less than $5,200 (see Table 1 after the *Key Findings*).

Current coverage that includes embedded single-person deductibles in family-level DMHC-regulated plans or CDI-regulated policies was determined by a survey of the seven largest providers of health insurance in California. Responses to this survey represent:

- 75.08% of enrollees in the privately funded, DMHC-regulated market;
- 64.15% of enrollees in the CDI-regulated market; and
- 73.22% of enrollees in the privately funded market subject to state mandates.

Postmandate Benefit Coverage

Postmandate, 100% of DMHC-regulated plans or CDI-regulated policies would be mandate compliant, either because they have no family deductible or have an embedded per-person deductible in family plans or policies. To be IRS-compliant postmandate, 100% of the embedded per-person deductibles of family HDHPs would have to be no lower than $2,600 (see Table 2 in the *Policy Context* section). Keeping with the insurance structure carriers reported for family-level HDHPs, 100% of total family deductibles are assumed to increase to $5,200.

Utilization

Premandate (Baseline) Utilization

Because AB 1305 does not mandate coverage of an actual service, CHBRP measured baseline utilization under AB 1305 as the average PMPM covered benefits paid for either by the enrollee or by the DMHC-regulated plan or CDI-regulated policy for all enrollees (see Table 1Table 1. AB 1305 Impacts on Benefit Coverage, Utilization, and Cost, 2015), according to the Milliman Health Cost Guidelines (HCGs). The premandate average PMPM covered benefits paid for by the plan or policy equaled a total average of covered health services of $399.81.

[21] CHBRP used NORC/CHCF data for the most recent California Employer Health Benefits Survey (2014) and excluded self-insured employers.

[22] As previously noted, CHBRP assumes that family deductibles are twice the per-person/self-only deductible levels as is reported by both health insurance carriers and the ratio used by the federal government in setting limits.

Postmandate Utilization

As deductibles increase under the 2:1 family to per-person deductible (see the introductory paragraphs in this section), individuals may reduce their overall service use, which leads to a reduction in overall expenditures. This reduction can be mitigated somewhat by having a tax-advantaged account, such as an HSA or if their employers deposit money into a Health Reimbursement Account (Peter et al., 2015). To estimate the postmandate impact, CHBRP used the family deductible factors from the Milliman Health Cost Guidelines (HCGs).[23] This yielded an average estimated decrease in the covered benefits paid for by the DMHC-regulated plans and CDI-regulated policies of $0.06 (−0.019%), for a postmandate total of $347.11 PMPM in covered benefits paid for by the plans or policies (see Table 1). Direct costs to the enrollee will also decrease by $0.04 (−0.04%), for a total postmandate of $52.59 PMPM in covered benefits paid for by the enrollee.

Taken together, the combined effect is a decrease of $0.11 (−0.027%) in overall expenditures, for an average postmandate total of $399.70 PMPM of covered benefits.

Impact on access and health treatment/service availability

AB 1305 affects the underlying cost-sharing structure of DMHC-regulated plans and CDI-regulated policies, and does not focus on any one procedure, medical device, pharmaceutical, or treatment. Therefore, the impact on access to any one treatment or service is too small to be measureable.

Premiums and Expenditures

Premandate (Baseline) Premiums and Expenditures

Table 4 presents PMPM premandate estimates for premiums and expenditures by market segment for DMHC-regulated plans and CDI-regulated policies.

PMPM by market segment is as follows for DMHC-regulated plans and CDI-regulated policies, respectively:

- Large group: $537.63 and $646.64.
- Small group: $451.81 and $558.76.
- Individual market: $422.03 and $334.65.

Total current annual expenditures for all DMHC-regulated plans and CDI-regulated policies are $135,986,114,000.

Postmandate Expenditures

Changes in total expenditures

AB 1305 would decrease total net annual expenditures by $37,754,000, or 0.028%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $25,319,000 decrease in total health

[23] Milliman Health Cost Guidelines are commonly used to price changes in premiums based on expected utilization changes when deductibles are modified.

insurance premiums paid by employers and enrollees for newly covered benefits, as well as a decrease in enrollee expenditures for covered benefits ($12,435,000). The majority of the cost savings ($20,767,000) will come from a decrease in premiums paid by enrollees for individually purchased insurance.

Postmandate premium expenditures and PMPM amounts per category of payer

Changes in insurance premiums as a result of AB 1305 would vary by market segment. Note that the total population in Table 5, reflects the full 24,557,000 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to AB 1305.

In DMHC-regulated plans, the effect on premiums varies by market segment. In the large group market, CHBRP estimates that premiums will increase by $0.11 PMPM. In the small group and individual markets, premium decreases range from $0.46 (individual) to $0.62 PMPM (small group). In CDI-regulated policies, CHBRP estimates premium effects that vary by market segment, as well. In the large group market, CHBRP estimates that premiums will increase by $1.01 PMPM. CHBRP estimates that the premium decrease in the small group market will be $0.82 PMPM and that there will be no change in premiums in the CDI individual market. This degree of variation is due to the concentration of HDHPs among large group employers.

Among publicly funded DMHC-regulated health plans, CHBRP estimates that CalPERS HMOs and Medi-Cal managed care plans (for both the elderly and nonelderly) will see no change in their premiums.

CHBRP may overstate the effect of coverage for enrollees purchasing self-only HDHPs. Due to data constraints, CHBRP's model estimates that all enrollees in self-only plans migrate to the higher deductible of $2,600 as illustrated by the Postmandate B scenario discussed in the *Policy Context* section. Because it is unlikely that all self-only enrollees would choose a higher $2,600 deductible, when another HDHP, at $1,300 is IRS-complaint for a single coverage, CHBRP's estimates may overstate the premium expenditure reductions. The reductions in premiums illustrated in Table 5 would likely be less.

Enrollee expenses for covered benefits will decrease for large group markets, from $0.14 PMPM in DMHC-regulated plans to $1.13 in CDI-regulated policies. In the small-group markets, changes in enrollee expenses for covered benefits increase, ranging from $0.16 PMPM in DMHC-regulated plans and $0.21 in CDI-regulated policies. CHBRP estimates no impact on enrollee expenses in CDI-regulated individual market policies, but an increase of $0.12 PMPM in DMHC-regulated plans.

Potential cost offsets or savings in the first 12 months after enactment

CHBRP estimates that AB 1305 would generate overall reduced expenditures within the first 12 months after enactment (see Table 1 and Table 3), and does not project any additional cost offsets or savings.

Postmandate administrative expenses and other expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies would remain proportional to the change in premiums. CHBRP assumes that if health care costs change as a result of decreased utilization or changes in unit costs, there is a corresponding proportional change in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Related Considerations for Policymakers

Cost of Exceeding Essential Health Benefits

AB 1305 does not mandate new benefit coverage, and therefore does not interfere, interact with, or exceed EHBs.

Postmandate Changes in Uninsured and Public Program Enrollment

Changes in the number of uninsured persons

CHBRP estimates premium decreases of less than 1% for each market segment; this premium decrease would not have a measurable impact on the number of persons who are uninsured. CHBRP does not anticipate gains of health insurance, changes in availability of the benefit beyond those subject to the mandate, changes in offer rates of health insurance, changes in employer contribution rates, changes in take-up of health insurance by employees, or purchase of individual market policies, due to the small size of the decrease in premiums after the mandate.

Changes in public program enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs or on utilization of covered benefits in the publicly funded insurance market.

How Lack of Coverage Results in Cost Shifts to Other Payers

AB 1305 addresses the underlying cost-sharing arrangements of aggregate family deductibles, and imposes embedded per-person deductibles if none exist in family plans. Due to federal tax law that gives favored status to HDHP/HSA plans, the single-person embedded deductible would have to be set at $2600 to be in compliance with federal law (see the *Policy Context* section), and it is likely that the corresponding family deductible would then increase to $5200 as per reported health insurance carrier practice. The costs of the lower current deductibles, therefore, are currently being borne by health insurance carriers, and CHBRP finds no measureable shift to other payers. Postmandate, more costs shift to enrollees in some markets, as described above.

Table 3. Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2015

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			**Publicly Funded Plans**			**Privately Funded Plans (by Market) (a)**			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (d)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (e)	8,651,000	2,094,000	3,757,000	836,000	6,891,000	533,000	534,000	690,000	571,000	24,557,000
Total enrollees in plans/policies subject to AB 1305	5,140,000	1,652,000	3,421,000	—	—	—	434,000	682,000	129,000	11,458,000
Premium costs										
Average portion of premium paid by employer	$423.58	$304.59	$0.00	$437.75	$179.24	$445.00	$511.84	$421.06	$0.00	$80,452,488,000
Average portion of premium paid by employee	$114.05	$147.22	$422.03	$109.44	$0.76	$0.00	$134.80	$137.71	$334.65	$40,023,653,000
Total premium	**$537.63**	**$451.81**	**$422.03**	**$547.19**	**$180.00**	**$445.00**	**$646.64**	**$558.76**	**$334.65**	**$120,476,140,000**
Enrollee expenses										
Enrollee expenses for covered benefits (deductibles, copays, etc.)	$36.95	$89.15	$141.84	$29.78	$0.00	$0.00	$99.91	$166.51	$105.38	$15,510,004,000
Enrollee expenses for benefits not covered (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$574.58**	**$540.97**	**$563.87**	**$576.98**	**$180.00**	**$445.00**	**$746.55**	**$725.28**	**$440.03**	**$135,986,144,000**

Source: California Health Benefits Review Program, 2015.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance, inside and outside the exchange.

(b) As of September 30, 2013, 57.5%, or 462,580 CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2015.

(c) Includes children formerly in Health Families, which was moved into Medi-Cal Managed Care in 2013 as part of the 2012–2013 state budget.

(d) Medi-Cal Managed Care Plan expenditures for members over 65 include those who also have Medicare coverage.

(e) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

(f) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 4. Postmandate Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2015

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			**Publicly Funded Plans**			**Privately Funded Plans (by Market) (a)**			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (d)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (e)	8,651,000	2,094,000	3,757,000	836,000	6,891,000	533,000	534,000	690,000	571,000	24,557,000
Total enrollees in plans/policies subject to AB 1305	8,651,000	2,094,000	3,757,000	836,000	6,891,000	533,000	534,000	690,000	571,000	24,557,000
Premium costs										
Average portion of premium paid by employer	$0.08	−$0.41	$0.00	$0.00	$0.00	$0.00	$0.80	−$0.61	$0.00	−$1,573,000
Average portion of premium paid by employee	$0.02	−$0.20	−$0.46	$0.00	$0.00	$0.00	$0.21	−$0.20	$0.00	−$23,746,000
Total premium	$0.11	−$0.62	−$0.46	$0.00	$0.00	$0.00	$1.01	−$0.82	$0.00	**−$25,319,000**
Enrollee expenses										
Enrollee expenses for covered benefits (deductibles, copays, etc.)	−$0.14	$0.16	$0.12	$0.00	$0.00	$0.00	−$1.31	$0.21	$0.00	−$12,435,000
Total expenditures	−$0.04	−$0.45	−$0.35	$0.00	$0.00	$0.00	−$0.29	−$0.61	$0.00	**−$37,754,000**
Postmandate percent change										
Percent change insured premiums	0.0200%	−0.1362%	−0.1091%	0.0000%	0.0000%	0.0000%	0.1564%	−0.1460%	0.0000%	−0.0210%
Percent change total expenditures	−0.0065%	−0.0841%	−0.0612%	0.0000%	0.0000%	0.0000%	−0.0395%	−0.0835%	0.0000%	−0.0278%

Source: California Health Benefits Review Program, 2015.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance, inside and outside the exchange.

(b) As of September 30, 2013, 57.5%, or 462,580 CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2015.

(c) Includes children formerly in Health Families, which was moved into Medi-Cal Managed Care in 2013 as part of the 2012–2013 state budget.

(d) Medi-Cal Managed Care Plan expenditures for members over 65 include those who also have Medicare coverage.

(e) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

LONG-TERM IMPACT OF AB 1305

In this section, CHBRP estimates the long-term impact of AB 1305, defined as impacts occurring beyond the first 12 months of implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

In the long term, recent growth trends suggest that the number of Californians enrolled in DMHC-regulated or CDI-regulated policies HDHPs will increase. According to the Association of Health Insurance Plans (AHIP), national enrollment in HDHPs has grown from 1 million in March 2005 to 17.4 million in January 2014 (AHIP, 2014). As the number of enrollees with HDHPs in California increases, the potential total cost savings postmandate could increase proportionally. These increases are likely to be supported and encouraged under the Affordable Care Act (ACA), as recently enumerated by Morse (2014),[24] who argues that HDHPs fulfill many needs of employers, including religious freedom exemptions.

Long-Term Utilization and Cost Impacts

Utilization Impacts

In the 12 months following enactment, CHBRP estimates that the changes in embedded per-person deductibles will bring premium costs down in the HDHP market. The premium decrease is because of the increase in deductible for single coverage and corresponding expected decreases in utilization during the first year postmandate (see the *Benefit Coverage, Utilization, and Cost Impacts* section). In later years, the recent growth of HDHPs as a proportion of health insurance coverage in the overall market will likely continue, and the negative impact on utilization that has been identified in many studies will also grow proportionally.

As an example of the types of utilization decrease that could be expected, one study of the utilization effects of HDHPs concluded that enrollment was associated with decreased emergency department use, and increased use in prescription medications (Waters et al., 2011). However, the authors point out that these effects varied by subgroup. Kullgren et al. (2010) found that low-income families with HDHP coverage reported more delayed or foregone health care than higher-income families, confirming the price sensitivity and noting that needed care was eliminated, potentially affecting future long-term health outcomes. Galbraith et al. (2012) found that HDHPs were associated with delayed or foregone health care due to cost, among adults and children with chronic conditions, raising serious concerns about the potential health outcomes impacts of increasing costs on enrollees to a level at which they cannot afford needed care. More recently, Reddy et al. (2014) found that having an HDHP was associated with decreases in outpatient visits for chronic conditions, again raising concerns about foregoing needed health care that would have led to better health outcomes. Because AB 1305 would reduce cost-sharing for families with HDHPs, in the long-term, there could be an increase in utilization due to lower family cost-sharing limits.

[24] Morse E. Health Accounts/Arrangements: An Expanding Role Under the Affordable Care Act?, 47 John Marshall L. Rev. 991 (2014).

Cost Impacts

CHBRP estimates cost savings during the first 12 months, postmandate, and this is likely to proportionally increase over time should the growth in HDHP/HSA plans as a proportion of the overall market continues as expected. Most recently, Peter et al. (2015) found that having an HDHP/HSA was correlated with reduced overall spending, and that the size of the deductible mattered depending whether the cost of the treatment sought was higher than the deductible level.

Because a Public Health Impacts analysis was not requested by the Legislature, estimating how these long-term effects could potentially impact public health (including economic loss, increased mortality, racial and ethnic disparities, and gender disparities) is beyond the scope of this report. However, in previous reports, CHBRP has identified literature that clearly show cost-sharing barriers can have the unintended impact of delaying necessary care (CHBRP, 2012, 2014). Additionally, CHBRP also identified literature noting that disparities in utilization among racial and ethnic groups already exist (CHBRP, 2012, 2014) and that these consequences could be further magnified over time, although they cannot be quantified here.

APPENDIX A TEXT OF ASSEMBLY BILL AB 1305

SECTION 1.
Section 1367.006 of the Health and Safety Code is amended to read:
1367.006.
(a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.
(b) (1) For nongrandfathered health care service plan contracts in the individual or small group markets, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4.
(2) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care consistent with Section 3 1371.4. This limit shall only apply to essential health benefits, as defined in Section 1367.005, that are covered under the plan to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health care service plan contracts in the large group market.
(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.
(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.
(3) For family coverage, the limit described in subdivision (b) shall include a maximum out-of-pocket limit for each individual covered by the plan that is less than or equal to the maximum out-of-pocket limit for individual coverage under the plan contract.
(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.
(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.
(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.
(g) If a health care service plan contract for family coverage includes a deductible, the plan contract shall include a deductible for each individual covered by the plan that is less than or equal to the deductible for individual coverage under the plan contract.
For nongrandfathered health plan contracts in the group market, “plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, “plan year” means the calendar year.
“PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 2.
Section 10112.28 of the Insurance Code is amended to read:
10112.28.

(a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.
(b) (1) For nongrandfathered health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27,
including out-of-network emergency care.
(2) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health insurance policies in the large group market.
(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA and any subsequent rules, regulations, or guidance issued under that section (2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.
(3) For family coverage, the limit described in subdivision (b) shall include a maximum out-of-pocket limit for each individual covered by the policy that is less than or equal to the maximum out-of-pocket limit for individual coverage under the policy.
(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.
(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the *l*imit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.
(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.
(g) If a health insurance policy for family coverage includes a deductible, the policy shall include a deductible for each individual covered under the policy that is less than or equal to the deductible for individual coverage under the policy.
(h) For nongrandfathered health insurance policies in the group market, “policy year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, “policy year” means the calendar year. “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010
(Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B LITERATURE SEARCH

Appendix B describes methods used in the effectiveness literature review conducted for this report.

As previously detailed, AB 1305 would require state-regulated family insurance plans or policies to use the same per-person deductible and per-person annual out-of-pocket limit as the corresponding self-only health insurance contract.

The literature search was limited to studies published in English from January 2013 to present.

Search Terms

The search terms used to locate studies relevant to SB 289 were as follows:

- High-deductible health plans (HDHPs)
- Health Savings Accounts (HSAs)
- Health Reimbursement Accounts (HRAs)
- Savings Options (SOs)
- Taxes
- IRS
- Cost-sharing
- Limits on cost-sharing
- Family health insurance plans/policies
- Individual health insurance plans/policies
- Family out-of-pocket maximum/Individual out-of-pocket maximum
- Family/individual deductible
- Aggregated deductible
- Aggregated out-of-pocket maximum
- Affordable Care Act cost-sharing limits

APPENDIX C GLOSSARY OF COST-SHARING TERMINOLOGY

In health insurance, the cost of covered benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee (the insured or "covered" individual). An enrollee is responsible for paying their portion of the insurance premium and for meeting the cost-sharing components required under the health insurance plan or policy. Any expenses for noncovered services or treatments; noncovered services or treatments are generally paid in full by the enrollee. Cost sharing is the portion that enrollees are responsible for paying out-of-pocket directly to the provider for a covered health care service or treatment. Common cost-sharing mechanisms include copayments (as called copays), coinsurance, and/or deductibles.

Deductibles

Deductibles are a fixed dollar amount (lump sum for one or more health care 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. It is important to note that not all plans have deductibles, but for those plans that do, often not all covered benefits are subject to the deductible. For example, as a result of the ACA most plans are required to cover the full cost of specified preventive services, regardless of whether an enrollee has met their deductible. Some services, such as office visits, may also be exempt from the deductible, but have a copay. For family coverage, there are potentially two arrangements:

- Per-person (embedded) deductibles: Plans may have a deductible that applies to each family member, with a maximum deductible amount a family would pay in a given year. For example, each enrollee in a family may have a deductible of $500 per year, but the family deductible is capped at $1,000 per year. In this situation, the plan would begin to pay for services for an enrollee when he or she had expenditures of $500, regardless of whether the entire family has reached $1,000.
- Aggregated deductibles: Other family coverage may require the total family deductible to be met, before the insurer begins to pay for covered health care services. AB 1305 targets these specific types of arrangements. In this type of coverage, the plan would not pay for an enrollee's expenses until the entire family had at least $1,000 in expenditures.

Copayments and Coinsurance

Copayments and coinsurance apply after the deductible has been met (if a plan has a deductible).

- Copayments: A copayment (or copay) is a form of cost sharing in which an enrollee pays a predetermined, flat dollar amount out-of-pocket when receiving a health care service, such as a $20 copayment for a physician office visit, or when paying for a prescription, such as a $5 copayment for a generic prescription drug. As with deductibles, a plan may not require any copayments or may only require copayments for certain benefits.
- Coinsurance: Coinsurance is the percentage of covered health care costs for which an enrollee is responsible, such as 20% of a hospital stay. Similar to deductibles and copayments, coinsurance percentages can vary across covered benefits, and a plan may not require any coinsurance or may only require coinsurance for some covered benefits.

Annual Out-of-Pocket Maximums

Annual out-of-pocket maximums are limits on an enrollee's cost-sharing (copayments, coinsurance, and deductibles) obligations in a 1-year period. The ACA established an annual out-of-pocket maximum for all nongrandfathered plans. In 2015, the annual out-of-pocket maximum allowed under the ACA is $6,600 for self-only coverage and $13,200 for family coverage (

Table 2. Federal Cost-Sharing Limits for High-Deductible Health Plans). Grandfathered plans and policies are not subject to this requirement and so could have higher annual out-of-pocket maximums.

APPENDIX D COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

This appendix describes data sources, estimation methodology, as well as general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP website at: www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Los Angeles, and the University of California, Davis, as well as the contracted actuarial firm, Milliman, Inc.[25]

Data Sources

This subsection discusses the variety of data sources CHBRP uses. Key sources and data items are listed below, in Table 6.

Table 5. Data for 2016 Projections

Data Source	Items
California Department of Health Care Services (DHCS) administrative data for the Medi-Cal program, data available as of end of December 2014	Distribution of enrollees by managed care or FFS distribution by age: 0–17; 18–64; 65+ Medi-Cal Managed Care premiums
California Department of Managed Health Care (DMHC) data from the interactive website "Health Plan Financial Summary Report," August–October, 2014	Distribution of DMHC-regulated plans by market segment*
California Department of Insurance (CDI) Statistical Analysis Division data; data as of December 31, 2013	Distribution of CDI-regulated policies by market segment
California Health Benefits Review Program (CHBRP) Annual Enrollment and Premium Survey of California's largest (by enrollment) health care service plans and health insurers; data as of September 30, 2014; responders' data represent approximately 97.3% of persons not associated with CalPERS or Medi-Cal with health insurance subject to state mandates – 98.0% of full-service (nonspecialty) DMHC-regulated plan enrollees and 97.0% of full-service (nonspecialty) CDI-regulated policy enrollees.	Enrollment by: • Size of firm (2–50 as small group and 51+ as large group) • DHMC vs. CDI regulated • Grandfathered vs. nongrandfathered Premiums for individual policies by: • DMHC vs. CDI regulated • Grandfathered vs. nongrandfathered

[25] CHBRP's authorizing legislation requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact (www.chbrp.org/docs/authorizing_statute.pdf).

California Employer Health Benefits Survey, 2014 (conducted by NORC and funded by CHCF)	Enrollment by HMO/POS, PPO/indemnity self-insured, fully insured, Premiums (not self-insured) by: • Size of firm (3–25 as small group and 25+ as large group) • Family vs. single • HMO/POS vs. PPO/indemnity vs. HDHP employer vs. employer premium share
California Health Interview Survey (CHIS) 2012/2013/T7 ("T7" representing the first 6 months of 2014)	Uninsured, age: 65+ Medi-Cal (non-Medicare), age: 65+ Other public, age: 65+ Employer-sponsored insurance, age: 65+
California Public Employees' Retirement System (CalPERS) data, enrollment as of October 1, 2014	CalPERS HMO and PPO enrollment • Age: 0–17; 18–64; 65+ HMO premiums
California Simulation of Insurance Markets (CalSIM) Version 1.9.1 (projections for 2016)	Uninsured, age: 0–17; 18–64 Medi-Cal (non-Medicare) (a), age: 0–17; 18–64 Other public (b), age: 0–64 Individual market, age: 0–17; 18–64 Small group, age: 0–17; 18–64 Large group, age: 0–17; 18–64
Centers for Medicare and Medicaid (CMS) administrative data for the Medicare program, annually (if available) as of end of September	HMO vs. FFS distribution for those 65+ (noninstitutionalized)
Milliman estimate	Medical trend influencing annual premium increases

Notes: (*) CHBRP assumes DMHC-regulated PPO group enrollees and POS enrollees are in the large-group segment.
Key: CDI = California Department of Insurance; CHCF = California HealthCare Foundation; CHIS = California Health Interview Survey; CMS = Centers for Medicare & Medicaid Services; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care; FFS = fee-for-service; HMO = health maintenance organization; NORC = National Opinion Research Center; POS = point of service; PPO = preferred provider organization.

Further discussion of external and internal data follows.

Internal data

- CHBRP's Annual Enrollment and Premium Survey collects data from the seven largest providers of health insurance in California (including Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and United Healthcare/PacifiCare) to obtain estimates of enrollment not associated with CalPERS or Medi-Cal by purchaser (i.e., large and small group and individual), state regulator (DMHC or CDI), grandfathered and nongrandfathered status, and average premiums. CalSIM and market trends were applied to project 2016 health insurance enrollment in DMHC-regulated plans and CDI-regulated policies.

- CHBRP's other surveys of the largest plans/insurers collect information on benefit coverage relevant to proposed benefit mandates CHBRP has been asked to analyze. In each report, CHBRP indicates the proportion of enrollees – statewide and by market segment – represented by responses to CHBRP's bill-specific coverage surveys. The proportions are derived from data provided by CDI and DMHC.

- External sources

- California Department of Health Care Services (DHCS) data are used to estimate enrollment in Medi-Cal Managed Care (beneficiaries enrolled in Two-Plan Model, Geographic Managed Care, and County Operated Health System plans), which may be subject to state benefit mandates, as well as enrollment in Medi-Cal Fee For Service (FFS), which is not. The data are available at: www.dhcs.ca.gov/dataandstats/statistics/Pages/Monthly_Trend_Report.aspx. Medi-Cal enrollment is projected to 2016 based on CalSIM's estimate of the continuing impact of the Medi-Cal expansion implemented in 2014.

- California Employer Health Benefits Survey data are used to make a number of estimates, including: premiums for employment-based enrollment in DMHC-regulated health care service plans (primarily health maintenance organizations [HMOs] and point of service [POS] plans) and premiums for employment-based enrollment in CDI-regulated health insurance policies regulated by the (primarily preferred provider organizations [PPOs]). Premiums for fee-for-service (FFS) policies are no longer available due to scarcity of these policies in California. This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. More information on the CHCF/NORC data is available at: www.chcf.org/publications/2014/01/employer-health-benefits.

- California Health Interview Survey (CHIS) data are used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage. CHIS data are also used to determine the number of Californians with incomes below 400% of the federal poverty level. CHIS is a continuous survey that provides detailed information on demographics, health insurance coverage, health status, and access to care. More information on CHIS is available at: www.chis.ucla.edu.

- California Public Employees Retirement System (CalPERS) data are used to estimate premiums and enrollment in DMHC-regulated plans, which may be subject to state benefit mandates, as well as enrollment in CalPERS' self-insured plans, which is not. CalPERS does not currently offer enrollment in CDI-regulated policies. Data are provided for DMHC-regulated plans enrolling non-Medicare beneficiaries. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOC) documents publicly available at: www.calpers.ca.gov. CHBRP assumes CalPERS's enrollment in 2016 will not be affected by continuing shifts in the health insurance market as a result of the ACA.

- California Simulation of Insurance Markets (CalSIM) estimates are used to project health insurance status of Californians aged 64 and under. CalSIM is a microsimulation model that projects the effects of the Affordable Care Act on firms and individuals. More information on CalSIM is available at: http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Pages/default.aspx.

- Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are

supplied by health insurance companies, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed health care plans, generally those characterized as PPO plans. More information on the Milliman HCGs is available at: http://us.milliman.com/Solutions/Products/Resources/Health-Cost-Guidelines/Health-Cost-Guidelines---Commercial/.

- The MarketScan databases, which reflect the health care claims experience of employees and dependents covered by the health benefit programs of large employers. These claims data are collected from insurance companies, Blue Cross Blue Shield plans, and third party administrators. These data represent the medical experience of insured employees and their dependents for active employees, early retirees, individuals with COBRA continuation coverage, and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. No Medicaid or Workers Compensation data are included.
- Ingenix MDR Charge Payment System, which includes information about professional fees paid for health care services, based upon claims from commercial insurance companies, HMOs, and self-insured health plans.

Projecting 2016

This subsection discusses adjustments made to CHBRP's Cost and Coverage Model to project 2016, the period when mandates proposed in 2015 would, if enacted, generally take effect. It is important to emphasize that CHBRP's analysis of specific mandate bills typically addresses the incremental effects of a mandate – 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 the *Benefit Coverage, Utilization, and Cost Impacts* section of this report.

Baseline premium rate development methodology

The key components of the baseline model for utilization and expenditures are estimates of the per member per month (PMPM) values for each of the following:

- Insurance premiums PMPM;
- Gross claims costs PMPM;
- Member cost sharing PMPM; and
- Health care costs paid by the health plan or insurer.

For each market segment, we first obtained an estimate of the insurance premium PMPM by taking the 2014 reported premium from the abovementioned data sources and trending that value to 2016. CHBRP uses trend rates published in the Milliman HCGs to estimate the health care costs for each market segment in 2016.

The large-group market segments for each regulator (CDI and DMHC) are split into grandfathered and nongrandfathered status. For the small-group and individual markets, further splits are made to indicate association with Covered California, the state's health insurance marketplace. Doing so allows CHBRP to separately calculate the impact of ACA and of specific mandates, both of which may apply differently among these subgroups. The premium rate data received from the CHCF/NORC California Employer Health Benefits survey did not split the premiums based on grandfathered or exchange status. However, CHBRP's Annual Enrollment and Premium (AEP) survey asked California's largest health care service plans and health insurers to provide their average premium rates separately for grandfathered and

nongrandfathered plans. The ratios from the CHBRP survey data were then applied to the CHCH/NORC aggregate premium rates for large and small group, to estimate premium rates for grandfathered and nongrandfathered plans that were consistent with the NORC results. For the individual market, the premium rates received from CHBRP's AEP survey were used directly.

The remaining three values were then estimated by the following formulas:

- Health care costs paid by the health plan = insurance premiums PMPM × (1 − profit/administration load);
- Gross claims costs PMPM = health care costs paid by the health plan ÷ percentage paid by health plan; and
- Member cost sharing PMPM = gross claims costs × (1 − percentage paid by health plan).

In the above formulas, the quantity "profit/administration load" is the assumed percentage of a typical premium that is allocated to the health plan/insurer's administration and profit. These values vary by insurance category, and under the ACA, are limited by the minimum medical loss ratio requirement. CHBRP estimated these values based on actuarial expertise at Milliman, and their associated expertise in health care.

In the above formulas, the quantity "percentage paid by health plan" is the assumed percentage of gross health care costs that are paid by the health plan, as opposed to the amount paid by member cost sharing (deductibles, copays, etc.). In ACA terminology, this quantity is known as the plan's "actuarial value." These values vary by insurance category. For each insurance category, Milliman estimated the member cost sharing for the average or typical plan in that category. Milliman then priced these plans using the Milliman Health Cost Guidelines to estimate the percentage of gross health care costs that are paid by the carrier.

General Caveats and Assumptions

This subsection discusses the general caveats and assumptions relevant to all CHBRP reports. The projected costs are estimates of costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

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

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

- Cost impacts are shown only for plans and policies subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed mandate.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of the premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.

- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for 1 year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts, please see: www.chbrp.org/analysis_methodology/docs/longterm_impacts08.pdf.
- Several studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew et al., 2005; Glied and Jack, 2003; Hadley, 2006). Chernew et al. (2005) estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, whereas Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and a 0.84 percentage point decrease in the number of insured, respectively. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. For more information on CHBRP's criteria for estimating impacts on the uninsured, please see: www.chbrp.org/analysis_methodology/docs/Uninsured_paper_Final_01012009.pdf.

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

- Population shifts by type of health insurance: If a mandate increases health insurance costs, some employer groups and individuals may elect to drop their health insurance. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefits: To help offset the premium increase resulting from a mandate, deductibles or copayments may be increased. Such changes would have a direct impact on the distribution of costs between health plans/insurers and enrollees, and may also result in utilization reductions (i.e., high levels of cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.
- Adverse selection: Theoretically, persons or employer groups who had previously foregone health insurance may elect, postmandate, to enroll in a health plan or policy because they perceive that it is now to their economic benefit to do so.
- Medical management: Health plans/insurers may react to the mandate by tightening medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan/policy types that previously had the least effective medical management (i.e., PPO plans).
- Geographic and delivery systems variation: Variation exists in existing utilization and costs, and in the impact of the mandate, by geographic area and by delivery system models. Even within the health insurance plan/policy types CHBRP modeled (HMO, including HMO and POS plans, and non-HMO, including PPO and FFS policies), there are likely variations in utilization and costs. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans/insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery

system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.

- Compliance with the mandate: For estimating the postmandate impacts, CHBRP typically assumes that plans and policies subject to the mandate will be in compliance with the benefit coverage requirements of the bill. Therefore, the typical postmandate coverage rates for persons enrolled in health insurance plans/policies subject to the mandate are assumed to be 100%.

Analysis Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant to specifically to an analysis of AB 1305. To conduct our analysis, CHBRP assumes:

1) Health insurance companies will follow the usual structure of embedded single-person deductibles within family coverage, and maintain the ratio of 2:1 for aggregated family deductible compared to the embedded single-person deductible.

2) Health insurance companies and employers will implement HDHP/HSAs that do, in fact, follow the IRS regulations and will not go below the legal deductible levels.

3) Health insurance companies will price these new products following accepted actuarial industry guidelines concerning expected utilization, based on current risk pools. The risk pool mix will not change in their analysis for the first year postmandate.

4) The non–mandate-compliant segment of the health insurance market is evenly split between DMHC plans and CDI policies that have an aggregate family-level deductible higher than or equal to $5,200, and those plans and policies that have a deductible lower than $5,200.

To perform the analysis, CHBRP segregated the population into six categorizations as shown in Table 6. CHBRP Approach to Modeling the Impact of AB 1305.

Table 6. CHBRP Approach to Modeling the Impact of AB 1305

Scenario	Health Insurance Arrangement	Impact of AB 1305 on Health Insurance
1	Members in Medi-Cal HMO or CalPERS	These plans are already in compliance, and there is no impact.
2	Members in grandfathered plans	There is no impact for these members.
3	Members in Covered CA	These plans are already in compliance, and there is no impact.
4	Members in non-grandfathered plans with embedded deductible	These plans are already in compliance, and there is no impact.
5	Members in nongrandfathered plans with aggregate family deductible greater than or equal to	Aggregate deductible will change to embedded deductible. CHBRP assumed the premandate family deductible is $5,200 and the premandate individual deductible is $2,600. CHBRP assumed the postmandate family deductible is $2,600 and

Scenario	Health Insurance Arrangement	Impact of AB 1305 on Health Insurance
	$5,200	the postmandate individual deductible is $2,600.
6	Members in nongrandfathered plans with aggregate family deductible less than $5,200	Aggregate deductible will change to embedded deductible. CHBRP used the 2014 NORC/CHCF California Employer Health Benefits Survey to determine the current distribution of deductible amounts among fully insured firms in California. CHBRP assumed the postmandate family deductible is $2,600 and the postmandate individual deductible is $2,600.

Cases 1–4 above did not require any cost impact estimate. For cases 5 and 6, CHBRP priced the premandate and postmandate plan designs using the Milliman Health Cost Guidelines.

Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits AB 1305 would mandate. Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS currently have the largest number of enrollees. The CalPERS PPOs currently provide products with embedded deductibles.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated only HDHPs appeared to have aggregated deductibles.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

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.

Faculty Task Force

Joy Melnikow, MD, MPH, *Vice Chair for Public Health*, University of California, Davis
Ninez Ponce, PhD, Co-*Vice Chair for Cost*, University of California, Los Angeles
Nadereh Pourat, PhD, Co-*Vice Chair for Cost*, University of California, Los Angeles
Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Susan L. Ettner, PhD, University of California, Los Angeles
Sheldon Greenfield, MD, University of California, Irvine
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Sara McMenamin, PhD, University of California, San Diego

Task Force Contributors

Wade Aubry, MD, University of California, San Francisco
Diana Cassady, DrPH, University of California, Davis
Shana Charles, PhD, MPP, University of California, Los Angeles
Janet Coffman, MA, MPP, PhD, University of California, San Francisco
Shauna Durbin, MPH, University of California, Davis
Margaret Fix, MPH, University of California, San Francisco
Ronald Fong, MD, MPH, University of California, Davis
Brent Fulton, PhD, University of California, Berkeley
Erik Groessl, University of California, San Diego
Gerald Kominski, PhD, University of California, Los Angeles
Stephen McCurdy, MD, MPH, University of California, Davis
Ying-Ying Meng, PhD, University of California, Los Angeles
Jack Needleman, PhD, University of California, Los Angeles
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Los Angeles
AJ Scheitler, MEd, University of California, Los Angeles
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego

National Advisory Council

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Hanh Kim Quach, MBA, Principal Policy Analyst
Karla Wood, Program Specialist

California Health Benefits Review Program
University of California
Office of the President
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876 Fax: 510-763-4253
chbrpinfo@chbrp.org www.chbrp.org

The California Health Benefits Review Program is administered by the Division of Health Sciences and Services at the University of California, Office of the President. The Division is led by John D. Stobo, MD, Senior Vice President.

ACKNOWLEDGMENTS

Bruce Abbott, MLS, of the University of California, Davis conducted the literature search. Shana Charles, PhD, MPP, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, and Chankyu Lee of Milliman, provided actuarial analysis. David Gamage, Assistant Professor of Law at the University of California, Berkeley, provided technical assistance with expert input on the analytic approach. Hanh Kim Quach, MBA, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. Joy Melnikow, MD, MPH, of University of California, Davis, Nadereh Pourat, PhD, of University of California, Los Angeles, and Edward Yelin, PhD, of the University of California, San Francisco reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

Please direct any questions concerning this document to:

California Health Benefits Review Program
University of California, Office of the President
Division of Health Sciences and Services
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-763-4253
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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP Faculty Task Force comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis.

CHBRP staff coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature.

CHBRP is also grateful for the valuable assistance of its National Advisory Council, who provide expert reviews of draft analyses and offer general guidance on the program. CHBRP is administered by the Division of Health Sciences and Services at the University of California, Office of the President, led by John D. Stobo, MD, Senior Vice President.

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Garen Corbett, MS
Director