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

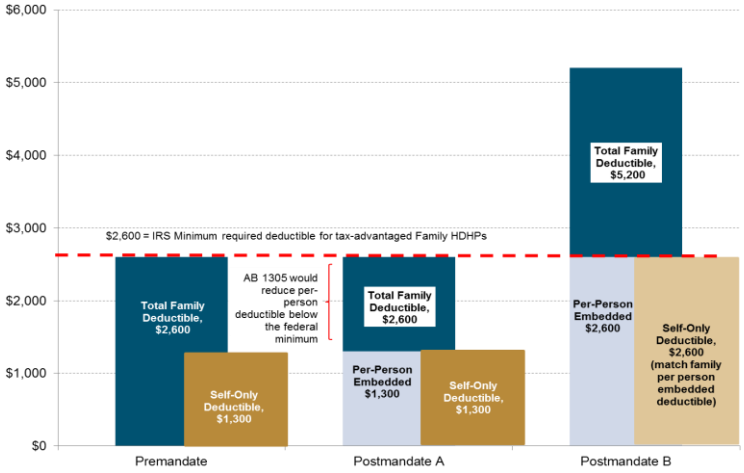
- **Aggregated family deductibles**: These types of HDHPs count all of a family's cost sharing to the deductible limit, whether the deductible is met by one family member or multiple family members.
  - Example: for a family plan with the minimum deductible amount, $2,600, the plan would not pay for 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.