Updated Analysis:

Analysis of California Assembly Bill 1860
Prescription Drugs

Summary to the 2017-2018 California State Legislature, June 20, 2018

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

CHBRP analyzed the impacts of the sunset of oral anticancer medication cost sharing provisions, should Assembly Bill (AB) 1860 not pass. CHBRP estimates that, in 2018, 13.4 million Californians enrolled in state-regulated health insurance will be impacted by the sunset of cost sharing provisions included in current law.

1. **Benefit coverage.** Enrollees with health insurance offered through Covered California or an off-exchange mirror product are subject to Covered California standard plan benefit design rules (which includes cost sharing limits for prescription drugs), therefore the sunset of cost sharing provisions in current law are unlikely to directly impact these enrollees.
2. **Utilization.** CHBRP estimates 9,200 enrollees in plans and policies subject to current cost sharing provisions have oral anticancer medication outpatient prescription drug claims that hit the current cost sharing limitation of $200 per prescription for up to a 30-day supply, or about 0.1% of the impacted population. Since the majority of enrollees with high cost oral anticancer medication will reach their maximum out of pocket (MOOP) limits, CHBRP predicts no change in utilization.
3. **Expenditures.** The sunset of oral anticancer medication cost sharing provisions in current law would decrease annual expenditures by $174,000 or -0.0001% for enrollees with DMHC-regulated plans and CDI-regulated policies. This decrease is largely due to a decrease of $1,017,000 in total health insurance premiums paid by employers and enrollees, adjusted by an increase of $844,000 in enrollee expenses. These estimates are an overestimate of premium reduction since the impact of cost sharing increases on utilization of other medical services are not incorporated in the cost model.
4. **Impacts of Out of Pocket Maximums and Deductibles.** Should current law's cost sharing limits sunset, a majority of enrollees who use high cost prescription drugs would be protected from increases in cost sharing due to health insurance plan designs. Limitations in overall enrollee cost sharing are incorporated in virtually all medical plan designs through out of pocket maximums. Approximately 90.7% of enrollees utilizing high cost oral anticancer medications would be expected to reach their out of pocket maximums under the assumed plan design and therefore would continue to be protected from increases in cost sharing due to the sunset of current law. For the 9.3% of enrollees who do not meet their out of pocket maximums within the plan year, increases in cost sharing may lead to changes in utilization of prescription drugs due to cost. However, as utilization may not change for enrollees impacted by the increases in cost sharing due to the availability of cost sharing assistance programs. Patient assistance programs can help income-qualified patients pay for the more expensive prescription drugs, which may help shield some enrollees from increases in cost sharing for prescription drugs. If enrollees are not helped by patient assistance programs and reduce their prescription drug use due to increased cost sharing/out of pocket costs to the enrollee, it could result in significant clinical consequences; however, because CHBRP is unable to estimate the magnitude of this problem and cannot estimate the costs of clinical care when drugs are forgone, the expenditure and premium impacts presented here do not reflect any changes to medical care utilization or costs.
5. **Long-term impacts.** Over time, an increasing number of enrollees utilizing high cost prescription drugs may experience increases in cost sharing due to rising drug costs or the availability of new and more expensive medications. This may place more enrollees at risk of experiencing high cost sharing early in the plan year and may potentially result in utilization changes.

CONTEXT

Upon request from the Assembly Health Committee, CHBRP analyzed AB 1860 Cancer Treatment, as introduced, and submitted the report to the Legislature on April 20, 2018. On May 8, 2018, the Senate Health Committee requested additional analysis on the impacts on premiums and utilization of oral anticancer medications should AB 1860 not pass and the cost sharing limitation in current statute sunset.

BILL SUMMARY

AB 1860, introduced by Assembly Member Limón on January 10, 2018, amends provisions of current law that limit cost sharing for oral anticancer medications. Additional information about oral anticancer medications is included in CHBRP's analysis of AB 1860 published April 20, 2018.[1]

Current law limits cost sharing for oral anticancer medications to $200 per prescription for up to a 30-day supply for enrollees in DMHC-regulated plans and CDI-regulated policies, including CalPERS and exempting Medi-Cal Managed Care plans. Plans and policies are allowed to increase the cost sharing limit by the Consumer Price Index yearly beginning in 2016, although no insurers had done so as of March 2018. This provision of current law sunsets January 1, 2019, unless extended through the passage of AB 1860.

Another current law, enacted through the passage of AB 339, limits cost sharing for covered outpatient prescription drugs to $250 per prescription for up to a 30-day supply for enrollees in DMHC-regulated plans and CDI-regulated policies, including CalPERS and exempting Medi-Cal Managed Care plans. For enrollees in high deductible health plans (HDHPs), cost sharing is limited to $500 per prescription for up to a 30-day supply. This provision of current law sunsets January 1, 2020, unless extended through the passage of SB 1021.

Therefore, if AB 1860 were to not pass and current law limiting cost sharing for oral anticancer medications sunsets on January 1, 2019, cost sharing for oral anticancer medications would increase by a maximum of $50 per prescription or $300 per prescription for enrollees in HDHPs until January 1, 2020. If SB 1021 were to also not pass, there would be no cost sharing limits for oral anticancer medications beginning in 2020. CHBRP discusses the impact should all cost sharing limits in current law sunset, effective January 1, 2020.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

This section reports the potential incremental impacts should current cost sharing limits sunset on estimated baseline benefit coverage, utilization, and overall cost. For further details on the underlying data sources and methods, please see Appendix A.

Currently, 100% of the 15.9 million enrollees with health insurance subject to current law currently have coverage with cost sharing limits for oral anticancer medications of $200 per prescription for up to a 30-day supply. Should AB 1860 and SB 1021 not be enacted and current law sunset, 100% of these enrollees would have health insurance no longer required to include cost sharing limits for oral anticancer medications. Due to these interacting laws, CHBRP has analyzed the impacts of the sunset of cost sharing limitations on premiums and utilization for oral anticancer medications in 2020.

[1] CHBRP's analysis of AB 1860 published on April 20, 2018 is available at: http://chbrp.org/completed_analyses/index.php

Cost sharing limits in current law sunset by January 1, 2020. CHBRP has adapted the cost model that estimates impacts on benefit coverage, utilization, and expenditures in 2019 by continuing to trend increases in premiums and expenditures, while assuming enrollment and population estimates remain constant in order to estimate impacts in 2020. Changes at the federal and state level that impact enrollment, as well as population changes, will alter the results obtained in this analysis.

As described in the previous analysis of SB 1021,[2] enrollees with health insurance offered through Covered California or an off-exchange mirror product are subject to Covered California plan benefit design regulations. Covered California included cost sharing limits for prescription drugs in the plan benefit design beginning in 2016, and therefore CHBRP assumes enrollees in Covered California and mirror plans would continue to have health insurance that includes cost sharing limits for prescription drugs. Therefore, 81% of all enrollees in the individual market and 23% of all enrollees in the small group market have health insurance that would not change should current law sunset.

To model the expenditure impact of allowing current law to sunset, CHBRP applied an average benefit design for enrollees in large and small group plans based on information from PwC's Touchstone Report (2017) and the 2017 Kaiser/HRET Survey of Employer-Sponsored Health Benefits (KFF/HRET, 2017). The average plan design incorporated a $1,350 deductible, 20% coinsurance, and $3,500 maximum out of pocket costs (MOOP). Under a 20% coinsurance provision, any drug costing at least $1,000 could exceed the $200 per prescription limitation that is currently in place. The impacts of removing limits on cost sharing for prescription drugs must be considered in conjunction with the likelihood enrollees will reach their overall MOOP limits and be spared further cost sharing for the year. Enrollees taking high cost oral anticancer medications (defined as medications costing at least $1,000 per prescription) have much higher total healthcare costs than average, and the majority of these enrollees will meet their benefit plan's MOOP limit. As a result, the removal of cost sharing limits on high cost oral anticancer medications has little effect on plan costs and enrollees' annual cost sharing amounts. Appendix A includes more detail on how different plans have differing MOOPs and the results of a sensitivity analysis to see how estimated impacts are affected by assumed MOOP.

Key Assumptions

- Many oral anticancer medications are available in generic form, are very low cost, and have low cost sharing requirements. Not all oral anticancer medications are placed in Tier 4 of prescription drug formularies, which dictate cost sharing for enrollees. CHBRP is also aware that not all enrollees have health insurance with four tiers, and therefore cost sharing may vary for some specialty prescription drugs. For this analysis, CHBRP assumes all high cost oral anticancer drugs are placed on Tier 4 of prescription drug formularies.

- CHBRP assumes prescription drugs available in 2016 will continue to be the only drugs available in 2020. CHBRP is unable to predict the number of these drugs nor the cost of new prescription drugs.

- CHBRP assumes deductibles apply to both medical and prescription drug benefits, though some enrollees may have separate deductibles for medical benefits and prescription drug benefits.

- CHBRP assumes plans and policies will continue to include out of pocket maximums in plan designs in all markets. However, only nongrandfathered plans and policies offered on the small

[2] CHBRP's analysis of SB 1021 published on April 9, 2018 is available at: http://chbrp.org/completed_analyses/index.php

group, large group and individual markets are required to include out of pocket maximums in plan design. Although grandfathered plans in all markets are not required to include out of pocket maximums, CHBRP has assumed that these plans include maximums.

Baseline and Post-sunset Benefit Coverage

Currently, 15.9 million enrollees are subject to the oral anticancer medication cost sharing provisions of current law. Because enrollees with health insurance offered through Covered California or an off-exchange mirror product are subject to Covered California standard plan benefit design rules that include cost sharing limits for all prescription drugs, cost sharing provision mandate changes are likely not to directly impact the benefit design of health insurance for these enrollees. Thus, excluding this group of individual and small group enrollees, there are 13.4 million enrollees with health insurance likely to be impacted by the sunset of current law. This represents 57% of the 23.4 million Californians who have health insurance regulated by the state that may be subject to any state health benefit mandate law or law affecting the terms and conditions of coverage.[3]

Based on the analysis of the California Employer Benefit Survey, CHBRP estimates that approximately 1.4% of enrollees in plans regulated by DMHC or policies regulated by CDI have no coverage for outpatient prescription drugs (OPDs) and 3.0% of these enrollees have OPD coverage that is not regulated by DMHC or CDI. Taking this into account, CHBRP estimates that 12.4 million enrollees have health insurance likely affected by the sunset of oral anticancer medication cost sharing limitations included in current law.

Baseline and Post-sunset Utilization

CHBRP extracted all medical and drug claims for enrollees with at least one high cost oral anticancer medication prescription from the 2016 MarketScan® commercial claims and enrollment data for the state of California. Using this database, CHBRP estimates 9,200 enrollees in plans and policies subject to current cost sharing provisions have outpatient prescription drug claims that hit the current cost sharing limitation (Table 1). If current law sunsets, the oral anticancer medication cost sharing limit that is currently in place will cease and affect the 9,200 enrollees who are currently subject to the cost sharing limit. This group of 9,200 enrollees represents about 0.1% of all enrollees with health insurance likely impacted by the sunset of current law (13.8 million). Since the majority of enrollees with high cost oral anticancer medication will reach their MOOP limits, CHBRP predicts no change in utilization.

Impact of Out of Pocket Maximums and Deductibles

Should cost sharing limits that exist in current law sunset January 1, 2020, a majority of enrollees who use high cost oral anticancer medications would be protected from increases in cost sharing due to health insurance plan designs. Limitations in overall enrollee cost sharing are incorporated in virtually all medical plan designs through maximum out of pocket (MOOP) cost provisions. MOOP provisions typically range from $2,000 to $6,750 per benefit year and limit the total cost sharing for medical and/or prescription drugs an enrollee is exposed to each year. To analyze the impact of a sunset of the $200 per prescription

[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 DMHC and the CDI. 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. CHBRP's estimates of the source of health insurance available at: www.chbrp.org/other_publications/index.php.

cost sharing limitation, it is important to consider the likelihood that enrollees would reach their benefit plans' MOOPs, thus protecting them from increases in cost sharing as a result of the sunset of cost sharing provisions in current law. Approximately 90.7% of enrollees utilizing high cost oral anticancer medications would be expected to reach their out of pocket maximums under the assumed plan design and therefore would continue to be protected from increases in cost sharing due to the sunset of current law. For the 9.3% of enrollees who do not meet their out of pocket maximums within the plan year, increases in cost sharing may lead to changes in utilization of prescription drugs due to cost. However, as described above, utilization is not expected to change for enrollees impacted by the increases in cost sharing due to the availability of cost sharing assistance programs.

The impact of the sunset is highly dependent on the underlying plan design, and in particular, on the MOOP limit. If the drug cost sharing limitations included in current law sunset, enrollees with high cost oral anticancer medication prescriptions will have annual cost sharing increases ranging from 1.0% to 10.0%, on average, with the lowest impact experienced by enrollees in benefit plans with low MOOP limits and the highest impact experienced by enrollees in benefit plans with high MOOP limits. Individual enrollees may experience changes in cost sharing that are significantly more than that indicated by average impact.

Goldman and colleagues (2006) found the price elasticity of oral anticancer medications could be estimated at -0.01, meaning that enrollees who experience an increase of out-of-pocket costs for oral anticancer medications of 100% decrease their utilization of oral anticancer medications by 1%. While CHBRP has assumed that overall utilization of high cost oral anticancer medications will not significantly change due to the small number of enrollees who utilize high cost oral anticancer medications, there may be a small number of enrollees who face increases in out of pocket costs and are not able to afford this additional burden or are not assisted by cost sharing assistance programs. For these enrollees, the increase in cost sharing may in fact lead to decreases in utilization.

One potential outcome of the elimination of cost sharing limits for high cost drugs is that enrollees may reach their deductibles and out of pocket maximums sooner in the plan year. Whereas previously an enrollee who is not in a HDHP may pay a $200 cost share for a prescription drug for three months to reach their $500 deductible, an enrollee may now reach that $500 deductible after the first month if the prescription's cost share at a 20% coinsurance exceeds their deductible. This may place an insurmountable financial burden on enrollees who are lower income and are less able to afford high costs upfront, versus spread over multiple months.

However, an enrollee's response to increases in cost sharing is variable depending on the disease or condition for which they are taking medications. Enrollees with cancer who are taking oral anticancer medications are less likely to reduce utilization due to increases in cost sharing. The average annual cost of medical and prescription drug services for enrollees taking high cost oral anticancer medications is approximately $187,700, compared to just under $5,000 for enrollees not taking high cost oral anticancer medications. Enrollees taking high cost oral anticancer medications are more likely to have substantial medical needs and require additional medical services and prescriptions, therefore meeting their deductible and out of pocket maximums.

Impact of Cost Sharing on Utilization of Other Medical Service Utilization

Utilization of other medical services could change in a variety of ways based on changes in cost sharing for specialty prescription drugs. As described above, CHBRP assumes utilization of oral anticancer medications will not change due to cost sharing increases. However, there may be a small number of enrollees for whom the increase cost sharing increases due to the sunset of current law could decrease

utilization of high cost oral anticancer medications. This in turn may lead to a deterioration of health status that could result in additional medical utilization.

However, some enrollees who may reach their deductibles or out of pocket maximums earlier in their plan year may utilize more medical services due to the lack of cost sharing responsibility for additional services. Enrollees who previously had not reached these limits may have delayed or forgone other medical care until their deductible or out of pocket maximums were reached. Since these limits are reached sooner in the plan year, if utilization of these additional medical services continue throughout the plan year, a higher overall utilization of medical services may occur.

Average Cost of Prescriptions and Cost Sharing Assistance Programs

As discussed in the April 20, 2018 analysis of AB 1860, the average cost of oral anticancer medications per prescription in 2019 is $1,362. However, the three most commonly prescribed oral anticancer medications (Methotrexate, Tamoxifen citrate, and Anastrozole) account for 62% of prescriptions, but only 1.5% of total cost. The majority of prescribed oral anticancer medications have costs that would result in cost sharing lower than $200 per prescription, assuming typical coinsurance rates of 10% to 30%. Additionally, patient assistance programs (i.e., pharmaceutical company-sponsored rebates and coupons, foundation payments) can help income-qualified patients pay for the more expensive oral anticancer drugs. IMS Institute for Healthcare Informatics (2016) reported that, nationally, about 25% of patients received pharmaceutical manufacturer coupons or rebates for retail anticancer drugs in 2015, up from 7% in 2011. These patient assistance programs averaged patient savings of about $750 per prescription. According to Robert Mowers, PharmD, BCPS, content expert for CHBRP's analysis of AB 1860, almost all patients in California receive assistance from patient assistance programs when obtaining oral anticancer medications through specialty pharmacies, therefore protecting them against increases in cost sharing. However, not all enrollees are guaranteed to receive this cost sharing assistance, and therefore a small share of enrollees will likely experience cost sharing increases.

Baseline and Post-sunset Expenditures

Table 2 and Table 3 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

The sunset of oral anticancer medication cost sharing provisions would decrease annual expenditures by $174,000 or -0.0001% for enrollees with DMHC-regulated plans and CDI-regulated policies. This decrease is largely due to a decrease of $1,017,000 in total health insurance premiums paid by employers and enrollees, adjusted by an increase of $844,000 in enrollee expenses. However, due to the availability of patient assistance programs and the impact of potential utilization changes due to cost sharing increases of prescription drugs on utilization of other medical services, these estimates may overestimate the impact of the sunset of cost sharing limits.

Premiums

Changes in premiums as a result of the sunset of oral anticancer medication cost sharing provisions would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 2 and Table 3) with health insurance affected by the sunset of current law.

The largest reduction in per member per month premium is in the CDI-regulated plans, with small group CDI-regulated plans having the highest reduction (-0.0021%). The individual and large group DMHC-regulated plans have the lowest changes in premiums, -0.0004% and -0.0007% respectively.

Since plans offered through Covered California and mirrored plans are not impacted by the sunset of current law, the impacts on premiums and expenditures are larger in the grandfathered and other non-grandfathered plans for plans and policies in the individual and small group markets. Specifically within the DMHC-regulated small group market, premiums are estimated to decrease by -0.0011% among grandfathered plans and by -0.0022% among other non-grandfathered plans. Within the DMHC-regulated individual market, premiums are estimated to decrease by -0.0013% among grandfathered plans and by -0.0038% among other non-grandfathered plans. Within the CDI-regulated small group market, premiums are estimated to decrease by -0.0023% among grandfathered policies and -0.0026% among other non-grandfathered policies. Within the CDI-regulated individual market, premiums are estimated to decrease by -0.0014% among grandfathered policies and -0.0036% among other non-grandfathered policies.

Among publicly funded DMHC-regulated health plans, CalPERS HMOs are the only plans impacted by the sunset of current law; CHBRP estimates a -0.0008% decrease in premiums for this market segment.

Enrollee Expenses

With a sunset of oral anticancer medication cost sharing limitations, enrollee out of pocket expenses for oral anticancer medications are expected to increase for the enrollees who are currently subject to a limit in cost sharing. Enrollee expenses for covered benefits (deductibles, copays, etc.) and enrollee expenses for noncovered benefits would vary by market segment. The small group CDI-regulated market would likely experience the largest increase in expenditures by enrollees at $0.0110 per member per month. The lowest increase in expenditures by enrollees is estimated to be $0.0019 per member per month for DMHC-regulated individual market enrollees.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase or decrease in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase or decrease in premiums. CHBRP assumes that if health care costs decrease as a result of decreased utilization or changes in unit costs, there is a corresponding proportional decrease 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.

Long Term Impacts

Over time, an increasing number of enrollees utilizing oral anticancer medications may experience increases in cost sharing due to rising drug costs or the availability of new and more expensive medications. This may place more enrollees at risk of experiencing high cost sharing early in the plan year and may potentially result in utilization decreases.

Over time, the share of enrollees in high deductible health plans (HDHPs) has increased. The CDC found enrollment in employment based HDHPs increased from 24% in 2011 to 34.9% in 2016, nationally (Cohen and Zammatti, 2017). If this trend continues, enrollees in these plans face higher upfront costs and are at an increased risk of being adversely impacted through lower utilization due to higher cost sharing.

Table 1. 2020 Impacts of Sunset of Cost Sharing Provisions for Oral Anticancer Medication on Benefit Coverage, Utilization, and Cost

	Baseline	Post-sunset	Increase/ Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	23,433,000	23,433,000	0	0%
Total enrollees with health insurance subject to cost sharing provision in current law	15,923,000	15,923,000	0	0%
Total enrollees with health insurance impacted by sunset of current law	13,383,000	13,383,000	0	0%
Total enrollees with health insurance impacted by sunset of current law with OPD coverage	12,362,000	12,362,000	0	0%
Utilization and unit cost				
Number of enrollees with high cost oral anticancer prescription drug claims **subject** to the cost sharing limitation	9,200	0	-9,200	-100.0%
Percentage of enrollees with high cost oral anticancer prescription drug claims **subject** to the cost sharing limitation	0.1%	0.0%	-0.1%	-100.0%
Expenditures				
Premiums by payer				
Private Employers for group insurance	$73,817,182,000	$73,816,508,000	-$674,000	-0.0009%
CalPERS HMO employer expenditures (b)	$5,598,878,000	$5,598,835,000	-$43,000	-0.0008%
Medi-Cal Managed Care Plan expenditures (d)	$30,139,205,000	$30,139,205,000	$0	0.0000%
Enrollees for individually purchased insurance	$16,540,870,000	$16,540,796,000	-$74,000	-0.0004%
Individually Purchased – Outside Exchange	$7,043,319,000	$7,043,245,000	-$74,000	-0.0011%
Individually Purchased – Covered California	$9,497,551,000	$9,497,551,000	$0	0.0000%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (c)	$22,630,493,000	$22,630,266,000	-$227,000	-0.0010%
Enrollee expenses				

Enrollee out of pocket expenses for covered benefits (deductibles, copayments, etc.)	$15,903,248,000	$15,904,092,000	$844,000	0.0053%
Enrollee expenses for noncovered benefits (d)	$0	$0	$0	0.00%
Total expenditures		**$164,629,876,000**	**$164,629,702,000**	**-$174,000**

Source: California Health Benefits Review Program, 2018.

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) Approximately 56.17% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees have an OPD benefit not subject to DMHC (see Appendix D in CHBRP's April 20, 2019 analysis of AB 1860), so CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

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

(d) Includes only expenses 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; OPD = outpatient prescription drug.

Table 2. Baseline (Before Sunset) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	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+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state Mandates (d)	9,371,000	3,117,000	2,081,000	887,000	6,832,000	678,000	214,000	133,000	120,000	23,433,000
Total enrollees in plans/policies **subject** to cost sharing provisions in current law	9,371,000	3,117,000	2,081,000	887,000	0	0	214,000	133,000	120,000	15,923,000
Total enrollees in plans/policies **impacted** by sunset of current law	9,371,000	2,381,000	313,000	887,000	0	0	214,000	107,000	110,000	13,383,000
Premiums										
Average portion of premium paid by employer	$514.09	$366.33	$0.00	$526.01	$284.98	$832.76	$593.41	$489.18	$0.00	$109,555,265,000
Average portion of premium paid by employee	$130.20	$168.77	$633.86	$85.63	$0.00	$0.00	$187.26	$178.19	$494.57	$39,171,362,000
Total premium	**$644.29**	**$535.11**	**$633.86**	**$611.64**	**$284.98**	**$832.76**	**$780.67**	**$667.37**	**$494.57**	**$148,726,627,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	$51.27	$118.87	$172.03	$52.15	$0.00	$0.00	$142.65	$187.88	$121.42	$15,903,248,000
For noncovered benefits (e)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$695.55**	**$653.97**	**$805.88**	**$663.80**	**$284.98**	**$832.76**	**$923.33**	**$855.25**	**$616.00**	**$164,629,875,000**

Source: California Health Benefits Review Program, 2018.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 56.17% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) 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.

(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; MCMC = Medi-Cal Managed Care.

Table 3. Postmandate (After Sunset) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	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+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state Mandates (d)	9,371,000	3,117,000	2,081,000	887,000	6,832,000	678,000	214,000	133,000	120,000	23,433,000
Total enrollees in plans/policies **subject** to cost sharing provisions in current law	9,371,000	3,117,000	2,081,000	887,000	0	0	214,000	133,000	120,000	15,923,000
Total enrollees in plans/policies **impacted** by sunset of current law	9,371,000	2,381,000	313,000	887,000	0	0	214,000	107,000	110,000	13,383,000
Premiums										
Average portion of premium paid by employer	-$0.0037	-$0.0059	$0.0000	-$0.0040	$0.0000	$0.0000	-$0.0097	-$0.0101	$0.0000	-$717,000
Average portion of premium paid by employee	-$0.0009	-$0.0027	-$0.0024	-$0.0007	$0.0000	$0.0000	-$0.0031	-$0.0037	-$0.0094	-$301,000
Total premium	**-$0.0046**	**-$0.0086**	**-$0.0024**	**-$0.0047**	**$0.0000**	**$0.0000**	**-$0.0128**	**-$0.0137**	**-$0.0094**	**-$1,017,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	$0.0039	$0.0069	$0.0019	$0.0040	$0.0000	$0.0000	$0.0109	$0.0110	$0.0075	$844,000
For noncovered benefits [e]	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	**-$0.0007**	**-$0.0017**	**-$0.0005**	**-$0.0007**	**$0.0000**	**$0.0000**	**-$0.0019**	**-$0.0027**	**-$0.0019**	**-$174,000**
Percent change										
Premiums	-0.0007%	-0.0016%	-0.0004%	-0.0008%	0.0000%	0.0000%	-0.0016%	-0.0021%	-0.0019%	-0.0007%
Total expenditures	**-0.0001%**	**-0.0003%**	**-0.0001%**	**-0.0001%**	**0.0000%**	**0.0000%**	**-0.0002%**	**-0.0003%**	**-0.0003%**	**-0.0001%**

Source: California Health Benefits Review Program, 2018.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 56.17% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) 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.

(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; MCMC = Medi-Cal Managed Care.

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

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, PricewaterhouseCoopers (PwC).[4]

Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.[5]

This appendix describes analysis-specific data sources, estimation methods, caveats and assumptions used in preparing this cost impact analysis.

Approach – Data Sources

- Costs and patient counts were modeled using 2016 MarketScan® commercial claims and enrollment data for the state of California. CHBRP extracted all medical and drug claims for enrollees with at least one high cost oral anti-cancer prescription. These enrollees represented approximately 0.1% of all enrollees in the California MarketScan data, and have an average allowed cost that is 38 times that of enrollees without oral anti-cancer high cost drugs (see Table below).

Enrollee Category:	Average 2016 Allowed Cost Per Cohort
Impacted by OPD Cost Sharing Sunset	$187,690
Not Impacted by OPD Cost Sharing Sunset	$4,920
Total CA Mandate Population Subject to Current Law	$5,050

Analysis-Specific Assumptions

This subsection discusses the caveats and assumptions specifically relevant to the sunset of enrollee out of pocket cost-sharing limitations for oral anticancer drugs that would sunset January 1, 2019 and January 1, 2020. This assumes that AB 1860 and SB 1021, which would extend cost sharing provisions of current law, do not pass.

- CHBRP trended the data to 2020 using the trend assumptions shown in the table below. Because CHBRP is unable to predict the prescription drugs that will be introduced in the future and unable to predict the potential changes in utilization of drugs due to new products or changes in existing products, CHBRP assumed the mix of drugs remains unchanged from 2016 and no new high cost drugs become available. Additionally, CHBRP assumes no changes in plan/insurer methods of utilization management that may impact the coverage of medical and drug treatments between baseline and sunset periods, such as use of prior authorization requirements and medical review for medical treatments or mandatory generic substitutions for drug treatment.

[4] CHBRP's authorizing statute, available at www.chbrp.org/docs/authorizing_statute.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[5] See *2017 Cost Impact Analyses: Data Sources, Caveats, and Assumptions*, available at www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

CHBRP also assumes no changes in use of formularies, tiered copayments, or assignment of a drug to a formulary tier. The table below provides source information for annual cost trends.

Service Category:	Annual Cost Trend	Source
Inpatient	2.6%	"Behind the Numbers 2018: Medical Cost Trend" by PwC.
Outpatient/Professional	2.6%	"Behind the Numbers 2018: Medical Cost Trend" by PwC.
Outpatient Prescription Drugs (not high-cost drugs)	1.0%	"2017 Drug Trend Report" by Express Scripts.
Outpatient Prescription Drugs (specialty, not oral anticancer)	11.0%	"2016 Drug Trend Report" by Express Scripts.
Outpatient Prescription Drugs (oral anticancer)	10.0%	"2016 Drug Trend Report" by Express Scripts.

- Cost relatively factors are also applied to 2016 MarketScan® commercial claims to adjust covered benefits upwards to reflect estimated 2020 expenditures by plan.

Benefit Design Sensitivity Analysis

- To estimate the protections afforded by MOOP benefit provisions on those enrollees who have high cost oral anticancer prescription drugs, CHBRP modelled a range of benefit designs, varying deductibles, coinsurance percentages, and MOOP limits. To simplify benefit cost modeling, CHBRP assumed simplified benefit plans under which all services were covered under a common deductible, coinsurance, and maximum out of pocket cost. Impact on member cost sharing payments due to the cost sharing limitation was evaluated for each member identified in the MarketScan data as having a high cost oral anti-cancer prescription drug. Due to time and data constraints and other complexities, it was not feasible to perform date-order readjudication of the claims to precisely calculate plan costs and member cost sharing under the baseline and sunset scenarios, and a number of simplifying assumptions were employed. For example, CHBRP assumed all other medical services and non-specialty drugs are subject to the plan design deductible and MOOP before modeling the removal of the OPD cost sharing limitations on high cost oral anticancer drugs.

- To analyze the impact sensitivity due to variations in primary benefit design elements, plan costs and member cost sharing were modeled for benefit plans with combined medical and drug deductibles ranging from $1,350 to $3500, member coinsurance from 20% to 30%, and maximum out of pocket cost from $3,500 to $6,750. The results of the sensitivity analysis demonstrate that the impact of the mandate sunset is highly dependent on the underlying plan design, and in particular, on the MOOP limit. The sensitivity analysis indicated that if the drug cost sharing limitation is allowed to sunset, enrollees with high cost oral anti-cancer drugs will have annual cost sharing increases ranging from 1.0% to 10.0%, on average, with the lowest impact experienced by enrollees in benefit plans with low MOOP limits and the highest impact experienced by enrollees in benefit plans with high MOOP limits. Individual enrollees may experience changes in cost sharing that are significantly more than that indicated by average impact.

- To model the expenditure impact of allowing the mandate to sunset, CHBRP applied an average benefit design for enrollees in large and small group plans based on information from PwC's Touchstone Report (2017) and the 2017 Kaiser/HRET Survey of Employer-Sponsored Health Benefits. The average plan design incorporated a $1,350 deductible, 20% coinsurance, and

$3,500 MOOP. Under a 20% coinsurance provision, any drug costing at least $1,000 could exceed the $200 per prescription limitation that is currently in place. This results in an effective cost sharing of 1.50% before and 1.53% after current law sunsets on January 1, 2020. Effective cost sharing refers to the enrollee cost share as a percentage of total allowed cost of all medical and pharmacy services. Enrollees with high cost oral anticancer drugs will have annual cost sharing increases of 2.20% (calculated as (1.53/1.50)-1).

Interaction between Spending on Outpatient Prescription Drug and Medical Services

- Enrollees with high cost oral anticancer medication prescription drug claims who are affected by the cost sharing limits in current law have higher costs of medical services and higher annual cost sharing for these medical services ($244,690 and $4,160, respectively) compared to those who do not reach the outpatient prescription drug limit ($6,130 and $830, respectively). This is important to note given the annual deductibles or out of pocket maximums of health plans include costs of both medical expenses and outpatient prescription drugs. Enrollees who have high outpatient drug costs are likely to have high medical service costs. While CHBRP did not assume a change in medical services due to a change in outpatient drug utilization in the cost model (i.e. a price elasticity of demand was not applied for medical services), the potential medical and financial consequences of a change in utilization of medical services is briefly described qualitatively in this analysis.

- The table below shows the distribution of enrollees with high cost oral anti-cancer drugs using the average plan design (as noted above, this average plan design includes a $1,350 deductible, 20% coinsurance, and $3,500 MOOP). The majority of enrollees with high cost oral anti-cancer drugs reach the MOOP limit under both the baseline and sunset scenarios, which means these enrollees experience no change in total cost sharing. This has the effect of reducing the impact of the sunset of the cost sharing limits.

Categorization:	% of those Subject to Cost Sharing Limitation
Subject to cost sharing limitation	**100.0%**
1. Does not meet deductible	0.0%
2. Hits the maximum out of pocket (pre-sunset and post-sunset)	90.7%
3. Estimated to be impacted by cost sharing limitation	9.3%

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