# Abbreviated Analysis

# California Assembly Bill 2180: Cost Sharing

## as amended on April 10, 2024

Report to the 2023–2024
California State Legislature

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CHBRP

California Health Benefits Review Program (CHBRP), Office of Research, University of California, Berkeley

www.chbrp.org

# Summary

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of California Assembly Bill (AB) 2180, Cost Sharing, as amended on April 10, 2024.

AB 2180 as amended on April 10, 2024, would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to apply any amounts paid by either an enrollee or "third-party patient assistance programs" to the enrollee's annual cost-sharing requirement. Third-party patient assistance programs are defined in the bill as "manufacturer or charitable cost-sharing or copay assistance programs that provide financial assistance intended to assist patients in paying their out-of-pocket (OOP) cost-sharing obligations for prescription drugs." The bill excludes discounts, product vouchers, and coupons in the form of a percentage-based discount off the list price of a prescription drug. In essence, AB 2180 as amended on April 10, 2024, would prohibit the implementation of copayment adjustment programs on drug manufacturer coupons and drug copay assistance programs administered by nonprofit organizations.

## Context

In 2022, DMHC-regulated health plans in California, including those regulating plans for Medi-Cal beneficiaries, paid approximately $12.1 billion for prescription drugs — an increase of 12.3% from the previous year — which accounted for 14.2% of total DMHC-regulated health plan premiums. Specialty drugs[2] (which typically include high-cost brand-name drugs delivered by specialty pharmacies) accounted for only 1.6% of all prescription drugs dispensed yet represented 64% of total annual spending on prescription drugs.

Several initiatives currently exist with the intention to reduce some of the high OOP costs patients face when purchasing prescriptions. AB 2180 as amended on April 10, 2024, addresses two of them: (1) drug manufacturer coupons, and (2) drug copay assistance programs, which are administered by nonprofit organizations to provide financial support for prescription drugs — particularly specialty drugs — to underinsured populations.

To help control the cost of prescription drugs, existing California law prohibits pharmaceutical manufacturers from offering discounts or other reductions to an enrollee's OOP expenses associated with their health insurance coverage, if a lower-cost, therapeutically equivalent generic drug is available. To further counter the potential for financial assistance programs to drive up drug prices, many health plans/insurers and pharmacy benefit managers (PBMs) impose copayment adjustment programs in their pharmacy benefit designs. Copayment adjustment programs offset the impacts of certain pharmaceutical financial assistance; they operate by prohibiting the contributions made by a third party from counting towards the enrollee's OOP maximum. Copayment adjustment programs are intended to encourage the use of lower-cost prescription drugs, drive down drug prices, and reintroduce price sensitivity to enrollees who use financial assistance for OOP costs.

## Bill Language

The requirements of AB 2180 as amended on April 10, 2024, are similar to what was proposed in the bill as introduced. However, there are two primary differences between the two bills.

First, the language of AB 2180 as amended on April 10, 2024, is broader than that as introduced, and would apply to financial assistance programs from for-profit organizations; therefore, it would apply to drug manufacturer coupons, whereas the bill as introduced applied to only nonprofit (charitable) organizations. One notable difference between these two programs is that

[1] Refer to CHBRP's full report for full citations and references.
[2] Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs often cost $1,000 or more per month, and spending on them is growing 15 to 20 percent a year. Many prescription drug plans that cover specialty drugs have a separate "tier" that specifies how much an individual has to pay for specialty drugs.

while drug copay assistance provides financial support for a particular disease state and not a specific drug, drug manufacturer coupons provide financial support for a specific drug.

Second, AB 2180 as amended on April 10, 2024, specifies that third-party financial assistance does not include discounts, product vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug, whereas the bill as introduced was silent regarding the form in which the financial assistance was provided.

# Relevant Populations

If enacted, AB 2180 would apply to the health insurance of approximately 22.3 million enrollees (58.6% of all Californians). This represents those who have commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

# Analytical Approach

AB 2180 as amended on April 10, 2024, would apply to two forms of third-party financial assistance for prescription drugs: (1) drug manufacturer coupons, and (2) drug copay assistance programs from nonprofit organizations. With this in mind, CHBRP makes the following assumptions for its analysis:

- As discussed in CHBRP's analysis of AB 2180, as introduced, it is generally not possible for drugs administered in a medical setting (i.e., those on the medical benefit) to be subject to copayment adjustment programs. Thus, CHBRP assumes that all third-party financial assistance — including that from drug manufacturer coupons and drug copay assistance programs — for drugs administered in a medical setting already counts towards an enrollee's annual cost-sharing requirements and is compliant with AB 2180.
- The number of prescription drugs with coupons that would be impacted by AB 2180 as amended on April 10, 2024, is limited based on current federal and state laws. Based on these laws, CHBRP assumes the group of prescription drugs that are relevant to AB 2180 as amended on April 10, 2024, are limited to specialty drugs that have a generic equivalent, including biosimilars, where the generic or biosimilar drug is not covered on a lower cost-sharing tier.

# Impacts

## Benefit Coverage

At baseline, 13,162,000 enrollees have an outpatient pharmacy benefit regulated by DMHC or CDI and therefore have health insurance that would be impacted by AB 2180. However, the pharmacy benefit of Medi-Cal beneficiaries in DMHC-regulated plans is carved out into the Medi-Cal Rx program and therefore would not be impacted by AB 2180. CHBRP assumes health plans and policies that do not have a pharmacy benefit at baseline are compliant with the mandate.

Postmandate, CHBRP estimates AB 2180 as amended April 10, 2024, would result in approximately 5.6 million enrollees gaining coverage for drug manufacturer coupons and drug copay assistance counting toward their deductibles and OOP maximum.

CHBRP also estimated the impacts of AB 2180 in year 2 (2026) as the projected impacts of AB 2180 come into effect. See Appendix B.

## Utilization and Expenditures

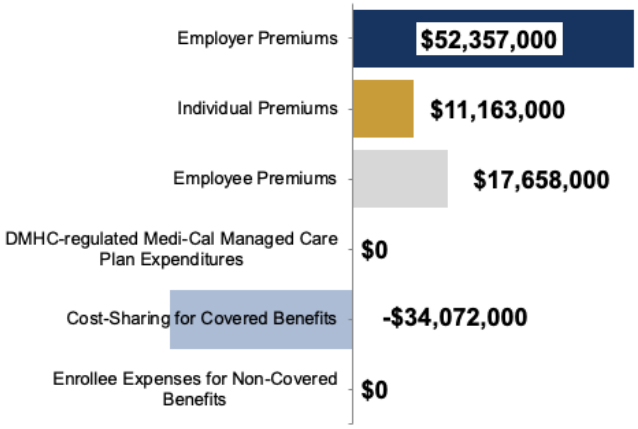
CHBRP estimates the number of specialty prescriptions filled that have drug copay assistance or are filled using drug manufacturer coupons (161,000) would not change due to AB 2180 in the first year. This represents approximately 15,800 enrollees who would be impacted by AB 2180. Similarly, the average unit cost (for a 30-day fill) for specialty medications of $8,001 would not change from baseline to postmandate.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers.

Overall, AB 2180 as amended on April 10, 2024, would increase total net annual expenditures by $47,106,000, or 0.03%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $81,178,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $34,072,000 decrease in enrollee

expenses for covered and/or noncovered benefits (Figure A).

**Figure A. Expenditure Impacts of AB 2180 as Amended on April 10, 2024**




**Source: California Health Benefits Review Program, 2024.**
Key: DMHC = Department of Managed Health Care.

## Premiums

Changes in premiums as a result of AB 2180 as amended on April 10, 2024, would vary by market segment. Among DMHC-regulated plans, large-group and individual market premiums would increase by 0.05%, and CalPERS would increase by 0.01%. However, DMHC-regulated small-group premiums would increase by 0.18%. In the CDI-regulated market, the large-group market would face the smallest increase (0.21%), while individual (0.32%) and small group (0.27%) would have the highest increase across all markets.

## Enrollee Expenses

CHBRP estimates AB 2180 as amended on April 10, 2024, would result in enrollees in non-CalPERS commercial plans in all markets paying less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a $0.06 reduction in enrollee expenses per member per month (PMPM) on the low end, with small-group DMHC-regulated enrollees experiencing a $0.71 PMPM decrease in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group ($1.43 PMPM decrease) and individual market ($1.25 PMPM decrease) policies would see the largest reduction in OOP expenses, while enrollees in large-group policies would experience $0.70 PMPM in reduced enrollee expenses on average.

Overall, enrollee expenses would decrease by $34,072,000 across all markets.

Due to the decreases in cost sharing, measurable public health impacts at the population level may occur if the bill results in increased adherence to a prescription drug.

## CalPERS

Postmandate, for enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% ($0.10 PMPM, $898,000 total increase in expenditures).

## Covered California – Individually Purchased

Postmandate, premiums for enrollees in individual plans purchased through Covered California would increase by less than 0.01% (approximately $180,000 increase in total expenditures).

## Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2180 as amended on April 10, 2024.

## Long-Term Impacts

In the longer term, CHBRP anticipates that AB 2180 as amended on April 10, 2024, if enacted, would incentivize manufacturers to increase the number of coupons available for specialty drugs and to a lesser extent the funding to drug copay assistance programs through nonprofit organizations. Manufacturers would stand to benefit from increased coupons and drug copay assistance because by removing barriers to patient access to high-cost medications, manufacturers may increase the overall demand for specialty medications. Health plans and insurers may respond by removing specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary; off-formulary drugs are not considered covered benefits, and therefore AB 2180 would not apply to these drugs.

One key uncertainty of the potential impact of AB 2180 is the degree to which patients may be willing to switch to alternative therapies when presented with an opportunity to reduce OOP expenditures. Drug copay assistance and coupons may influence patient behavior, as patients

with these types of financial assistance may be less likely to search for lower cost, alternative treatment options. Furthermore, these programs may even minimize or eliminate cost sharing for all other medical services throughout the year if the OOP maximum is reached. The presence of these programs may have the long-term potential to encourage patients to continue a specific therapy even as less costly, equivalent therapies become available. Therefore, these programs may have the potential to increase overall costs for drugs from both the perspective of the patient and the health plan over time. In particular, because AB 2180 would only impact specialty drugs with generics or biosimilars available due to existing requirements, it would seem that increased drug costs would be a likely outcome of AB 2180.

There is also the potential for pharmaceutical industry dynamics to reduce the overall volume of drug copay assistance programs and coupons. For example, biosimilar competition could potentially drive down drug prices and conceivably reduce overall demand for programs to help with patient cost sharing. Likewise, a decrease in list prices for drugs with high manufacturer rebates could have a similar impact.

Another significant consideration of the potential impact of AB 2180 is the degree to which the mandate impacts patients with chronic disease versus terminal diseases. Due to the ongoing nature of treatments for chronic disease, the potential for higher utilization is greater for medications for chronic conditions than those for terminal diseases.

CHBRP also notes that AB 2180 may address inequalities because of the current consequences of cost sharing on low-income patients. At baseline, some patients may face financial hardships to receive needed treatments or even postpone treatment if nonprofit organizations have insufficient drug copay assistance to meet patient demand. Assuming AB 2180 leads to an influx of additional financial contributions from pharmaceutical manufacturers and other organizations to copay assistance programs, and an increase in the number of available coupons for specialty prescription drugs, the mandate may benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower income populations with commercial insurance.

In addition, postmandate, some patients may no longer be compelled to pay up-front for their prescriptions, as AB 2180 eliminates the requirement to cover the deductible and OOP maximum for these patients, through coupons or drug copay assistance and a card processed by the PBM at the point of sale. This would benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower-income populations with commercial insurance. In Year 2 (2026), CHBRP assumes that this factor would lead to increased utilization (see Appendix B of the main report for more details, including estimates of Year 2 expenditures). It stands to reason that in the long run, AB 2180 may improve the health status of patients who would not have otherwise received treatment.

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# Policy Context

The California Health Benefits Review Program (CHBRP) was asked by the Assembly Health Committee staff on April 19, 2024, to provide an evidence-based assessment of the financial impacts of Assembly Bill (AB) 2180 (Weber), Cost Sharing, as amended on April 10, 2024.

CHBRP previously analyzed AB 2180 as introduced (2024) and a similar bill, AB 874 (2023), and uses approaches from those reports for its analysis of AB 2180 as amended on April 10, 2024, where appropriate (CHBRP, 2023 and 2024). Background on patient financial assistance programs, copayment adjustment programs, cost sharing, and relevant state and federal laws can be found in CHBRP's analysis of AB 2180, published on April 16, 2024, available at www.chbrp.org (CHBRP, 2024).

# Bill-Specific Analysis of AB 2180, Cost Sharing, as Amended April 10, 2024

## Bill Language

AB 2180 as amended on April 10, 2024, would prohibit the implementation of copayment adjustment programs on financial assistance from drug copay assistance programs, and also extend this prohibition to drug manufacturer coupons. More specifically, as amended on April 10, 2024, AB 2180 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to apply any amounts paid by either an enrollee or a third-party patient assistance program to the enrollee's cost-sharing requirement, excluding discounts, product vouchers, and coupons that provides a percentage-based discount off the list price of the prescription drug. The bill is limited to only those enrollees who have a chronic disease or terminal illness.

AB 2180 includes the following definitions:

- **Cost-sharing requirement:** any copayment, coinsurance, deductible, or annual limitation on cost sharing, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan or policy.
- **Third-party patient assistance program:** manufacturer or charitable programs that provide financial assistance intended to augment existing prescription drug coverage. The bill specifies that "third-party patient assistance program" excludes discounts, drug vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug.
- **Chronic disease:** conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.
- **Terminal illness:** a medical condition that is life-limiting and expected to result in death.

The full text of AB 2180 can be found in Appendix A.

## Differences Between Bill Versions

The requirements of AB 2180 as amended on April 10, 2024, are similar to what was proposed in the bill as introduced. However, there are some differences between the two bills, as noted below:

- **Relevant financial assistance programs:** The April 10, 2024, amendments alter the definition of "third-party patient assistance program" to include cost-sharing or copay assistance programs from both for-profit (manufacturer) and nonprofit (charitable) organizations. The bill as introduced only applied to nonprofit organizations. For-profit cost-sharing and copay assistance programs include drug manufacturer coupons. Coupons are typically a fixed dollar

amount up to a maximum per prescription or annual maximum (or both) but may also be percentage-based. Nonprofit organizations, such as drug manufacturer foundations and independent charities, provide such assistance through drug copay assistance programs. Therefore, the bill as amended would apply to drug manufacturer coupons and drug copay assistance programs, whereas the bill as introduced applied to only the latter. One notable difference between the two programs is that while drug copay assistance provides financial support for a particular disease state and not a specific drug, drug manufacturer coupons provide financial support for a specific drug.

- **Form of financial assistance:** AB 2180 as amended on April 10, 2024, specifies that third-party financial assistance does not include discounts, product vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug, whereas the bill as introduced was silent regarding the form in which the financial assistance was provided.

## Relevant Populations

If enacted, AB 2180 would apply to the health insurance of approximately 22.3 million enrollees (58.6% of all Californians). This represents those who have commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

The pharmacy benefit for Medi-Cal beneficiaries is carved out and administered through the Medi-Cal Rx program; therefore, CHBRP estimates Medi-Cal beneficiaries would not be impacted by the bill.

# Programs Subject to AB 2180

Table 1 shows how AB 2180 as amended on April 10, 2024, relates to patient financial assistance programs and copayment adjustment programs.

**Table 1. Relation of AB 2180 to Patient Financial Assistance Programs and Copayment Adjustment Programs**

| | Pharmacy Benefit Design (Relative to Copayment Adjustment Programs) | | |
|---|---|---|---|
| | **Accumulators** | **Accumulators + Maximizers** | **No Accumulator** |
| **Third-party contributions toward cost sharing** | | | |
| Patient assistance programs (a) | Does not exist | Does not exist | Out of scope |
| Drug copay assistance programs (i.e., nonprofit organizations such as drug manufacturer foundations and independent charities) | Impacted by AB 2180 | Impacted by AB 2180 | No impact due to current compliance |
| Drug manufacturer coupons and discounts (b) | Impacted by AB 2180 | Impacted by AB 2180 | No impact due to current compliance |
| Cash card programs (c) | Out of scope | Out of scope | Out of scope |
| None | No impact | No impact | No impact |

**Source: California Health Benefits Program, 2024.**
Notes: (a) Patient assistance programs provide financial assistance for prescription drugs to the uninsured population.
(b) Coupons and discounts must not be designed in a manner that provides a percentage-based discount off the list price of a prescription drug.
(c) Cash card programs are prescription discounts administered typically by online prescription discount programs. They are not used in conjunction with health insurance.

# Analytical Approach and Assumptions

## Terminology

CHBRP uses the following terminology throughout this analysis:

- **Copayment adjustment program:** a pharmacy benefit design that prohibits certain contributions — such as drug manufacturer coupons and drug copay assistance — made by the enrollee or a third party from counting towards the enrollee's out-of-pocket (OOP) maximum.
- **Copay accumulator:** a type of copayment adjustment program that prohibits any amounts collected at the point of sale when using financial assistance from third parties for a prescription drug from counting towards their deductible or annual OOP maximum.
- **Copay maximizer:** a type of copayment adjustment program under which amounts collected at the point of sale when using financial assistance from third parties for a prescription drug do not count towards their deductible or annual OOP maximum; however, the cost share is adjusted to maximize the value of the financial assistance and applied throughout the benefit year. Copay maximizers only operate in conjunction with a copay accumulator.
- **Drug copay assistance:** financial assistance provided to patients by nonprofit organizations (i.e., drug manufacturer foundations and independent charities) to aid in the cost of prescription drugs. Drug copay assistance is distributed to patients via annual grants for certain drugs based on eligibility criteria — including diagnosis of an explicit disease and condition — specified by the nonprofit.
- **Drug manufacturer coupon:** prescription discount offered by a drug manufacturer.
- **Pharmacy benefit managers (PBMs):** entities that manage prescription drug benefits for health plans and insurers.

## Forms of Financial Assistance

As shown in Table 1, AB 2180 as amended on April 10, 2024, would apply to two forms of third-party financial assistance for prescription drugs: (1) drug copay assistance programs from nonprofit organizations, and (2) drug manufacturer coupons.

Drug copay assistance programs award eligible applicants (patients) annual grants that must be used to pay for drugs specific to their condition or disease. These grants may be distributed through either a card that must be processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient).

The value of drug manufacturer coupons typically takes the form of a flat rate (that is, a fixed dollar amount) or a percentage-based discount. Coupons with percentage-based discounts are excluded from AB 2180 as amended on April 10, 2024. CHBRP assumed that postmandate, drug manufacturers would be incentivized to increase the number of flat-rate discounts offered, and to decrease the number of percentage-based discounts. While percentage-based discounts may continue to be offered postmandate, they would not be impacted by AB 2180.

## Drug Type and Benefit

As discussed in CHBRP's analysis of AB 2180 as introduced (CHBRP, 2024), PBMs typically only work with specialty pharmacies on implementation of copayment adjustment programs; accordingly, CHBRP has assumed that AB 2180 as amended on April 10, 2024, would only impact specialty drugs, which are typically high-cost brand-name drugs.[3]

Specialty drugs that are administered by a health professional in a medical setting are billed on the medical benefit. Due to the complex billing system for prescription drugs on the medical benefit, it is difficult for PBMs to track claims for these drugs; these claims are not typically submitted to PBMs or the specialty pharmacy associated with the PBM. Therefore, it is generally not possible for these drugs to be subject to copayment adjustment systems. Thus, CHBRP assumes that all

[3] CHBRP is aware that some copayment adjustment programs also impact high-cost brand medications that are nonspecialty.

third-party financial assistance — including that from drug copay assistance programs and drug manufacturer coupons — for drugs administered in a medical setting already counts towards an enrollee's annual cost-sharing requirements and is compliant with AB 2180.

## Relevant Prescription Drugs

The universe of prescription drugs that would be impacted by AB 2180 as amended on April 10, 2024, and ultimately determine the fiscal impact of the bill, would vary depending on the funding source. One group of drugs would come from any of those purchased using charitable funds for drug copay assistance. The second group would be for those drugs with available drug manufacturer coupons; eligibility of prescription drugs to qualify for this latter group is limited based on current federal and state laws.

As of the date of publication of this analysis, the Centers for Medicare and Medicaid Services (CMS) 2020 final rule on copayment adjustment programs is in effect. This rule limits health plans/insurers to restricting only drug manufacturer financial assistance that has available generic equivalents from applying to OOP maximums; if there is no generic equivalent, drug manufacturer financial assistance must be applied towards the enrollee's OOP maximum (CMS, 2019).

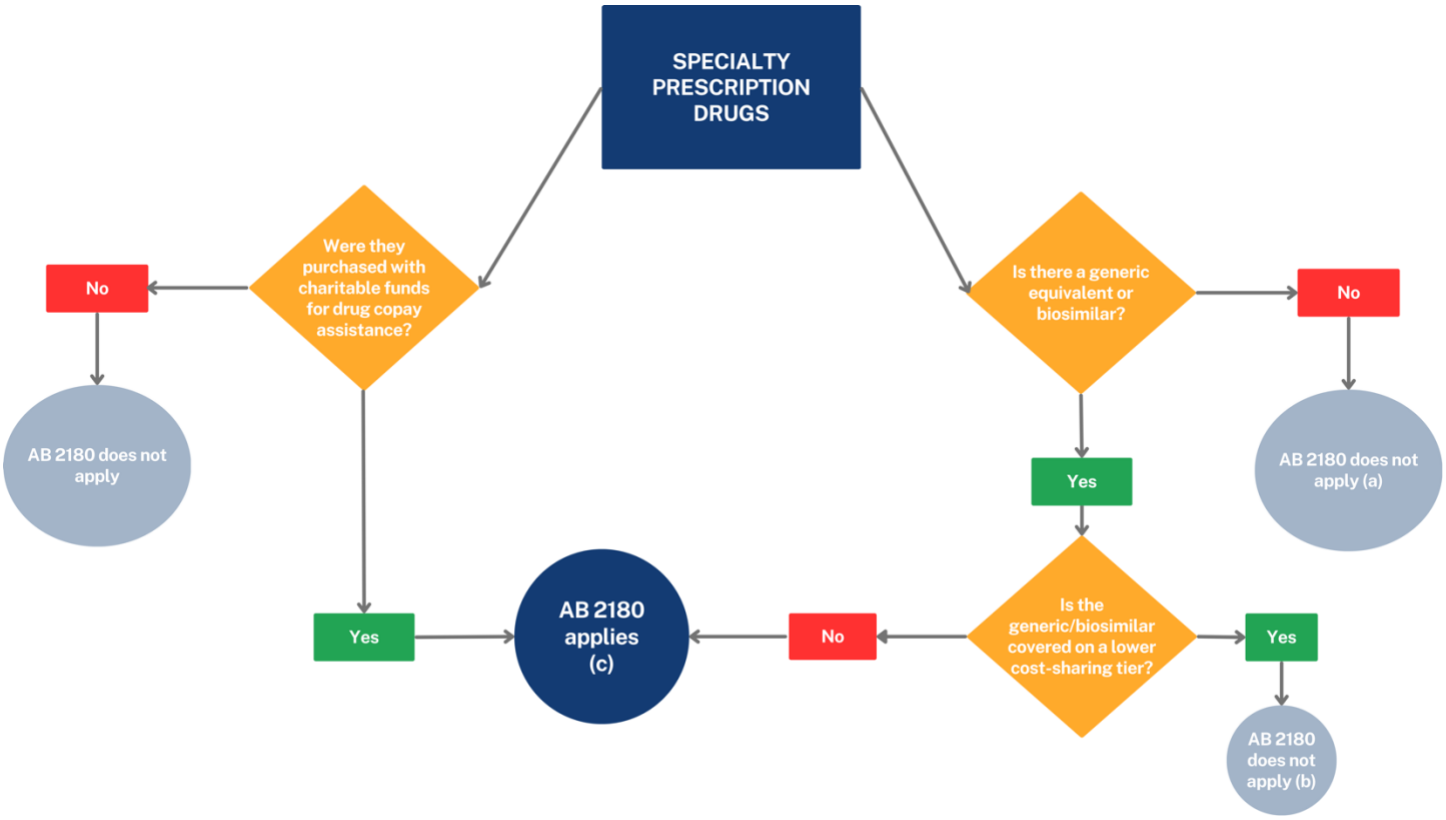
Under existing California law, pharmaceutical manufacturers are prohibited from offering discounts or other reductions to an enrollee's OOP expenses associated with their health insurance coverage, if a lower-cost, therapeutically equivalent generic drug is available on a lower cost-sharing tier.[4] California law defines a generic drug as one that has been approved as a drug by the U.S. Health and Human Services agency, or a biosimilar.[5]

Based on these federal and state laws, CHBRP assumes the group of prescription drugs with drug manufacturer coupons that are relevant to AB 2180 as amended on April 10, 2024, are limited to those specialty drugs that have a generic equivalent, including biosimilars, where the generic equivalent (or biosimilar) is not covered on a lower cost-sharing tier.

Figure 1 provides a visualization of which prescription drugs would be impacted by AB 2180.

[4] Health and Safety Code (HSC) §132000.
[55] HSC §127691.

## Figure 1. Prescription Drugs Impacted by AB 2180 as Amended on April 10, 2024, in Relation to Existing State and Federal Law




**Source: California Health Benefits Review Program, 2024; HSC §132000 and 127691; CMS, 2019.**
Notes: (a) Federal law requires pharmaceutical manufacturer discounts be applied to enrollee cost-sharing requirements for these drugs. Therefore, there are no copayment adjustment programs for these drugs.
(b) California law prohibits pharmaceutical manufacturers from offering discounts or other reductions for these drugs. Therefore, there are no copayment adjustment programs for these drugs.
(c) Coupons are allowed for these drugs under state law; copayment adjustment programs are allowed under the federal rule and state law at baseline.

# Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, AB 2180 as amended on April 10, 2024, would prohibit health plans and health policies regulated by DMHC or CDI from implementing copayment adjustment programs on financial assistance from drug copay assistance programs and drug manufacturer coupons.

In addition to commercial enrollees, 74% of enrollees associated with CalPERS and 80% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[6] As noted in the *Policy Context* section, AB 2180 would impact these CalPERS enrollees' benefit coverage but would not impact that of Medi-Cal beneficiaries due to the pharmacy carveout through the Medi-Cal Rx program.

This section reports the potential incremental impacts of AB 2180 as amended on April 10, 2024, on estimated baseline benefit coverage, utilization, and overall cost.

## Analytic Approach and Key Assumptions

### General Assumptions

As discussed in the *Policy Context* section, there are a range of programs that reduce the costs of drugs from the perspective of patients. AB 2180 as amended on April 10, 2024, would impact drug copay assistance provided through nonprofit organizations, including drug manufacturer foundations and independent charities, as well as drug manufacturer coupons. For each of these programs, CHBRP takes the following approach:

- Drug copay assistance provided through nonprofit organizations can take different forms. These programs may provide financial assistance through either a card that must be processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient) (ACCC, 2022; PAN, 2024). At baseline, CHBRP has assumed that the mechanism of financial assistance will influence the extent to which it counts towards an enrollee's cost sharing.
    - When a card is used and processed by the PBM to provide drug copay assistance, the PBM may have a copayment adjustment program in place. These programs are typically used for specialty drugs that can only be filled by specialty pharmacies with a relationship with the PBM. These specialty pharmacies may be owned by the PBM or have an exclusive contractual relationship with the PBM.
    - Reimbursement to enrollees after the point of sale is not tracked by health plans or insurers and therefore is not part of any copayment adjustment program. For example, if a patient goes to a pharmacy to fill a prescription and their copayment amount is $1,500 for any prescription drug through their health plan or insurer, the pharmacy will enter that amount in the patient's out-of-pocket (OOP) share and the patient will pay that amount directly to the pharmacy. That amount will later be reimbursed by the drug copay assistance program. This will result in patients getting "credit" for $1,500 of spending toward their deductible or OOP maximum regardless of AB 2180.
- Drug manufacturer coupons may also take different forms, as discussed in the *Policy Context* section. While some coupons provide a percentage-based discount on prescription drugs, others offer a flat-rate discount (that is, a fixed dollar amount). CHBRP assumes any percentage-based drug manufacturer coupons could be offered in the future as a flat-rate coupon.
    - CHBRP also assumes pharmaceutical manufacturers would be incentivized to provide coupons with a flat-rate discount due if AB 2180 as amended on April 10, 2024, were enacted, because the bill would only allow drug manufacturer coupons without a percentage-based discount to count towards enrollees' OOP maximum, and the

[6] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

application of drug manufacturer coupon assistance towards an enrollee's OOP maximum would encourage enrollees' use of drugs with available coupons.

- Both biologic and nonbiologic drugs with drug manufacturer coupons were included in the analysis. Only those biologic drugs with a biosimilar that is either not covered or is covered on the same formulary tier as the reference drug were included. Likewise, only those nonbiologic drugs with a generic equivalent that is either not covered or is covered on the same formulary tier as the reference drug were included. CHBRP assumed these levels of coverage occur for 50% of the biologic and nonbiologic drugs with coupons.

CHBRP also makes the following general assumptions:

- AB 2180 as amended on April 10, 2024, would impact all copayment adjustment programs, including copay accumulator programs and copay maximizer programs. CHBRP also assumes that copay maximizer programs are always implemented in conjunction with copay accumulator programs. AB 2180 would only impact how copayment adjustment programs count drug copay assistance and drug manufacturer coupons towards enrollees' deductibles and OOP maximum.
- CHBRP assumed that some patient assistance programs (i.e., state- or charity-funded payments for drugs that are not covered by the health plan) would not be subject to AB 2180. Payments through these programs typically help offset the cost of noncovered services and take place outside of an enrollee's insurance coverage.
- Prescription drug impacts would only be expected to apply to the portion of the population with outpatient prescription drug coverage who are currently covered by a policy that is not compliant with AB 2180 and that are using a combined copay maximizer and accumulator program (NCSL, 2024) or copay accumulator program (Galloway, 2022).
- Almost all (96.2%) commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications.[7] Of the remaining commercial/CalPERS enrollees, 1.2% do not have a pharmacy benefit and 2.6% have a pharmacy benefit that is not regulated by DMHC or CDI. For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and administered by the Department of Health Care Services (DHCS) under the Medi-Cal Rx program; therefore, it is not subject to DMHC regulation. Because AB 2180 would not require the creation of a pharmacy benefit — only compliant benefit coverage when a pharmacy benefit is present — baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is compliant.

It should be noted that the cost impacts of AB 2180 as amended on April 10, 2024, are dependent on how the bill is implemented by DMHC and CDI; the impacts of the bill could be greater or smaller depending on how the regulators determine third-party financial assistance should be applied to the pharmacy benefit, and which prescription drugs are relevant to the bill.

## Baseline Assumptions on Utilization and Cost

- The total cost-sharing requirements for specialty drugs with drug copay assistance were assumed to be the same as the average cost sharing for all services covered by the plan or policy. For enrollees in non–high deductible health plans (HDHPs) or enrollees in HDHPs after the deductible has been satisfied, cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost per service. For enrollees in HDHPs within the deductible phase of coverage, cost sharing is equal to 100% of drug expenses. More information on HDHPs is available in CHBRP's analysis of AB 2180 as introduced (CHBRP, 2024).
- At baseline, it is assumed that drug copay assistance programs and drug manufacturer coupons can help all enrollees with their cost-sharing requirements, but that any dollars tracked by copay accumulator and/or copay maximizer programs are not counted towards an enrollee's deductible of OOP maximum.
- At baseline, copay maximizer programs are assumed to have a potential benefit to plans that exceed the value of enrollee cost sharing (i.e., plans may use these programs to realize the full value of drug copay assistance, beyond

[31] For more on outpatient prescription drug coverage among Californians with state-regulated health insurance, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

the plan benefit cost-sharing requirements). This additional value to the plan is treated like a drug manufacturer rebate for these medications and has a benefit to the plan premiums that is not evident to the enrollee filling medications. For example, suppose that an enrollee fills a specialty prescription drug monthly that costs $8,000 per fill with a cost-sharing requirement of a $250 copay. Suppose that this member is receiving drug copay assistance through a charity that is provided in the form of funding on a payment card (i.e., that may be tracked by a PBM) and that the drug copay assistance program provides annual assistance of up to $5,000. At baseline, CHBRP assumes that the PBM will process this transaction such that, for each fill, $250 of funding will be used to satisfy the member's copay and the remaining $167 ($5,000/12 - $250) of available drug copay assistance (less a cut taken by the PBM to administer the maximizer program) will benefit the plan alone. None of these dollar amounts will accumulate towards the enrollee's OOP maximum if they are provided through a funding source that can be tracked by the plan's PBM. It is not currently clear how this bill would be interpreted related to these payment amounts. For the purposes of this analysis of AB 2180 as amended on April 10, 2024, CHBRP assumed all drug copay assistance and drug manufacturer coupon amounts would be tracked toward the enrollee deductible and OOP maximum (including those that exceed plan benefit–required cost sharing).

## Postmandate Assumptions on Utilization and Cost

- CHBRP assumed that if AB 2180 were enacted, there would be an increase in other medical utilization and plan expenses due to a portion of enrollees who use these programs hitting their OOP maximum earlier in the year and receiving full coverage without cost sharing for subsequent services. CHBRP assumed that for every $1 of cost sharing "saved," there would be $0.35 in additional spending due to utilization of other services.
  - The rate of increase was determined by market segment using induced utilization[8] (IU) adjustment factors. For enrollees filling specialty drugs in plans where monthly cost-sharing requirements for the specialty drugs alone are high enough to satisfy the OOP maximum in the year, the postmandate IU factor was a blend of the baseline IU factor and the IU factor reflecting a plan with zero cost-sharing requirements. IU factors were blended based on the month in the year when enrollee OOP maximums would be satisfied using copay assistance–eligible specialty drug fills alone.
  - For postmandate estimates, utilization was not adjusted for plans where specialty drug cost-sharing requirements were not high enough to meet the OOP maximum. The baseline utilization was multiplied by a ratio of the postmandate IU factor divided by the baseline IU factor.
  - CHBRP assumes that some drug copay assistance and drug manufacturer coupons are currently being used to help patients with cost-sharing requirements for drugs administered in a medical setting. CHBRP assumes that this financial assistance is provided through reimbursements and therefore currently counts towards enrollees' cost-sharing requirements. See the *Policy Context* section for additional information about claims for drugs under the medical benefit.
- CHBRP assumed the total available drug manufacturer coupons available would increase if AB 2810, as amended. Pharmaceutical manufacturers would be incentivized to increase the number of coupons available — for both specialty drugs that had coupons at baseline and those that did not previously have coupons — to encourage the use of certain drugs.
- CHBRP also assumed that the total available funding for drug copay assistance would increase if AB 2180 as amended on April 10, 2024, were to be enacted. CHBRP considered that the following factors would influence drug copay assistance programs:
  - Pharmaceutical manufacturers would be encouraged to make charitable contributions to foundations that provide drug copay assistance. Pharmaceutical manufacturers would potentially benefit from these programs because they increase the market demand for drugs by addressing cost sharing.
  - Because drug copay assistance is provided by charitable organizations and the grants provided are typically tied to a disease state, these funds may be used for drugs from multiple pharmaceutical manufacturers. These funds may also be used in a medical setting. Therefore, while any single manufacturer may benefit from a charitable

[8] Induced utilization can be described as the additional demand for prescriptions created by an increased level of coverage in the plan/policy (AAA, 2008).

contribution, there is an indirect relationship between the total funding available for these programs and the benefit accrued to a specific manufacturer.

- For enrollees in plans with only copay accumulator programs in the plan design, CHBRP assumed that drug copay assistance and drug manufacturer coupons would apply only until enrollee OOP maximum cost-sharing requirements were satisfied through the combination of drug copay assistance and enrollee contributions, described above.
- Postmandate, it is assumed that copay assistance programs or payments made using drug manufacturer coupons would not assist HDHP enrollees with cost sharing until they have covered the first $1,600 of deductible expenses out of pocket. However, any amounts paid by drug copay assistance programs or using drug manufacturer coupons to non-HDHP enrollees or HDHP enrollees after the first $1,600 paid out of pocket would track toward the enrollee's deductible and OOP maximum.
- For enrollees enrolled in plans with copayment maximizer programs in the plan design, CHBRP assumed that drug copay assistance would first be used to satisfy enrollee cost-sharing requirements. Any drug copay assistance or coupon value remaining after enrollee cost-sharing requirements had been satisfied would be used to reduce plan expenses, net of an assumed 25% PBM fee charged to administer these programs.
    - CHBRP assumed that patient financial assistance (through drug manufacturer coupons or drug copay assistance) would apply only until enrollee OOP maximum cost-sharing requirements were satisfied by the sum of patient financial assistance payments used to satisfy cost-sharing requirements, enrollee cost-sharing contributions (described below), plus any patient financial assistance payments used to offset plan expenses.
- CHBRP assumed the average per enrollee per month (PMPM) allowed cost of total services would increase proportionally to the increase in utilization described above and did not assume a change in the average cost per service.

For further details on the underlying data sources and methods used in this analysis, see Appendix B.

# Baseline and Postmandate Benefit Coverage

Table 2 provides estimates of how many Californians have health insurance that would have to comply with AB 2180 as amended on April 10, 2024, in terms of benefit coverage.

**Table 2. Impacts of AB 2180 as Amended on April 10, 2024, on Benefit Coverage, 2025**

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| Total enrollees with health insurance subject to state-level benefit mandates (a) | 22,297,000 | 22,297,000 | 0 | 0.00% |
| Total enrollees with health insurance subject to AB 2180 (b) | 13,688,000 | 13,688,000 | 0 | 0.00% |
| Total enrollees with health insurance and outpatient prescription drug benefits impacted by AB 2180 | 13,162,000 | 13,162,000 | 0 | 0.00% |
| Total enrollees with health insurance, but without outpatient prescription drug benefits impacted by AB 2180 (c) | 526,000 | 526,000 | 0 | 0.00% |
| Total enrollees with coverage fully compliant with AB 2180 | 8,084,000 | 13,688,000 | 5,604,000 | 69.32% |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[9]
(b) Includes enrollees with commercial and CalPERS insurance with an outpatient prescription drug benefit. Excludes Medi-Cal beneficiaries in DMHC-regulated plans due to the pharmacy carveout through Medi-Cal Rx.
(c) CHBRP assumes health insurance without an outpatient prescription drug (pharmacy) benefit is compliant with AB 2180 as amended on April 10, 2024, at baseline.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

At baseline, 13,162,000 enrollees have an outpatient pharmacy benefit regulated by DMHC or CDI and therefore have health insurance that would be impacted by AB 2180. In addition, there are 526,000 enrollees at baseline with state-regulated health insurance that would otherwise be subject to AB 2180, but who do not have an outpatient pharmacy benefit; CHBRP assumed these enrollees' health insurance is compliant at baseline.

Postmandate, AB 2180 as amended on April 10, 2024, would result in approximately 5.6 million enrollees gaining coverage for the use of patient financial assistance (i.e., payments made using drug copay assistance and drug manufacturer coupons) counting toward their deductibles and OOP maximum out of 13.16 million enrollees with outpatient prescription drug benefits in commercial plans. This represents a 69.32% percent increase from baseline. Although AB 2180 does apply to coverage for Medi-Cal beneficiaries in DMHC-regulated plans, it would not have an impact due to the carve out of pharmacy benefits through the Medi-Cal Rx program.

# Baseline and Postmandate Utilization and Unit Cost

Below, Table 3 provides estimates of the impacts of AB 2180 as amended on April 10, 2024, on utilization and unit cost of specialty prescriptions and other pharmacy and medical expenses.

[9] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

### Table 3. Impacts of AB 2180 as Amended on April 10, 2024, on Utilization and Unit Cost, 2025

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| Number of impacted prescriptions filled (specialty prescriptions with drug copay assistance available or specialty prescriptions with drug manufacturer coupons available where generic option is not covered on a lower tier for enrollees in noncompliant plans) | 161,000 | 161,000 | - | 0.00% |
| Number of enrollees with impacted prescriptions filled in noncompliant plans | 15,800 | 15,800 | - | |
| Average unit cost of impacted prescriptions filled | $8,001 | $8,001 | $0 | 0.00% |
| Average third-party or manufacturer funding used to offset member cost-sharing requirements (total) | $1,005 | $629 | -$376 | -37.43% |
| Average drug copay assistance or drug manufacturer coupons used to reduce member cost-sharing requirement (but not tracked to deductible/OOP max) for impacted prescriptions filled | $1,005 | $0 | -$1,005 | -100.00% |
| Average drug copay assistance or drug manufacturer coupons used to reduce member cost-sharing requirement (and tracked to deductible/OOP max) for impacted prescriptions filled | $0 | $629 | $629 | 0.00% |
| Average member contribution towards cost-sharing requirement for impacted prescriptions filled | $251 | $87 | -$165 | -65.45% |
| Average drug copay assistance or drug manufacturer coupon used to offset plan costs beyond member cost sharing for impacted prescriptions filled | $24 | $0 | -$24 | -100.00% |
| Average net plan expense for impacted prescriptions filled | $6,721 | $7,285 | $565 | 8.40% |
| Additional expenditure from increased utilization due to lower cost sharing (a) | | $11,802,000 | $11,802,000 | |

**Source: California Health Benefits Review Program, 2024.**
Note: (a) Includes costs for nonspecialty drugs and other medical or pharmacy expenses once the enrollee meets their OOP max.
Key: OOP max = annual out-of-pocket maximum.

CHBRP estimates the number of specialty prescriptions filled that have drug copay assistance or have drug manufacturer coupons available (161,000), and the number of enrollees with impacted prescriptions filled in noncompliant plans (15,800) would not change due to AB 2180 as amended on April 10, 2024, in the first year. Similarly, the average unit cost of these specialty prescriptions of $8,001 would not change from baseline to postmandate. However, CHBRP estimates the amount of financial assistance from drug copay assistance programs and drug manufacturer coupons would decrease from $1,005 at baseline to $629 postmandate due to the increased likelihood that individual enrollees would hit their OOP

maximum earlier and would not use either type of financial assistance for the remainder of the year. Postmandate, third-party financial assistance from drug copay assistance programs and drug manufacturer coupons would contribute, on average, $629 to cost sharing that would be used to calculate total enrollee deductible spending and OOP maximum (Table 3). Overall, CHBRP anticipates net expenses for specialty drugs would increase for health plans and policies.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers. The amount of spending related to that additional utilization is discussed further below.

# Baseline and Postmandate Expenditures

Below, Table 4 provides estimates of the impacts of AB 2180 as amended on April 10, 2024, on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

### Table 4. Impacts of AB 2180 as Amended on April 10, 2024, on Expenditures, 2025

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| ***Premiums*** | | | | |
| Employer-sponsored (a) | $64,203,365,000 | $64,254,824,000 | $51,459,000 | 0.08% |
| CalPERS employer (b) | $6,974,311,000 | $6,975,209,000 | $898,000 | 0.01% |
| Medi-Cal (excludes COHS) (c) | $30,043,243,000 | $30,043,243,000 | $0 | 0.00% |
| ***Enrollee premiums*** | | | | |
| Enrollees, individually purchased insurance | $20,751,015,000 | $20,762,178,000 | $11,163,000 | 0.05% |
| Outside Covered California | $5,089,510,000 | $5,099,794,000 | $10,284,000 | 0.20% |
| Through Covered California | $15,661,505,000 | $15,662,384,000 | $879,000 | 0.01% |
| Enrollees, group insurance (d) | $20,397,418,000 | $20,415,076,000 | $17,658,000 | 0.09% |
| ***Enrollee out-of-pocket expenses*** | | | | |
| Cost sharing for covered benefits (deductibles, copays, etc.) | $15,689,351,000 | $15,655,279,000 | -$34,072,000 | -0.22% |
| Expenses for noncovered benefits (e) (f) | $835,000 | $835,000 | $0 | 0.00% |
| **Total expenditures** | $158,059,538,000 | $158,106,644,000 | $47,106,000 | 0.03% |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[10] 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) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to health insurance sponsored by an employer (or union or other organization), health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

For DMHC-regulated plans and CDI-regulated policies, AB 2180 as amended on April 10, 2024, would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered and/or noncovered benefits would decrease. This would result in an increase in total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

## Premiums

At the end of this section, Table 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present PMPM premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of AB 2180 as amended on April 10, 2024, would vary by market segment. Note that such changes are related to the number of enrollees (see Table 2, Table 5, and Table 6) with health insurance that would be subject to AB 2180 as amended on April 10, 2024.

Premium increases due to AB 2180 would be relatively lower in the DMHC-regulated commercial market than the CDI-regulated commercial market. Among DMHC-regulated plans, large-group and individual market premiums would increase by 0.05%, and CalPERS would increase by 0.01%. However, DMHC-regulated small-group premiums would increase by 0.18%. In the CDI-regulated market, the large-group market would face the smallest increase (0.21%), while individual (0.32%) and small group (0.27%) would have the highest increase across all markets.

## Enrollee Expenses

AB 2180–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and OOP expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 2, Table 5, and Table 6) with health insurance that would be subject to AB 2180 as amended on April 10, 2024, expected to use the relevant outpatient prescription drugs during the year after enactment.

AB 2180 would cause enrollees in CalPERS/commercial plans in all markets to pay less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a $0.06 reduction per member per month (PMPM) in enrollee expenses on the low end, with small-group DMHC-regulated enrollees experiencing a $0.71 decrease PMPM in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group ($1.43 decrease PMPM) and individual market ($1.25 decrease PMPM) plans would experience the greatest reduction, while large-group enrollees would experience $0.70 in reduced enrollee expenses PMPM on average. Enrollees with health insurance associated with CalPERS would have a reduction in enrollee expenses of approximately one cent PMPM. Overall, enrollee expenses would decrease by $34,072,000 across all markets (Table 4).

[10] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

### *Average enrollee out-of-pocket expenses per user*

The impact on enrollee OOP expenses would vary depending on the enrollee's plan design as well as the value of drug manufacturer coupons, and funding availability from the nonprofit organizations (i.e., drug manufacturer foundations and independent charities, that administer copay assistance programs [which may range from $2,000 to $10,000]). In general, enrollees in leaner plans receiving large grants would see the largest reductions in OOP expenses.

Due to the decreases in cost sharing, measurable impacts at the population level may occur if it results in increased adherence to a prescription drug.

The presence of a deductible not yet met for the year[11] could result in the enrollee paying the full unit cost; however, hitting the annual OOP maximum[12] would result in the enrollee having no further cost sharing.

## Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase 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. In this case, the infrastructure for tracking cost sharing already exists in the PBMs and specialty pharmacies.

# Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

## Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 4, Table 5, and Table 6), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2180 as amended on April 10, 2024.

## Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 2180 as amended on April 10, 2024.

[11] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.
[12] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (H&SC 1342.73; IC 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

## Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Commercial Plans (by Market) (a) | | | Publicly Funded Plans | | | Commercial Policies (by Market) (a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS (b)* | *Medi-Cal (Excludes COHS) (c)* | | *Large Group* | *Small Group* | *Individual* | Total |
| | | | | | *Under 65* | *65+* | | | | |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 7,864,000 | 2,161,000 | 2,378,000 | 894,000 | 7,791,000 | 818,000 | 293,000 | 62,000 | 36,000 | 22,297,000 |
| Total enrollees in plans/policies subject to AB 2180 | 7,864,000 | 2,161,000 | 2,378,000 | 894,000 | 0 | 0 | 293,000 | 62,000 | 36,000 | 13,688,000 |
| **Premiums** | | | | | | | | | | |
| Average portion of premium paid by employer (e) | $527.59 | $461.25 | $0.00 | $650.10 | $263.09 | $554.83 | $585.36 | $533.03 | $0.00 | $101,220,919,000 |
| Average portion of premium paid by enrollee | $138.26 | $193.80 | $716.04 | $133.99 | $0.00 | $0.00 | $215.50 | $174.12 | $736.61 | $41,148,433,000 |
| Total premium | **$665.85** | **$655.05** | **$716.04** | **$784.09** | **$263.09** | **$554.83** | **$800.87** | **$707.15** | **$736.61** | **$142,369,352,000** |
| **Enrollee expenses** | | | | | | | | | | |
| Cost sharing for covered benefits (deductibles, copays, etc.) | $48.82 | $146.52 | $209.79 | $56.41 | $0.00 | $0.00 | $119.25 | $246.95 | $203.25 | $15,689,351,000 |
| Expenses for noncovered benefits (f) | $0.00 | $0.01 | $0.01 | $0.00 | $0.00 | $0.00 | $0.01 | $0.01 | $0.01 | $835,000 |
| **Total expenditures** | **$714.67** | **$801.58** | **$925.83** | **$840.51** | **$263.09** | **$554.83** | **$920.13** | **$954.11** | **$939.87** | **$158,059,538,000** |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five (20.8%) of these enrollees has a pharmacy benefit not subject to DMHC.[13] 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) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[14]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

[13] For more detail, see CHBRP's resource *Estimates of Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at https://www.chbrp.org/other-publications/resources.
[14] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

(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 covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

## Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Commercial Plans (by Market) (a) | | | Publicly Funded Plans | | | Commercial Policies (by Market) (a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS (b)* | *Medi-Cal (Excludes COHS) (c)* | | *Large Group* | *Small Group* | *Individual* | Total |
| | | | | | *Under 65* | *65+* | | | | |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 7,864,000 | 2,161,000 | 2,378,000 | 894,000 | 7,791,000 | 818,000 | 293,000 | 62,000 | 36,000 | 22,297,000 |
| Total enrollees in plans/policies subject to AB 2180 | 7,864,000 | 2,161,000 | 2,378,000 | 894,000 | 0 | 0 | 293,000 | 62,000 | 36,000 | 13,688,000 |
| **Premiums** | | | | | | | | | | |
| Average portion of premium paid by employer (e) | $0.2565 | $0.8455 | $0.0000 | $0.0837 | $0.0000 | $0.0000 | $1.2068 | $1.4641 | $0.0000 | $52,357,000 |
| Average portion of premium paid by enrollee | $0.0672 | $0.3552 | $0.3552 | $0.0172 | $0.0000 | $0.0000 | $0.4443 | $0.4783 | $2.3804 | $28,821,000 |
| Total premium | $0.3237 | $1.2007 | $0.3552 | $0.1009 | $0.0000 | $0.0000 | $1.6511 | $1.9423 | $2.3804 | **$81,178,000** |
| **Enrollee expenses** | | | | | | | | | | |
| Cost sharing for covered benefits (deductibles, copays, etc.) | -$0.0567 | -$0.7086 | -$0.2158 | -$0.0112 | $0.0000 | $0.0000 | -$0.7009 | -$1.4282 | -$1.2514 | -$34,072,000 |
| Expenses for noncovered benefits (f) | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0 |
| Total expenditures | $0.2670 | $0.4921 | $0.1394 | $0.0897 | $0.0000 | $0.0000 | $0.9502 | $0.5141 | $1.1290 | **$47,106,000** |
| **Percent change** | | | | | | | | | | |
| Premiums | 0.0486% | 0.1833% | 0.0496% | 0.0129% | 0.0000% | 0.0000% | 0.2062% | 0.2747% | 0.3232% | 0.0570% |
| **Total expenditures** | 0.0374% | 0.0614% | 0.0151% | 0.0107% | 0.0000% | 0.0000% | 0.1033% | 0.0539% | 0.1201% | 0.0298% |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five (20.8%) of these enrollees has a pharmacy benefit not subject to DMHC.[15] 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) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

[15] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance,* available at www.chbrp.org/other-publications/resources.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[16]
(e) In some cases, a union or other organization – or Medi-Cal for its beneficiaries.
(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 covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[16] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

# Long-Term Impacts

CHBRP estimated the incremental impacts of AB 2180 as amended on April 10, 2024, for Year 2; results can be found in Appendix B.

## Long-Term Utilization and Cost Impacts

In the longer term, CHBRP anticipates that AB 2180 as amended on April 10, 2024, if enacted, would incentivize manufacturers to increase the number of coupons available for specialty drugs and to a lesser extent the funding to drug copay assistance programs through nonprofit organizations. Manufacturers would stand to benefit from increased coupons and drug copay assistance because by removing barriers to patient access to high-cost medications, manufacturers may increase the overall demand for specialty medications.

There is an existing process that could be applied more broadly to avoid implementation/enforcement of AB 2180. Currently, health plans and insurers remove specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary. They will still provide the drug through a specialty pharmacy based on medical necessity (which requires prior authorization). When a patient obtains the drug through that pharmacy, the accumulator- or maximizer-related discounts can be applied to make their copayment $0, but not be counted toward their deductible or out-of-pocket (OOP) maximum because it is off-formulary and is not considered a covered benefit. If AB 2180 were enacted, the use of this approach could increase to avoid oversight for drugs that can be provided off-formulary (e.g., if they have a substitute in a class of medication). This approach is used frequently in the self-insured market, but there are circumstances where a DMHC-regulated plan or CDI-regulated policy could use the same approach and still comply with state law. CHBRP cannot predict the degree to which health plans and insurers may choose this approach.

One key uncertainty that affects the potential impact of AB 2180 as amended on April 10, 2024, is the degree to which patients may be willing to switch to alternative therapies when presented with an opportunity to reduce OOP expenditures. Drug copay assistance and drug manufacturer coupons may influence patient behavior, as patients with financial assistance may be less likely to search for lower-cost, alternative treatment options. Furthermore, these programs may even minimize or eliminate cost sharing for all other medical services throughout the year if the OOP maximum is reached. The presence of these programs may have the long-term potential to encourage patients to continue a specific therapy even as less costly, equivalent therapies become available. Therefore, these programs may have the potential to increase overall unit costs for drugs over time.

CHBRP also considered the potential for pharmaceutical industry dynamics to reduce the overall volume of drug copay assistance programs and coupons. For example, biosimilar competition could potentially drive down drug prices and conceivably reduce overall demand for programs to help with patient cost sharing. Likewise, a decrease in list prices for drugs with high manufacturer rebates could have a similar impact.

Another significant consideration of the potential impact of AB 2180 is the degree to which the mandate impacts chronic disease versus terminal diseases. Due to the ongoing nature of treatments for chronic disease, the potential for higher utilization is greater for medications for chronic conditions than those for terminal diseases.

CHBRP also notes that AB 2180 may address inequalities because of the current consequences of cost sharing on low-income patients. At baseline, some patients may face financial hardships to receive needed treatments or even postpone treatment if nonprofit organizations have insufficient drug copay assistance to meet patient demand. Assuming AB 2180 as amended on April 10, 2024, leads to an influx of additional financial contributions from pharmaceutical manufacturers and other organizations to drug copay assistance programs, or an increase in the number of available drug manufacturer coupons, the mandate may benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower-income populations with commercial insurance.

In addition, postmandate, some patients may no longer be compelled to pay up front for their prescriptions, as AB 2180 as amended on April 10, 2024, eliminates the requirement to cover the deductible and OOP maximum for these patients, through either a coupon or drug copay assistance and a card processed by the PBM at the point of sale. This would benefit those who would otherwise suffer financial hardship, and may reduce health care disparities amongst lower-income populations with commercial insurance. In Year 2 (2026), CHBRP assumes that this factor would lead to increased utilization (see Appendix B for more details, including estimates of Year 2 expenditures). It stands to reason that in the long run, AB 2180 may improve the health status of patients who would not have otherwise received treatment.

# Appendix A. Text of Bill Analyzed

On April 19, 2024, the California Assembly Committee on Health requested that CHBRP analyze AB 2180, as amended on April 10, 2024.

AMENDED IN ASSEMBLY APRIL 10, 2024

CALIFORNIA LEGISLATURE— 2023–2024 REGULAR SESSION

**ASSEMBLY BILL**

**NO. 2180**

**Introduced by Assembly Member Weber**

**February 07, 2024**

An act to add Section 1367.0062 to the Health and Safety Code, and to add Section 10192.292 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2180, as amended, Weber. Health care coverage: cost sharing.

Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or ~~another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses~~ *a third-party patient assistance program, as defined,* toward the enrollee's or insured's ~~overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan contract or health insurance policy.~~ *cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness.* The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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**THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:**

**SECTION 1.** Section 1367.0062 is added to the Health and Safety Code, to read:

**1367.0062.** (a) (1) To the extent permitted by federal law, and consistent with Sections 132000 and 132002, a health care service plan or a pharmacy benefit manager that administers pharmacy benefits for a health care service plan shall apply any amounts paid by either the enrollee or third-party patient assistance program to the enrollee's cost-sharing requirement. This requirement shall be limited to only those enrollees who have a chronic disease or terminal illness.
*(2) When calculating an enrollee's overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health care service plan shall include expenditures for any item or service covered by the health care service plan, and include within a category of essential health benefits, as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health care service plan contract.*
~~(2)~~
*(3)* This section shall only apply with respect to health care service plan contracts issued, amended, delivered, or renewed on or after January 1, 2025.

(b) If under federal law, application of subdivision (a) would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of a policy after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this subdivision shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(c) This section does not apply with respect to self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

(d) For purposes of this section, the following definitions apply:

(1) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health care service plan contract. ~~When calculating an enrollee's overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health care service plan shall include expenditures for any item or service covered by the health care service plan, and include within a category of essential health benefits as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health care service plan contract.~~

(2) "Pharmacy ~~Benefit Manager"~~ *benefit manager"* means a person or business that administers the prescription drug or device program of one or more health care service plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

(3) "Third-party patient assistance program" shall include, but is not limited to, manufacturer or ~~other~~ charitable *cost-sharing or copay assistance* programs that provide financial assistance intended to ~~augment existing prescription drug coverage. "Third-party patient assistance program" does not include discounts, drug vouchers, or general manufacturer coupons.~~ *assist patients in paying their out-of-pocket cost-sharing obligations for prescription drugs. "Third-party patient assistance program" does not include discounts, product vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug.*

(4) “Chronic disease” is defined as conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.

(5) “Terminal illness” is defined as a medical condition that is life-limiting and expected to result in death.

**SEC. 2.** Section 10192.292 is added to the Insurance Code, to read:

**10192.292**. (a) (1) To the extent permitted by federal law, and consistent with Sections 132000 and 132002 of the Health and Safety Code, a health insurer or a pharmacy benefit manager that administers pharmacy benefits for a health insurer shall apply any amounts paid by either the insured, or third-party patient assistance program to the insured’s cost-sharing requirement. This requirement shall be limited to only those insureds who have a chronic disease or terminal illness.

*(2) When calculating an insured’s overall contribution to the annual limitation on cost sharing set forth in Sections 18022© and 300gg-6(b) of Title 42 of the United States Code, a health insurer shall include expenditures for any item or service covered by the health insurer, and include within a category of essential health benefits, as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health insurance policy.*

~~(2)~~

*(3)* This section shall only apply with respect to health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025.

(b) If under federal law, application of subdivision (a) would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of a policy after the insured has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this subdivision shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(c) This section does not apply with respect to self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

(d) For purposes of this section, the following definitions apply:

(1) “Cost-sharing requirement” means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health insurance policy. ~~When calculating an insured’s overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health insurer shall include expenditures for any item or service covered by the health insurer, and include within a category of essential health benefits as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health insurance policy.~~

(2) “Pharmacy ~~Benefit Manager”~~ *benefit manager”* means a person or business that administers the prescription drug or device program of one or more health insurance policies on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

(3) “Third-party patient assistance program” shall include, but is not limited to, manufacturer or ~~other~~ charitable *cost-sharing or copay assistance* programs that provide financial assistance intended to ~~augment existing prescription drug coverage. “Third party patient assistance program” does not include discounts, drug vouchers or general manufacturer coupons.~~ *assist patients in paying their out-of-pocket cost-sharing obligations for prescription drugs. “Third-party patient assistant program” does not include discounts, product vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug.*

(4) “Chronic disease” is defined as conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.

(5) “Terminal illness” is defined as a medical condition that is life-limiting and expected to result in death.

**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. Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[17] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impact analyses are available on CHBRP's website.[18]

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

## Analysis-Specific Data Sources

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act that include coverage of outpatient prescription drugs.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage that is already compliant with AB 2180. For carriers who did not respond to the survey, results from the 2023 survey of AB 874 were used as this mandate had a similar impact on copay adjustment programs (CHBRP, 2023).

Current coverage of specialty prescription drugs that is compliant with AB 2180 for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 87% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS plans were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies.

For this analysis, CHBRP relied on Current Procedural Terminology (CPT®) codes to identify relevant services: CPT copyright 2022 American Medical Association (AMA). All rights reserved. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the AMA.

### Health Cost Guidelines

The Health Cost Guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.

[17] CHBRP's authorizing statute, available at www.chbrp.org/about/faqs, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[18] See method documents posted at www.chbrp.org/about/analysis-methodology/cost-impact-analysis; in particular, see *Cost Analyses: Data Sources, Caveats, and Assumptions*.

- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small-group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures; inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

## Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

# Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

## Methodology and Assumptions for Baseline Utilization

### *Prescription drugs*

Prescription drugs relevant to the bill included those used in drug copay assistance programs and those with eligible drug manufacturer coupons.

#### Drug copay assistance programs

- CHBRP assumed that drug copay assistance programs are for medications with an average monthly cost of at least $3,000.
- CHBRP determined the number of specialty prescriptions filled per 1,000 commercially insured enrollees based on Milliman's proprietary 2022 Consolidated Health Cost Guidelines™ Sources Database. The definition of specialty used for the analysis of AB 2180 is described in the *Benefit Coverage, Utilization, and Cost Impacts* section.
- Table 7 shows the proportion of specialty drugs that CHBRP assumed would have drug copay assistance available in each time period.

### Table 7. Specialty Drugs With Copay Assistance, 2025 and 2026

| Time Period | Baseline | Postmandate |
|---|---|---|
| Year 1 (2025) | 20% | 20% |
| Year 2 (2026) | 24% | 25% |

**Source: California Health Benefits Review Program, 2024.**

- The rate of prescriptions filled per 1,000 commercially insured enrollees was trended from 2022 to 2025 or 2026 (year 1 and year 2 impacts, respectively; see Table 8) using the annual utilization trends for specialty drugs (Table 9), which are based on the 2022-2024 Commercial HCG trend assumptions.

### Table 8. Annual Prescription Utilization Rate Trends, 2022-2026

| Time Period | Prescriptions/1,000 Commercially Insured Enrollees Trend |
|---|---|
| 2022 to 2023 | 7.0% |
| 2023 to 2024 | 6.5% |
| 2024 to 2025 | 6.5% |
| 2025 to 2026 | 6.5% |

**Source: California Health Benefits Review Program, 2024; Commercial HCGs, 2022-2024.**

Table 9 includes the specialty drug classes on which the annual utilization trends were based for Table 8.

### Table 9. Top Therapeutic Classes with Specialty Prescription Drug Fills in California

| Therapeutic Class |
|---|
| 1. Analgesics - Anti-Inflammatory |
| 2. Dermatologicals |
| 3. Antineoplastics and Adjunctive Therapies |
| 4. Antivirals |
| 5. Psychotherapeutic and Neurological Agents |
| 6. Endocrine and Metabolic Agents |
| 7. Hematological Agents |
| 8. Respiratory Agents |
| 9. Cardiovascular Agents |
| 10. Gastrointestinal Agents |

**Source: California Health Benefits Review Program, 2024; Commercial HCGs, 2022-2024.**

### Drug manufacturer coupons

- Prescription drugs with available coupons were identified using historical claims experience from a large employer group. Drugs with other sources of payment identified (beyond member contribution to cost sharing and plan payments) were assumed to be included in drug manufacturer coupon programs. The generic product identifiers (GPI) from these prescription fills were used to generate a list of national drug codes (NDCs) corresponding to drugs offering coupons. Brand-name drugs with generic equivalents were identified using the Medi-Span Master Drug Data Base (MDDB). Biologic drugs with biosimilars were identified using the U.S. Food and Drug Administration (FDA) list found at https://www.fda.gov/drugs/biosimilars/biosimilar-product-information (based on information available as of April 24, 2024)
- CHBRP estimated the number of 30-day equivalents filled per 1,000 commercially insured enrollees based on Milliman's proprietary 2022 Consolidated Health Cost Guidelines™ Sources Database. Each fill was categorized as generic, brand, or specialty based on the Milliman Health Cost Guidelines™ (HCG) classification. Each fill was also categorized as being a coupon drug or a noncoupon drug based on the NDCs identified as described above.
- The 30-day equivalent fills per 1,000 rates were trended from 2022 to 2025 or 2026 (year 1 and year 2 impacts, respectively) using the annual utilization trends for specialty drugs (Table 8), which are based on the 2022-2025 Commercial HCG trend assumptions.
- CHBRP assumed that pharmaceutical manufacturers would provide coupons up to 20% of the ingredient cost of the drug (marketed as a flat rate, or fixed dollar amount).
- Specialty drugs were identified by Milliman HCGs for both biologic and nonbiologic drugs with drug manufacturer coupons.
  - CHBRP assumed that all biologic drugs with a biosimilar have a generic and also that the biosimilars themselves are deemed to have a generic equivalent.
  - Biologic drugs with coupons were included if they met both the following criteria:
    - Any drug that has a biosimilar, and
    - The biosimilar is either not covered or is covered on the same formulary tier as the reference drug.
  - Nonbiologic drugs with coupons were included if they met both the following criteria:
    - Any drug that has a generic equivalent, and
    - The generic drug is either not covered or is covered on the same formulary tier as the reference drug.
- CHBRP assumed that 50% of prescription drugs (both biologic and nonbiologic) with coupons and a generic equivalent have a generic drug covered on a lower tier of the formulary, and would not be impacted by AB 2180 as amended on April 10, 2024, due to existing restrictions on drug manufacturer coupons in California law. See the *Policy Context* section for more details.

## *Prescription drugs in a medical setting*

- CHBRP assumed that no prescription drugs administered in a medical setting would be impacted by AB 2180. While the grants available from nonprofits and drug manufacturer coupons would be available to cover drugs administered in a medical setting, it is generally not possible for these drugs to be subject to copayment adjustment programs because these claims are not typically submitted to pharmacy benefit managers (PBMs) or to the specialty pharmacy associated with the PBM. Therefore, currently, all grants and other charitable assistance provided for drugs administered in a medical setting, and payments made using coupons for these drugs, already count towards deductibles and out-of-pocket (OOP) maximums.
- As described in the *Long-Term Impacts* section, CHBRP anticipates that drug copay assistance and the number of available drug manufacturer coupons would increase over time. Therefore, drugs administered in a medical setting would have increased available financial assistance for them, thereby reducing enrollee cost sharing indirectly. CHBRP has not estimated this indirect impact of AB 2180 as amended on April 10, 2024.

# Methodology and Assumptions for Baseline Cost

## *Prescription drugs*

- CHBRP estimated the average cost per prescription based on Milliman's proprietary 2022 Consolidated Health Cost Guidelines™ Sources Database. The definition of specialty used for the analysis of AB 2180 is described in the *Benefit Coverage, Utilization, and Cost Impacts* section.
- The average costs per prescription were trended from 2022 to 2025 or 2026 (year 1 and year 2 impacts, respectively) using the annual cost trends summarized below, which are based on the 2022-2025 Commercial HCG trend assumptions.

**Table 10. Annual Cost Trends, 2022-2026**

| Time Period | Cost/Prescription Trend |
|---|---|
| 2022 to 2023 | 1.5% |
| 2023 to 2024 | 2.5% |
| 2024 to 2025 | 3.5% |
| 2025 to 2026 | 3.5% |

**Source: California Health Benefits Review Program, 2024; Commercial HCGs 2022-2024.**

## *Total services – PMPM total allowed cost*

- Baseline per member per month (PMPM) medical expenses were measured using the results of commercial and CalPERS surveys. The premium amounts provided by carriers were reduced by the reported administrative and profit loads to determine the expected annual plan covered expenses. The plan covered expenses were increased by the reported average enrollee cost sharing amounts to determine the average allowed total expenses on a PMPM basis.
- Total expenses PMPM were trended from 2022 to 2025 using historical market-specific trends and projected assumptions based on historical patterns.

# Methodology and Assumptions for Baseline Cost Sharing

CHBRP assumed that cost-sharing requirements for both prescription drug and medical services were the same as the average cost sharing for all services covered under major medical policies. Cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost of the service. For medical services, it is assumed that the enrollee is responsible for the total cost-sharing requirement. For enrollees in high deductible health plans (HDHPs), cost sharing is assumed to be 100% of expenses until the deductible is satisfied and the average cost-sharing rate for expenses incurred after the deductible is satisfied.

For enrollees in noncompliant policies offering outpatient prescription drug benefits, CHBRP assumed that 50% were enrolled in copay accumulator programs only and 50% were enrolled in combination copay accumulator and copay maximizer programs at baseline. The enrollee cost-sharing requirements for these two programs were not assumed to differ.

CHBRP assumed that HDHP plans that were HSA-eligible pre-mandate would make the necessary changes to be HSA-eligible postmandate. That is, copay assistance programs or payments made using drug manufacturer coupons would not assist HSA-eligible HDHP enrollees with cost sharing until they have covered the first $1,600 of deductible expenses out of pocket. However, any amounts paid by drug copay assistance programs or using drug manufacturer coupons to non-

HDHP enrollees or HSA-eligible HDHP enrollees after the first $1,600 paid out of pocket would track toward the enrollee's deductible and OOP maximum.

## Methodology and Assumptions for Postmandate Utilization

### *Drug copay assistance programs*

CHBRP assumes that in the first year of enactment, there would be increased overall funding available through nonprofits for drug copay assistance as charitable foundations and manufacturer-sponsored foundations recognize that their programs would be more effective at reducing patient OOP costs. The number of prescriptions filled that would be impacted by AB 2180 was determined by CHBRP based upon a review and consideration of the following sources of information:

- Publicly available financial statements from nonprofit organizations;
- The sources of insurance coverage for patients receive such grants;
- The requirements to receive drug copay assistance;
- The process by which patients submit and receive drug copay assistance; and
- Reforms under the Inflation Reduction Act that would reduce patient cost sharing for Medicare beneficiaries, thereby increasing the available funding for commercial enrollees.

Although CHBRP assumed that while the overall funding level would increase in the first year, it would not lead to an increase in the total number of specialty prescriptions in the first year. This is because CHBRP assumed there would be no change in patient behavior in the first year of enactment. Patients may not recognize that they have been impacted by a copay adjustment program until later in the year when their grant for drug copay assistance is exhausted and they are subject to cost sharing. Also, because there are a variety of funding sources other than drug copay assistance (such as drug manufacturer coupons) subject to copay adjustment programs, CHBRP anticipates that in the first year stakeholders may be slow to change behavior. The baseline in Table 2, Table 3, and Table 4 presents the number of impacted prescriptions with the overall estimated increase in funding because there is no change in the estimated number of prescriptions. While the analysis shows a reduction in drug copay assistance for each impacted prescription filled (Table 3) this is more than offset by the overall estimated increase in funding for these programs and estimates of the number of impacted prescriptions.

Because AB 2180 would allow drug copay assistance programs to increase their effectiveness in terms of reducing patient cost sharing, these nonprofit organizations would potentially be able to serve a greater number of patients with the same level of funding.

### *Drug manufacturer coupons*

- CHBRP assumed that the utilization of 30-day equivalent fills per 1,000 commercially insured enrollees for specialty drugs that are eligible for coupons would not increase postmandate.

### *General*

CHBRP also assumed that some enrollees may utilize drug manufacturer coupons and may also be eligible for, and utilize, drug copay assistance. To avoid overcounting the incremental impact of the bill, a dampening effect of 10% was applied to the total number of estimated enrollees that would be impacted.

Increases in the second year are discussed in the Second-Year Utilization and Unit Cost section below.

## Methodology and Assumptions for Postmandate Cost

### *Prescription drugs*

- CHBRP assumed the average cost per prescription would not change as a result of AB 2180.

### *Total services – PMPM total allowed cost*

- CHBRP assumed the average PMPM allowed cost of total services would increase proportional to the increase in utilization described above and did not assume a change in the average cost per service.

## Methodology and Assumptions for Postmandate Cost Sharing

The approach for cost sharing is discussed in the Analytic Approach and Key Assumptions section above.

CHBRP assumed that approximately $0.8M was paid through drug copay assistance programs funded by the State of California or charities to help enrollees cover the cost of noncovered drugs. These payments are understood to occur outside of the insurance market to pay for benefits without existing coverage and are not subject to this mandate. This amount is shown in Table 4 under “Expenses for noncovered benefits.” Because these payments occur outside of insurance, there would be no change to these amounts.

The OOP maximum is handled independently in determining the impact of coupon and drug copay assistance programs on specialty prescription drug costs and total enrollee costs. Because enrollees may receive more than one medication with coupons or drug copay assistance, the accumulation of these fills in combination with their use of other prescription drugs and medical services may cause the enrollee to exceed the out-of-pocket maximum at a faster rate than implied by this analysis. This analysis does not account for the interaction between the services and could overstate the cost-sharing thereby understating premium impact.

CHBRP did not assume enrollees would switch plans as a result of this mandate. However, some enrollees taking drugs with coupons or drug copay assistance who have multiple plan options available may select plans with leaner benefits and lower premiums, if coupons will satisfy some or all of their cost-sharing requirements. This behavioral change could cause a rise in overall premiums beyond the increase reflected in this report.

# Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by 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 have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers 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 that there were no substantive differences.

# Second-Year Impacts on Benefit Coverage, Utilization, and Cost

To develop Tables 11 through 13, CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 2180 as amended on April 10, 2024, would have a substantial impact on the utilization of either specialty drugs for which coverage was directly addressed, the utilization of any indirectly affected drug, or both. To generate these tables, CHBRP reviewed the literature, consulted content experts about the possibility of varied second-year impacts, and applied what was learned to a projection of a second year of implementation.

Some differences in expenditures and utilization are due to population changes between 2025 and 2026. Other differences are due to increased availability of coupons, increased funding for drug copay assistance, and the tendency for patients to utilize more specialty prescription drugs. As discussed above, because drug copay assistance and payments using drug manufacturer coupons would always count toward deductibles and OOP maximums postmandate, there may be more overall patients obtaining treatments from high-cost specialty drugs. There may also be fewer patients discontinuing treatment. Overall, CHBRP anticipates there would be an increase in the number of specialty prescriptions filled.

# Second-Year Benefit Coverage

Below, Table 11 provides estimates of how many Californians have health insurance that would have to comply with AB 2180 in terms of benefit coverage during 2026.

### Table 11. Impacts of AB 2180 as Amended on April 10, 2024, on Benefit Coverage, 2026

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| Total enrollees with health insurance subject to state benefit mandates (a) | 22,310,000 | 22,310,000 | 0 | 0.00% |
| Total enrollees with health insurance subject to AB 2180 (b) | 13,703,000 | 13,703,000 | 0 | 0.00% |
| Total enrollees with health insurance and outpatient prescription drug benefits impacted by AB 2180 | 13,177,000 | 13,177,000 | 0 | 0.00% |
| Total enrollees with health insurance, but without outpatient prescription drug benefits impacted by AB 2180 (c) | 526,000 | 526,000 | 0 | 0.00% |
| Number of enrollees with health insurance fully compliant with AB 2180 | 8,094,000 | 13,703,000 | 5,609,000 | 69.30% |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[19]
(b) Includes enrollees with commercial and CalPERS insurance with an outpatient prescription drug benefit. Excludes Medi-Cal beneficiaries in DMHC-regulated plans due to the pharmacy carveout through Medi-Cal Rx.
(c) CHBRP assumes health insurance without an outpatient prescription drug (pharmacy) benefit are compliant with AB 2180 as amended on April 10, 2024, at baseline.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[19] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

Postmandate, AB 2180 as amended April 10, 2024, would result in approximately 5.61 million enrollees gaining coverage for the use of patient financial assistance (i.e., payments made using drug copay assistance and drug manufacturer coupons) counting toward their deductibles and OOP maximum out of 13.18 million enrollees with outpatient prescription drug benefits in commercial plans.

# Second-Year Utilization and Unit Cost

Below, Table 12 provides second-year estimates of the impacts of AB 2180 on utilization and unit cost of specialty prescriptions and other pharmacy and medical expenses.

**Table 12. Impacts of AB 2180 as Amended on April 10, 2024, on Utilization and Unit Cost, 2026**

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| Number of impacted prescriptions filled (specialty prescriptions with drug copay assistance available or specialty prescriptions with drug manufacturer coupons available where generic option is not covered on a lower tier for enrollees in noncompliant plans) | 196,000 | 203,000 | 7,000 | 3.57% |
| Number of enrollees with impacted prescriptions filled in noncompliant plans | 18,100 | 18,700 | 600 | |
| Average unit cost of impacted prescriptions filled | $8,281 | $8,281 | $0 | 0.00% |
| Average third-party or manufacturer funding used to offset member cost sharing requirements (total) | $1,008 | $640 | -$368 | -36.48% |
| Average drug copay assistance or drug manufacturer coupons used to reduce member cost-sharing requirement (but not tracked to deductible/OOP max) for impacted prescriptions filled | $1,008 | $0 | -$1,008 | -100.00% |
| Average drug copay assistance or drug manufacturer coupons used to reduce member cost-sharing requirement (and tracked to deductible/OOP max) for impacted prescriptions filled | $0 | $640 | $640 | 0.00% |
| Average member contribution towards cost-sharing requirement for impacted prescriptions filled | $269 | $89 | -$180 | -66.83% |
| Average drug copay assistance or drug manufacturer coupons used to offset plan costs beyond member cost sharing for impacted prescriptions filled | $31 | $0 | -$31 | -100.00% |
| Average net plan expense for impacted prescriptions filled | $6,973 | $7,551 | $578 | 8.30% |
| Additional expenditure from increased utilization due to lower cost sharing (h) | | $14,409,000 | $14,409,000 | |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) Includes costs for nonspecialty drugs and other medical or pharmacy expenses once the enrollee meets their OOP maximum.
Key: OOP max = annual out-of-pocket maximum.

As discussed above, the number of specialty prescriptions filled that have drug copay assistance or a drug manufacturer coupon (196,000 prescriptions) would be anticipated to increase (to 203,000 prescriptions) due to AB 2180 in the second year. The number of enrollees that fill prescriptions that are impacted by the bill due to the bill postmandate (18,100 enrollees) would also increase (to 18,700 enrollees).

The average unit cost per impacted prescription drug ($8,281) would not change from baseline to postmandate although it would be anticipated to increase from the first year ($8,001) to the second year. The relationship between funding for specialty drugs for drug copay assistance and drug manufacturer coupons, enrollee cost sharing, and plan expenses would be similar to the first year. Overall, patient cost sharing and financial assistance from drug copay assistance and coupons would be expected to decrease while plan expenses increase as a result of AB 2180. Drug copay assistance and coupons would decrease as less funding is required to cover patient cost sharing postmandate because these funds would count towards deductible and OOP maximums. Overall, net expenses for specialty drugs would increase for health plans and policies.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers. The amount of spending related to that additional utilization is discussed below.

# Second-Year Expenditures

Below, Table 13 provides second-year estimates of the impacts of AB 2180 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits. Overall, second-year expenditures would be anticipated to be much higher than first-year expenditures.

**Table 13. Impacts of AB 2180 as Amended on April 10, 2024, on Expenditures, 2026**

| | Baseline | Postmandate | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| ***Premiums*** | | | | |
| Employer-sponsored (a) | $67,494,395,000 | $67,592,132,000 | $97,737,000 | 0.14% |
| CalPERS employer (b) | $7,435,629,000 | $7,438,448,000 | $2,819,000 | 0.04% |
| Medi-Cal (excludes COHS) (c) | $31,005,921,000 | $31,005,921,000 | $0 | 0.00% |
| ***Enrollee premiums*** | | | | |
| Enrollees, individually purchased insurance | $22,437,582,000 | $22,467,940,000 | $30,358,000 | 0.14% |
| Outside Covered California | $5,421,372,000 | $5,438,251,000 | $16,879,000 | 0.31% |
| Through Covered California | $17,016,210,000 | $17,029,689,000 | $13,479,000 | 0.08% |
| Enrollees, group insurance (d) | $21,469,949,000 | $21,503,075,000 | $33,126,000 | 0.15% |
| ***Enrollee out-of-pocket expenses*** | | | | |
| Cost sharing for covered benefits (deductibles, copays, etc.) | $16,690,545,000 | $16,647,632,000 | -$42,913,000 | -0.26% |
| Expenses for noncovered benefits (e) (f) | $1,028,000 | $1,028,000 | $0 | 0.00% |
| **Total expenditures** | $166,535,049,000 | $166,656,176,000 | $121,127,000 | 0.07% |

**Source: California Health Benefits Review Program, 2024.**
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five (20.8%) of these enrollees has a pharmacy benefit not subject to DMHC.[20] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its enrollees (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to health insurance sponsored by an employer (or union or other organization), health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

For DMHC-regulated plans and CDI-regulated policies, AB 2180 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered and/or noncovered benefits would decrease. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

[20] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

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# About CHBRP

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

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 researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, 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. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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

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