CHBRP

January 7, 2026

The Honorable Mia Bonta
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

The Honorable Sabrina Cervantes
Chair, Senate Appropriations Committee
1021 O Street, Suite 7620
Sacramento, CA 95814

The Honorable Caroline Menjivar
Chair, Senate Health Committee
1021 O Street, Room 6630
Sacramento, CA 95814

The Honorable Buffy Wicks
Chair, Assembly Appropriations Committee
1021 O Street, Suite 8140
Sacramento, CA 95814

Re: Requested Letter to the 2025-26 California State Legislature on Assembly Bill 298: Cost Sharing as Amended on January 5, 2026

Dear Chairs Bonta, Menjivar, Cervantes, and Wicks:

The California Health Benefits Review Program (CHBRP) was asked by Assembly Health Committee staff to provide a letter regarding Assembly Bill (AB) 298, Cost Sharing as amended on January 5, 2026. CHBRP submitted an analysis of the bill in March of 2025 based on the bill as amended on March 4, 2025. This letter details the differences between the two bill versions and provides an updated fiscal estimate based on the amendments made to the bill. Appendix A contains detailed revised Benefit Coverage, Utilization, and Cost estimates and tables.

Bill Language

As amended on January 5, 2026, AB 298 would prohibit large group and California Public Employees' Retirement System (CalPERS) plans and policies regulated by the California Department of Managed Care (DMHC) and California Department of Insurance (CDI) from imposing a deductible, coinsurance, copayment, and other cost sharing for covered in-network services provided to enrollees younger than 21 years.

For high deductible health plans (HDHPs) that qualify for health savings accounts (HSAs), AB 298 would prohibit the application of:

- A deductible, coinsurance, copayment, or other cost sharing for preventive care services, as defined at Section 223(c)(2) of Title 26 of the United States Code, provided to enrollees younger than 21 years; and

- Coinsurance, copayment, or other cost sharing for services provided to enrollees younger than 21 years once the deductible has been met.

The only difference between the two versions of the bill is the impacted coverage group.[1] The March 4, 2025 version of the bill, as analyzed by CHBRP, would have applied more broadly to all market segments of DMHC-regulated plans and CDI-policies, including those in the individual and small-group market. Medi-Cal does not have enrollee cost sharing and was already in compliance with AB 298 as amended on March 4, 2025.

Context

Cost can be a barrier to accessing care, even among people with health insurance coverage. In 2022, 7.4% of Californians younger than 21 years of age delayed or did not get medical care, and over one-third (37%) of them listed cost, lack of insurance, or other insurance-related issues as the reason (CHIS, 2022).

The cost of health insurance for covered workers has continued to increase, with the average premium for family coverage in employer sponsored plans increasing by 26% over the last five years (KFF, 2025). In addition to monthly premiums, enrollees of commercial and CalPERS plans have some level of out-of-pocket cost obligations for care due to the cost sharing tied to their plan or policy. Cost sharing includes deductibles — which is the amount enrollees must meet before the insurer begins to cover the cost of services — as well as coinsurance and/or copayments. After an enrollee meets the deductible, they usually still have copayments and coinsurance obligations for covered services until the out-of-pocket maximum is met. High deductible health plans (HDHPs) pair a deductible — of at least $1,700 for an individual and $3,400 for a family in 2026 — with a lower monthly premium.[2] These plans can be used with health savings accounts (HSAs) if they meet certain federal requirements.

State and federal law requires certain recommended preventive services to be covered without cost sharing by state-regulated plans and policies, including in HSA-qualified HDHPs. For other in-network covered services, plan design would determine the level and amount of cost sharing for enrollees. The impact of cost sharing on utilization can depend on the type of care. For instance, inpatient care has a minimal response to changes in cost sharing, whereas patients may delay or forgo behavioral health care due to cost. While care for persons younger than 21 years is often centered around regular, preventive care, these enrollees also have acute and chronic health care needs for which utilization can be influenced by cost (see CHBRP's previous analysis of AB 298 for greater detail).

Analytic Approach

CHBRP's approach to estimate the impact of AB 298 as amended on January 5, 2026 is similar to the original analysis published on March 30, 2025 (see Appendix B of CHBRP's previous analysis). In this updated analysis, only state-regulated large group and CalPERS health maintenance organization (HMO) populations, premiums, and cost sharing are included and modeled; impacts to the individual and small-group markets or Medi-Cal are not shown given that they are not subject to AB 298 as amended on January 5, 2026. The population, premiums, and cost sharing impacts shown in this letter have been updated to use 2027 population and premium estimates that were projected using CHBRP's 2025 California Coverage and Cost Model. As additional data becomes available and the model is updated, CHBRP's underlying 2027 premium and enrollment projections for bill analyses conducted later in 2026 may change.

Updates in Expenditure Impacts

CHBRP estimates that AB 298, as amended on January 5, 2026, would increase premiums for the state-regulated large group market and CalPERS plans by $710,970,000 across employers and enrollees, while decreasing enrollee out-of-pocket cost sharing expenses by $293,682,000.

[1] As with the March 4, 2025 version of the bill, the bill applies to covered medical services; outpatient pharmacy and durable medical equipment costs are not subject to cost sharing restrictions under AB 298.
[2] IRS Revenue Procedure 2025-19.

- In the large group market, employer premiums would increase by $495,102,000 (0.84%) and enrollee contributions towards premiums would increase by $132,152,000 (0.85%).

- For CalPERS HMO plans, employer premiums would increase by $70,141,000 (0.83%) and enrollee contributions towards the premiums would increase by $13,575,000 (0.83%).

Premium increases postmandate stem from three factors: increase in utilization (accounting for 50% of the premium increase), shift in cost sharing from point-of-service to premiums (41%), and administrative costs (8%).

Overall, this estimate is lower than CHBRP's previous estimated fiscal impact based on AB 298 as amended on March 4, 2025, which estimated an increase in employer, employee, and individual premiums by $1,405,405,000 for 2026, and a decrease in enrollee cost sharing for covered benefits by $694,205,000. The prior version of the bill applied to all DMHC-regulated plans and CDI-regulated policies, while the version of AB 298 as amended on January 5, 2026 applies to plans and policies in the large group market and CalPERS subject to state regulation. See Appendix A of this letter for additional details on the utilization and expenditure estimates of AB 298 as amended on January 5, 2026.

Public Health Impacts

CHBRP finds that AB 298, as amended, would increase utilization of services in large group and CalPERS plans and policies subject to state regulation, consistent with the prior analysis of AB 298.

As described in the prior analysis of AB 298, reduced cost sharing is associated with increased use of certain services and treatments, such as well-child visits, vaccinations, and diabetes monitoring and routine care. Notably, since well-child visits, routine immunizations, diabetes screening, and other types of routine care are considered preventive care, they currently are not subject to any cost sharing under federal and state law, and therefore associated cost-sharing requirements would not change postmandate.[3] Given that AB 298 does not impact application of deductibles in HSA-qualified HDHPs for nonpreventive care, utilization increases may be less amongst enrollees in HSA-qualified HDHPs.

To the extent that increased utilization results in improved health outcomes, there would be a public health impact within the large group and CalPERS market subject to state regulation.

CHBRP's faculty and staff appreciate the opportunity to provide this analysis, and we will be happy to respond to any of your questions.

Sincerely,

Garen L. Corbett, MS
Director
California Health Benefits Review Program

[3] Under IRS rules, HSA-qualified HDHPs are permitted to provide coverage for certain defined preventive services, including diabetes treatments such as insulin and continuous glucose monitors, without the application of the deductible. See IRS Notice 2024-75 and 2024-71.

Appendix A. Benefit Coverage and Cost Impacts

This appendix provides details related to the fiscal analysis of AB 298 as amended on January 5, 2026. For further information on the methods used in this analysis, refer to CHBRP's analysis of AB 298 published on March 30, 2025 (see Appendix B).

Benefit Coverage

All DMHC-regulated plans and CDI-regulated policies in the large group market have some cost sharing associated with medical benefits, and therefore are not currently compliant with AB 298. CHBRP estimates that at baseline, 9,235,000 Californians are enrolled in such state-regulated insurance subject to AB 298; approximately 2,588,000 of those enrollees are younger than 21 years. Among enrollees under 21 years, most (2,425,000) are in state-regulated large group commercial plans and policies and CalPERS plans that are not HSA-qualified. Meanwhile, 163,000 enrollees younger than 21 years are in large group commercial HSA-qualified HDHPs regulated by DMHC or CDI.

Postmandate, 100% of enrollees in commercial large group and CalPERS DMHC-regulated plans and CDI-regulated policies would have health insurance compliant with AB 298.

Utilization and Unit Cost

Postmandate, eliminating cost sharing for enrollees younger than 21 years would increase utilization of medical services overall (Table 1). In large groups plans or policies that are HSA-qualified HDHPs, the average per member per month (PMPM) charges across all enrollees of all ages would increase by 0.38% ($2.32). For enrollees in large group and CalPERS plans and policies that are not HSA-qualified, the estimated increase in PMPM charges for all ages would be 0.47% ($3.30) postmandate.

Table 1. Impacts of AB 298 on Utilization and Average PMPM Charges, 2027

	Baseline (2027)	Postmandate Year 1 (2027)	Increase/ Decrease	Percentage Change
Large group HSA-qualified HDHPs				
Number of enrollees under 21 in HSA Qualified Plans	163,000	163,000	0	0.00%
Average allowed PMPM for all ages in HSA Qualified Plans	$608.33	$610.65	$2.32	0.38%
Large group Non-HSA plans and policies and CalPERS plans				
Number of enrollees under 21 in non-HSA Qualified Plans and Policies	2,425,000	2,425,000	0	0.00%
Average allowed PMPM for all ages in non-HSA Qualified Plans	$705.18	$708.48	$3.30	0.47%

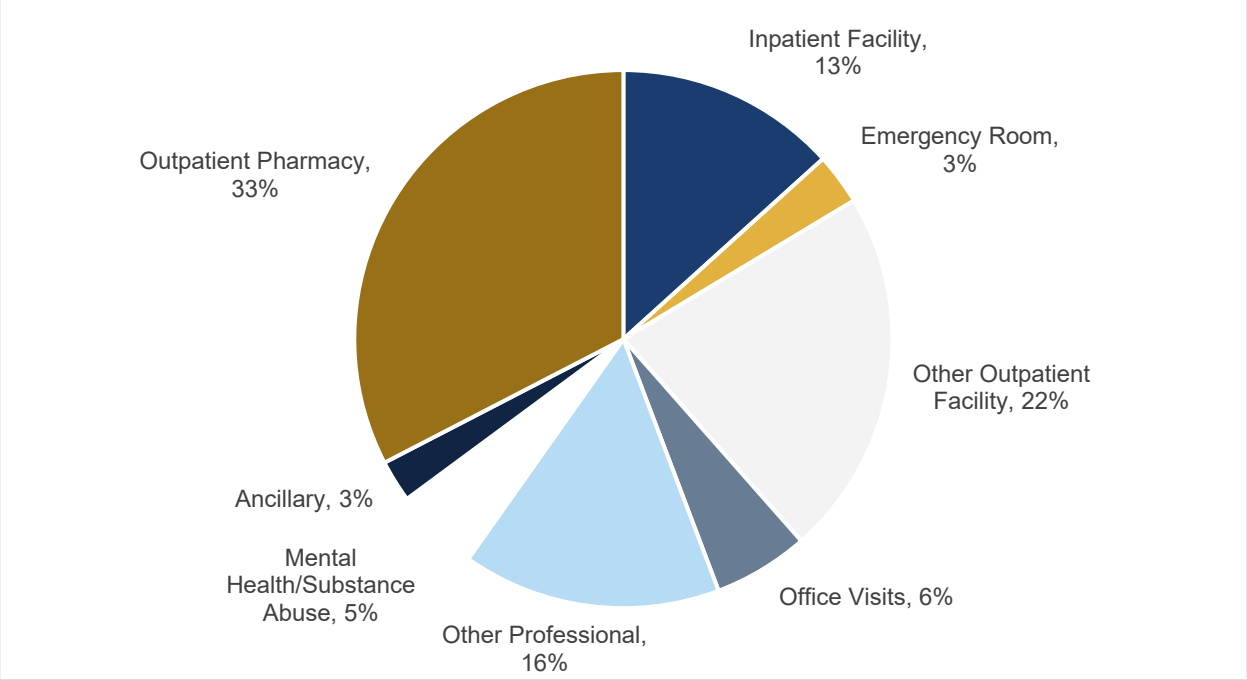
Source: California Health Benefits Review Program, 2025.
Key: CalPERS = California Public Employees' Retirement System; HSA = health savings account; HDHP = high deductible health plan; PMPM = per member per month.

Baseline Distribution of Cost by Types of Services in a Sample Large Group Plan

To better illustrate the services to which AB 298 would apply and how that may impact utilization and cost, Figure 1 below demonstrates the distribution of services by cost for a sample large group plan with a $400 individual deductible and a $2,500 out-of-pocket maximum. In general, cost sharing amounts at baseline vary by service category. And, due to a variety of factors including cost of the service, medical need, and access to care, elimination of cost-sharing may impact use of certain services more than others (see prior CHBRP analysis of AB

298 for further explanation, including how, postmandate, costs could shift by service category for a different sample plan with similar baseline distributions).

Figure 2. Baseline Distribution of Cost of Services, by Service Category, for a Sample Large Group Plan



Source: California Health Benefits Review Program, 2025

Baseline and Postmandate Expenditures

For large group and CalPERS DMHC-regulated plans and CDI-regulated policies, AB 298 would increase total premiums paid by employers and enrollees as a result of the elimination of cost sharing for enrollees younger than 21 years. Meanwhile, enrollee expenses for covered benefits would decrease. Below, Table 2 provides detailed estimates of the impacts of AB 298 on expenditures.

Table 2. Impacts of AB 298 on Expenditures, 2027 (a)

	Baseline (2027)	Postmandate (2027)	Increase/ Decrease	Percentage Change
Employer premiums				
Large group, not including CalPERS	$58,699,708,000	$59,194,810,000	$495,102,000	0.84%
CalPERS (b)	$8,438,709,000	$8,508,850,000	$70,141,000	0.83%
Enrollee premiums (c)				
Large group, not including CalPERS	$15,558,446,000	$15,690,598,000	$132,152,000	0.85%
CalPERS	$1,633,299,000	$1,646,874,000	$13,575,000	0.83%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$7,930,154,000	$7,636,472,000	-$293,682,000	-3.70%

Source: California Health Benefits Review Program, 2025.

Notes: (a) 2027 projections are based on premium and enrollment data received as of December 11, 2025. CHBRP's 2027 premium and enrollment projections may change as additional data becomes available.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 54.0% are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance.
Key: CalPERS = California Public Employees' Retirement System; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Premiums

At the end of this section, Table 4 and Table 5 present baseline and postmandate expenditures by DMHC-regulated plans and CDI-regulated policies in the commercial large group and CalPERS market segment. The tables present PMPM premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums plus enrollee expenses). Changes in premiums as a result of AB 298 would vary by the commercial large group and CalPERS market segments.[4]

Commercial Large Group

Premiums for DMHC-regulated commercial large group plans – which have the highest share (87.2%) of enrollees in plans and policies subject to AB 298 – would increase by 0.82% ($6.12 PMPM) postmandate. Premiums for CDI-regulated commercial large group plans – representing 2.9% of enrollees in plans and policies subject to AB 298 – would increase by 1.25% ($11.36 PMPM). These increases are due in part from a shift in costs to insurers, with reductions in enrollee expenses for covered benefits.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans – representing 9.9% of enrollees in plans and policies subject to AB 298 – PMPM premiums would increase by 0.83% ($7.61 PMPM) postmandate.

Enrollee Expenses

AB 298-related changes in cost sharing for covered benefits (deductibles, copays, coinsurance, etc.) would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 4 and Table 5) with health insurance that would be subject to AB 298 expected to use medical services during the year after enactment.

AB 298 distinguishes DMHC-regulated plans and CDI-regulated policies that are HSA-qualified from those that are not. Subsequently, average enrollee cost sharing for medical services for enrollees younger than 21 years are expected to decrease differently for these two types of plans among all market segments (see Table 3).

Average enrollee out-of-pocket expenses per user

To identify enrollees who would be impacted by AB 298, CHBRP estimated the number and changes to cost sharing for enrollees under 21 who use services under their health plan or policy (Table 3). For enrollees younger than 21 years in DMHC- and CDI-regulated commercial large-group HSA-qualified HDHPs who experienced cost sharing at baseline, average cost sharing PMPM is expected to decrease by $19.52, while for enrollees younger than 21 years in non–HSA-qualified HDHPs, average cost sharing PMPM is expected to decrease by $12.72. For enrollees younger than 21 who experienced cost sharing in CalPERS plans which are not HSA-qualified, cost sharing is expected to decrease by $4.97 PMPM postmandate.

[4] Premiums would also vary within each market segment by enrollee, by employer, and by each DMHC-regulated plan or CDI-regulated policy. CHBRP examines aggregate averages by market segment as the unit of analysis in Tables 4 and 5.

Table 3. Impact of AB 298 on Average Annual Enrollee Out-of-Pocket Expenses

	Large Group	CalPERS
HSA-qualified HDHPs		
Number of enrollees younger than 21 years impacted by AB 298 (a)	134,000	0
Avg. cost sharing PMPM change for impacted enrollees (a)	-$19.52	$0.00
Non–HSA-qualified plans and policies		
Number of enrollees younger than 21 years impacted by AB 298 (a)	1,776,000	216,000
Avg. cost sharing PMPM impact for enrollees impacted by AB (a)	-$12.72	-$4.97

Source: California Health Benefits Review Program, 2025
Notes: Average enrollee out-of-pocket expenses include expenses for both covered and noncovered benefits.
(a) Not including impacts on premiums.
Key: CalPERS = California Public Employees' Retirement System; HDHP = high deductible health plan; HSA = health savings account; PMPM = per member per month.

It should be noted the per-user annual impact in the form of cost-sharing savings shown in Table 3 reflect estimated population averages and will vary significantly between individual members. Sources of variation include the specific health services utilized by the enrollee and the cost sharing and utilization management protocols applicable to their specific plan or policy. Additionally, amongst families, the postmandate impact of eliminating cost sharing on out-of-pocket expenses could vary depending on how many enrollees under 21 are in the plan using services subject to AB 298.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of large group and CalPERS DMHC-regulated plans and 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.

Other Considerations for Policymakers

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums exceeds 1% for the CDI-regulated large group market (see Table 4 and Table 5), CHBRP expects a 0.42% increase in the number of uninsured persons.[5] CHBRP estimates that the increase in premiums would cause 260 enrollees in the CDI-regulated commercial market to lose or drop coverage.

Changes in Public Program Enrollment

CHBRP estimates that there would be no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 298 (as amended on January 5, 2026), consistent with its earlier analysis.

[5] For more information on the methodology, see CHBRP's resource *Criteria and Methods for Estimating the Impact of Mandates on the Uninsured Population*.

Other Considerations

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, there may be related considerations for policymakers. For example, AB 298 could interact with mental health parity laws, depending on how the financial requirements such as cost sharing shift for medical and surgical care compared to mental health and substance use disorder (the latter for the 21 and over population), as calculated under the law. For more detailed explanations on such considerations, please see the analysis of AB 298 as amended on March 4, 2025.[6]

[6] Note, the March 30, 2025 analysis of AB 298 described considerations and compliance for actuarial value requirements. However, this is no longer relevant for AB 298 as amended on January 5, 2026, since this version of the bill does not apply to individual marketplace plans or policies.

Table 4. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated		CDI-Regulated
	Commercial Plans (by Market) (a)	**Publicly Funded Plans**	**Commercial Plans (by Market) (a)**
	Large Group	*CalPERS (b)*	*Large Group*
Enrollee Counts			
Total enrollees in plans/policies subject to state mandates (c)	8,054,000	916,000	265,000
Total enrollees in plans/policies subject to AB 298	8,054,000	916,000	265,000
Premium Costs			
Average portion of premium paid by employer (d)	$585.57	$767.71	$662.20
Average portion of premium paid by enrollee	$152.96	$148.59	$243.80
Total Premium	**$738.53**	**$916.30**	**$906.00**
Enrollee Expenses			
Cost-sharing for covered benefits (deductibles, copays, etc.)	$67.74	$87.16	$133.66
Expenses for noncovered benefits (e)	$0.00	$0.00	$0.00
Total Expenditures	**$806.27**	**$1,003.47**	**$1,039.66**

Source: California Health Benefits Review Program, 2025.
Note: (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 51.7% are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. 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) Enrollees in plans and policies regulated by DMHC or CDI.
(d) In some cases, a union or other organization.
(e) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems

Table 5. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated		CDI-Regulated
	Commercial Plans (by Market) (a)	**Publicly Funded Plans**	**Commercial Plans (by Market) (a)**
	Large Group	*CalPERS (b)*	*Large Group*
Enrollee Counts			
Total enrollees in plans/policies subject to state mandates (c)	8,054,000	916,000	265,000
Total enrollees in plans/policies subject to AB 298	8,054,000	916,000	265,000
Premium Costs (postmandate change)			
Average portion of premium paid by employer (d)	$4.8495	$6.3811	$8.3042
Average portion of premium paid by enrollee	$1.2668	$1.2351	$3.0573
Total Premium	$6.1163	$7.6161	$11.3615
Enrollee Expenses (postmandate change)			
Cost-sharing for covered benefits (deductibles, copays, etc.)	-$2.6958	-$1.2927	-$5.9524
Expenses for noncovered benefits (e)	$0.0000	$0.0000	$0.0000
Total Expenditures	$3.4205	$6.3235	$5.4091
Postmandate Percent Change			
Percent change insured premiums	0.8282%	0.8312%	1.2540%
Percent Change total expenditures	0.4242%	0.6302%	0.5203%

Source: California Health Benefits Review Program, 2025.
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 51.7% are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. 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) Enrollees in plans and policies regulated by DMHC or CDI.
(d) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.
(e) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems.

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