Analysis of California Assembly Bill 298: Cost Sharing

MARCH 30, 2025

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

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 298: Cost Sharing

Summary to the 2025-2026 California State Legislature, March 30, 2025

Summary

The version of AB 298 analyzed by California Health Benefits Review Program (CHBRP) would prohibit California Department of Managed Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies from imposing a deductible, coinsurance, copayment, or other cost sharing for covered, in-network health care services provided to enrollees younger than 21 years.

In 2026, 100% of the 22.2 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 298.

Benefit Coverage

At baseline, there are 7.47 million enrollees younger than 21 in DMHC-regulated plans and CDI-regulated policies. Of these, 51% are in DMHC-regulated Medi-Cal plans and already have coverage for in-network medical services without cost sharing. The remaining 49% of the 7.47 million enrollees at baseline are in commercial/ California Public Employees' Retirement System (CalPERS) plans and policies that impose some cost sharing on in-network medical services.

Cost and Health Impacts

Overall, in 2026, AB 298 would increase total expenditures by $711,201,000 or 0.42%.

In 2026, AB 298 would reduce enrollee cost sharing by a total of $694,204,000. The average reduction in cost sharing per enrollee would vary based on market segment.

Total premiums would increase by $1,405,405,000.

Increases in premiums vary by market segment.

Because these premium increases are over 1% in the commercial market, CHBRP estimates that 6,430 Californians could become uninsured.

Overall, the reduction in cost sharing would increase utilization across most types of care. To the extent utilization results in improved health outcomes, there would be a public health impact.

Context[1]

In 2022, 7.4% of Californians younger than 21 delayed or did not get health care, and over one-third (37%) of them listed cost, lack of insurance, or other insurance-related issues as the cause.

Even among people with health insurance coverage, cost can be a barrier. 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 maximum out-of-pocket cap is met. High deductible health plans (HDHPs) pair a deductible — of at least $1,650 for an individual and $3,300 for a family in 2025 — with a lower monthly premium. These plans can be used with health savings accounts (HSAs) if they meet certain federal requirements.

State law requires certain recommended preventive services to be covered without cost sharing in state-regulated plans and policies, including in HSA-qualified HDHPs. Federal law further allows HSA-qualified HDHPs to cover certain additional preventive services

[1] Refer to CHBRP's full report for full citations and references.

prior to the application of a deductible, but other cost sharing may apply. For other services, plan design would determine the level and amount of cost sharing for enrollees.

The impact of cost 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, they also have acute and chronic health care needs for which utilization can be influenced by cost.

Bill Summary

AB 298 would prohibit DMHC-regulated plans and CDI-regulated policies from imposing:

- A deductible, coinsurance, copayment, or other cost sharing for covered in-network services provided to enrollees younger than 21 years.

For HSA-qualified HDHPs, AB 298 would prohibit the application of:

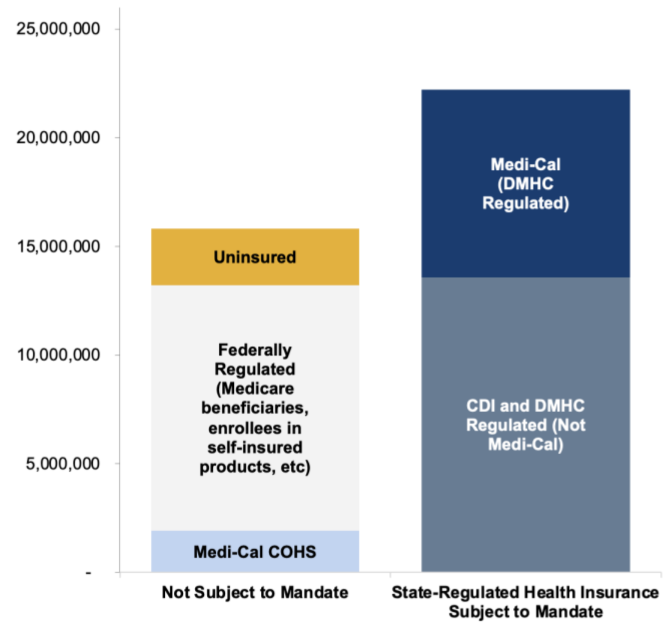
- A deductible, coinsurance, copayment, or other cost sharing for preventive care services, as defined at Section 223(c)(2) of Title 26 of the United States Code, provided to enrollees younger than 21 years; and
- Coinsurance, copayment, or other cost sharing for services provided to enrollees younger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

The elimination of cost sharing under AB 298 would apply to health care services under a plan or policy's medical benefit. The bill would not apply to services under the pharmacy benefit or durable medical equipment benefit.

AB 298 defines in-network health care services to include covered services for which the plan or policy design applies in-network cost sharing to enrollees receiving covered services from out-of-network providers and/or facilities, as applicable under federal and state law.

Figure A notes how many Californians have health insurance that would be subject to AB 298.

Figure A. Health Insurance in CA and AB 298



Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

At baseline, 51% of enrollees younger than 21 years with health insurance that would be subject to AB 298 already have fully compliant coverage for in-network health care services without cost sharing through coverage in DMHC-regulated Medi-Cal. The remainder of enrollees are in commercial or CalPERS plans or policies that impose some cost sharing for in-network health care services; 45% of enrollees younger than 21 years are in state-regulated plans and policies that are not HSA-qualified, and 4% are in state-regulated HSA-qualified HDHPs.

Postmandate, 100% of DMHC-regulated plans and CDI-regulated policies would have coverage in compliance with AB 298.

Utilization

Since AB 298 would apply broadly across all services in a plan or policy's medical benefit, CHBRP estimates changes in utilization through changes in per member per month (PMPM) costs. DMHC-regulated Medi-Cal

plans are already in compliance and therefore would see no change in utilization postmandate.

Postmandate, eliminating cost sharing for enrollees younger than 21 years would increase utilization of some medical services for enrollees in commercial/CalPERS plans or policies. In plans or policies that are not HSA-qualified, the estimated increase in average PMPM charges for all ages due to the increases in utilization across all medical services would be 0.57% ($3.90) postmandate. For enrollees in HSA-qualified HDHPs, average PMPM charges for all ages due to utilization would increase by 0.28% ($1.73).

Expenditures

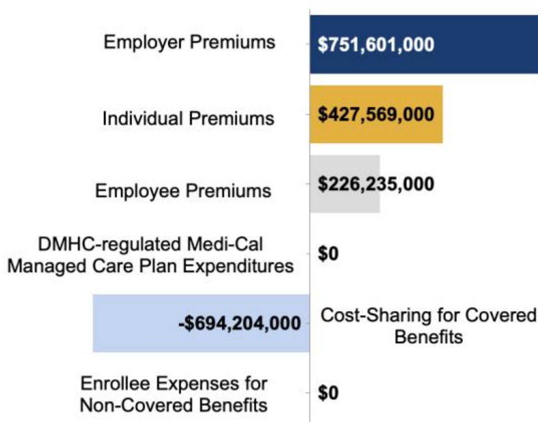
Overall, in 2026, AB 298 would increase total expenditures (premiums plus enrollee expenses) by $711,201,000 or 0.42% postmandate. This is in part due to a $1,405,405,000 increase in premiums.

Premium increases postmandate stem from three factors: increase in utilization (accounting for 44% of the premium increase), shift in cost sharing from point-of-service to premiums (49%), and administrative costs (7%).

AB 298 would result in a reduction in enrollee cost sharing by $694,204,000 postmandate.

Overall, premiums would increase as a result of AB 298, with variation by market segment. The increase would impact both employers and employees (Figure B).

Figure B. Expenditure Impacts of AB 298



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Commercial

PMPM premium increases in DMHC-regulated commercial plans range from 0.85% ($5.98 PMPM) for large-group plans to 1.95% ($15.96 PMPM) for individual plans. Among CDI-regulated policies, PMPM increases range from 1.29% ($10.79 PMPM) for large-group policies to 2.92% ($22.74 PMPM) for individual policies. These increases are due in part to new utilization, as well as a shift in costs to insurers, with reductions in enrollee expenses for covered benefits.

Reductions in enrollee cost sharing range from reductions of $2.69 PMPM for DMHC-regulated large-group plans to $11.84 PMPM for CDI-regulated individual policies.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, total expenditures are expected to increase by 0.61% and premiums are expected to increase by 0.82% ($7.04 PMPM) postmandate. Enrollee cost sharing, meanwhile, would be reduced by $1.32 PMPM postmandate.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there would be no impact as coverage at baseline is already compliant with AB 298.

Sample Small-Group Gold Plan

CHBRP also estimated the impact of AB 298 on a sample small-group gold plan in order to model the impact on specific types of care. In this sample plan, utilization would increase across nearly all types of care and stay the same for inpatient care and ancillary services as a result of AB 298. Behavioral health services, emergency room care, and office visits would experience the highest increases in PMPM costs postmandate (3.5%, 2.6%, and 2.2%, respectively). Enrollee cost sharing would decrease in each category of care except outpatient pharmacy; while AB 298 does not apply to pharmacy benefits, the increased utilization of health care (e.g., office visits) would result in an increase in prescription medication use.

Overall, enrollee cost sharing would decrease by $5.90 PMPM postmandate.

Number of Uninsured in California

Because the change in premiums would exceed 1% in the small-group and individual DMHC-regulated markets and the large-group, small-group, and individual CDI-regulated markets, CHBRP would expect a measurable change in the number of uninsured persons due to the enactment of AB 298. The premium increase in the DMHC-regulated CalPERS and large-group market segments are not above 1%, so CHBRP does not anticipate coverage losses in those markets.

Due to an estimated premium increase of greater than 1% due to AB 298 in several market segments, CHBRP estimates that the increases in premiums would cause more than 6,430 enrollees to lose or drop health insurance.

Public Health

In the first year postmandate, 3,632,000 enrollees younger than 21 years with health insurance subject to AB 298 would experience a change in cost-sharing requirements and overall would increase utilization of health care services. The increase in utilization would be across most types of care, including behavioral health, office visits, emergency room care, and more.

To the extent that the increase in utilization results in improved health outcomes, AB 298 would have a public health impact.

Essential Health Benefits and the Affordable Care Act

AB 298 would not require coverage for a new state benefit mandate and instead would modify cost-sharing terms and conditions of already covered services. Therefore, AB 298 would not exceed the definition of EHBs in California.

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.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

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

Suggested citation

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Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
ACIP – Advisory Committee on Immunization Practices
CA – California
CalPERS – California Public Employees' Retirement System
CDC – Centers for Disease Control and Prevention
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
COHS – County Organized Health System
DHCS – Department of Health Care Services
DMHC – Department of Managed Health Care
EHB – Essential Health Benefits
HMO – Health Maintenance Organization
HRSA – Health Resources and Services Administration
MHPAEA – Mental Health Parity and Addiction Equity Act
SB – Senate Bill
USPSTF – United States Preventive Services Task Force

Introduction

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[2] conduct an evidence-based assessment of the financial and public health impacts of Assembly Bill (AB) 298, Cost Sharing. AB 298 was amended on March 4, 2025, and the Assembly Committee on Health requested CHBRP incorporate these amendments into the analysis of AB 298. Additionally, the Committee requested CHBRP provide an additional estimate of an alternate cost sharing scenario ($10 copay and $100 emergency care; see more information in the *Benefit Coverage, Utilization, and Cost Impacts* section).

AB 298 Cost Sharing Bill Language

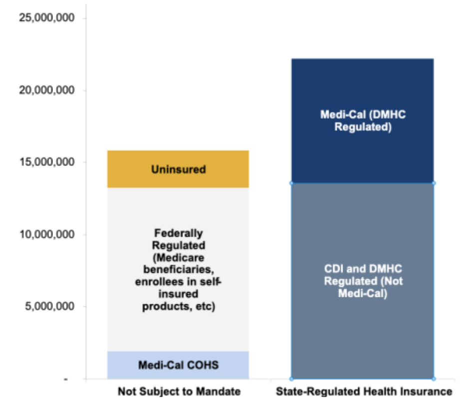
AB 298 would prohibit California Department of Managed Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies from imposing:

- A deductible, coinsurance, copayment, or other cost sharing for services provided to enrollees younger than 21 years.

For health savings account (HSA)-qualified high deductible health plans (HDHPs), 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.

Figure 1. Health Insurance in CA and AB 298



Additionally, the bill would prohibit individuals or entities from billing or seeking reimbursement for the services provided to enrollees younger than 21 years, except as permitted under HSA-qualified HDHPs.

See the full text of AB 298 in Appendix A.

If enacted, AB 298 would apply to the health insurance of approximately 22.2 million enrollees (58.6% of all Californians) (see Figure 1).

- **Includes:** enrollees in commercial, CalPERS, and Medi-Cal managed care health insurance regulated by DMHC and CDI.
- **Excludes:** Medi-Cal beneficiaries enrolled in county organized health system (COHS) plans.

Although DMHC-regulated Medi-Cal Managed Care plans are subject to the Health and Safety Code, these plans are already in compliance with AB 298 since there is no cost sharing for Medi-Cal covered services.

See the following *Analytic Approach and Assumptions* section for additional information.

[2] See CHBRP's authorizing statute.

Terminology

Cost sharing, which is addressed by AB 298, is the portion of cost that enrollees are responsible for paying out of pocket directly to the provider for a covered health care service or treatment. Common cost-sharing mechanisms include copayments, coinsurance, and deductibles.

- Copayment — A form of cost sharing in which an enrollee pays a specific dollar amount out of pocket at the time of receiving a health care service or when paying for a prescription, after any applicable deductible. These flat-dollar amounts generally differ depending on the type of care (e.g., enrollees may experience a $20 copayment for primary care, and a $100 copayment for emergency care).
- Coinsurance — A form of cost sharing in which an enrollee pays a specific percentage of the covered amount out of pocket at the time of receiving a health care service or when paying for a prescription, after any applicable deductible. For example, after the deductible has been met, an enrollee may be required to pay 20% of the cost of care, while the insurer pays 80%.
- Deductible — The amount an enrollee is required to pay out of pocket before the health plan or policy begins to reimburse providers for medically necessary use of covered benefits.

Appendix C provides additional information about cost sharing.

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Analytic Approach and Assumptions

CHBRP assumes that AB 298 would apply to covered services and items that fall under a plan or policy's medical benefit.[3] CHBRP assumes that AB 298 would not apply to pharmacy benefits and durable medical equipment (DME). Drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering scripts that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. Meanwhile, certain items could fall under the DME category, or be provided as a medical benefit. Claims data reflect current plan or policy practices on what is considered DME or within the medical benefit category. Examples of types of services covered under the medical benefit include, but are not limited to:

- Primary care and specialist visits;
- Mental health and substance use disorder services;
- Emergency services and ambulance rides;
- Inpatient and outpatient hospital services;
- Home health services; and
- Diagnostic and imaging services.

AB 298 defines in-network health care to include covered services for which the plan or policy design applies in-network cost sharing to enrollees receiving covered services from out-of-network providers and/or facilities, as applicable under federal and state law.

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[3] CHBRP's interpretation of "services" as stated in AB 298 is in alignment with the interpretation by the California Department of Insurance and the California Department of Managed Health Care, as determined through email correspondence.

Policy Context

Cost-sharing requirements may interact and align with the following state and federal mandates, programs, and policies.

California Law and Regulations

Below, CHBRP discusses state laws and regulations that may interact with AB 298. California has a number of benefit mandates on coverage and associated cost sharing, which are too large in number and complexity to be briefly summarized. More information on these laws can be found in the CHBRP resource *Health Insurance Benefit Mandates in California State and Federal Law*

Preventive Services

Existing California law requires coverage for the following preventive services without cost sharing for enrollees in grandfathered and nongrandfathered plans and policies, including HSA-qualified HDHPs.[4,5]

- The United States Preventive Services Task Force (USPSTF) A and B recommendations;
- The Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services;
- The HRSA-supported comprehensive guidelines for infants, children, and adolescents, which include:
  - The Bright Futures Recommendations for Pediatric Preventive Health Care; and
  - The recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- The Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

These requirements mostly align with the federal preventive services listed under the Affordable Care Act, which only applies to nongrandfathered plans and policies.[6]

Mental Health Parity

California's Mental Health Parity Act mandates coverage for all medically necessary mental health and substance use treatment and imposes certain parity requirements that exceed federal requirements. California law[7] requires plans and policies to cover all mental health and substance use disorders listed in the most recent edition of either the *International Classification of Disease* or the *Diagnostic and Statistical Manual of Mental Disorders* at parity with other medical services. For covered mental health or substance use disorders, cost-sharing terms and treatment limits must be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. This requirement is similar to those specified by the federal Mental Health Parity and Addiction Equity Act (MHPAEA, see below), but applies to all health insurance plans and policies subject to either the Health and Safety Code or the Insurance Code.

Additionally, among state-regulated plans and policies, necessary out-of-network services for mental health and substance use disorders must be covered immediately with in-network cost sharing terms in cases where lack of access to a provider violates state timeliness and geographic access regulations.[8] Patients are more likely to see out-of-network

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[4] Health and Safety Code (HSC) Section 1367.002; Insurance Code (INS) Section 10112.2
[5] More information about the state and federal requirements to cover specified preventive services is included in CHBRP's resource *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.
[6] As of the published date of this report, the federal preventive services mandate was being challenged in court. Due to the alignment between California and federal law regarding coverage, cost sharing, and utilization management of certain preventive services, the court case will not impact DMHC-regulated health plans or CDI-regulated health policies. For more information, see CHBRP's resource *Federal Recommendations and the California and Federal Preventative Services Benefit Mandates*.
[7] HSC 1374.72; INS 10144.5 and INS 10123.15.
[8] HSC 1374.72; INS 10144.5.

behavioral health providers than medical or surgical providers for a variety of reasons, including but not limited to choice and lack of access to in-network or preferred providers (Mark & Parish, 2024; Xu et al., 2019). AB 298 aligns with mental health parity laws by defining in-network health care to include out-of-network care that does not meet these timely access requirements established under state law. AB 298 does not change plan benefit design and still would permit cost-sharing requirements for behavioral health in other scenarios with out-of-network care.

Surprise Billing Restrictions

AB 298 defines in-network health care services to include covered emergency care and covered nonemergency care provided at in-network facilities. This definition aligns with federal and state surprise billing laws that prohibit out-of-network providers from “balance billing,” which is when patients are charged the difference between what the insurer paid and the full amount of the provider’s charges.

California state law aligns with federal law on prohibitions against balance billing for emergency services, and exceeds federal protections against balance billing in certain nonemergency settings (see below for federal requirements). For commercial enrollees and enrollees associated with CalPERS, out-of-network surprise billing is prohibited for the following:

- Nonemergency services provided by an out-of-network health professional at an in-network health facility. State law exceeds federal law in the definition of facility to include hospital, ambulatory surgical centers or other outpatient settings, laboratories, and radiology and imaging centers.
- Emergency services provided at out-of-network health facilities or by out-of-network providers.
- Air or ambulance services.[9] [10]

Previous California Legislation

CHBRP has not identified prior California legislation that would broadly eliminate cost sharing for all medical services for enrollees of state-regulated commercial or CalPERS plans or policies. However, a number of bills have been introduced over the years, and some signed into law, that require state-regulated plans and policies to cover certain specific services or items without cost sharing.[11] For example, California requires the coverage of at home test kits for sexually transmitted infections without cost sharing for DMHC-regulated plans and CDI- regulated policies.[12] California also prohibits cost sharing for abortion services.[13]

Similar Legislation in Other States

CHBRP was unable to identify states that prohibit cost sharing across service categories for enrollees of state-regulated commercial insurance. In 2022, New Mexico implemented a law prohibiting state-regulated plans and policies from charging any cost sharing for in-network behavioral health services and prescription drugs.[14] And, for HSA-qualified HDHPs, the law prohibits cost sharing once the deductible is met. Unlike AB 298, this law applies to all enrollees regardless of age, and does not apply to services received in an emergency department or urgent care center. The law is set to sunset at the end of 2026.

[9] California Health & Safety Code 1371.55. California Insurance Code 10126.65

[10] Note, although California law prohibits such out-of-network surprise billing for enrollees in plans and policies regulated by DMHC or CDI, an existing Federal Law, the Airline Deregulation Act of 1978, prohibits much state regulation related to air transport. Court rulings in other states have found that the Airline Deregulation Act preempts state law. Part I of the interim final rules to implement the No Surprises Act aligns with these court decisions. California Health & Safety Code 1371.55 and California Insurance Code 10126.65. Airline Deregulation Act. S.2493, 95th Congress (1978). Air Evac EMS, Inc. v. Cheatham; EagleMed LLC v. Cox; Guardian Flight, LLC v. Godfread; Bailey v. Rocky Mountain Holdings, LLC. Personal Management Office, Internal Revenue Service, Employee Benefits Security Administration, Health and Human Services Department. (2021). Requirements related to surprise billing; Part I. Interim Final Rule. Federal Register. 86 FR 36872.

[11] See CHBRP resource *Health Insurance Benefit Mandate,* available online.

[12] STIs Home Test Kits mandate HSC 1367.34 and INS 10123.208.

[13] Cost sharing for abortion services HSC 1367.251 and INS 10123.1961.

[14] New Mexico Legislature, Senate Bill 317, *Health Care Affordability Fund*, 55th Leg., Reg. Sess. (2021),

Federal Policy Landscape

High Deductible Health Plans (HDHPs) and Health Savings Account (HSA)-Qualified HDHPs

High deductible health plans (HDHPs) are a type of health plan with requirements set by federal regulation.[15,16] As the name implies, these plans include a deductible, but they are not allowed to have separate medical and pharmacy deductibles. For the 2025 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,650 for an individual and $3,300 for a family.[17] Annual out-of-pocket expenses for coverage of in-network tests, treatments, and services, which would result from cost sharing[18] applicable after the deductible is met, are not allowed to be more than $8,300 for an individual and $16,600 for a family.[19]

To be eligible to establish a health savings account (HSA) for taxable years beginning after December 31, 2003[20] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA-qualified HDHP.

In order for an HDHP to be HSA qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied – but federal law provides a safe harbor for the absence of a deductible applicable to preventive care.[21] Therefore an HDHP may cover preventive care benefits without any deductible or with a deductible below the minimum annual deductible – but is not required to do so for a specified list of preventive services. The list of preventive services for which application of a deductible is not required includes treatments for chronic conditions, insulin, and more.[22] AB 298 would require these preventive services, to the extent they are covered by the HSA-qualified HDHP, to be provided to enrollees younger than 21 years without the application of a deductible, copayment, or coinsurance. Meanwhile, for all other services, the individual and/or family deductible must be met before an enrollee younger than 21 years receives care without the application of a copayment or coinsurance.

No Surprises Act

The “No Surprises Act” is a federal law that aims to protect patients from unexpected medical bills, also known as “surprise billing,” by limiting the amount patients can be charged when receiving out-of-network care during emergency situations or when treated by an out-of-network provider at an in-network facility, essentially ensuring they only pay their in-network cost sharing for these services. Federal law differs from state law in scope (see details above); enrollees are protected from balance billing for nonemergency services received in in-network facilities, defined as hospitals, ambulatory surgical centers, hospital outpatient department, or critical access hospital.

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for behavioral health benefits.[23] The MHPAEA requires that when mental health or substance use disorder services are covered, cost-sharing terms (such as coinsurance and copays) and treatment limits (such as visit limits) be no more restrictive than the predominant terms or limits applied to substantially all medical/surgical benefits in a given classification. Furthermore, for any behavioral health benefits that are covered, coverage must be provided in all classification of benefits (e.g., inpatient in-network benefits, prescription drug benefits, emergency care benefits) in which comparative medical/surgical benefits are provided. The law protects enrollees from facing greater restrictions on access to behavioral health benefits as compared to medical/surgical

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[15] For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[16] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Accessed March 5, 2021.
[17] IRS Revenue Procedure 2024-25.4.
[18] Such as copayments and coinsurance applicable to the covered test, treatment, or service.
[19] There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.
[20] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.
[21] For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725.
For additional guidance on preventive care, see Notice 2004-50, 2004-2 C.B. 196, Q&A 26 and 27, available at; and Notice 2013-57, 2013-40 I.R.B. 293.
[22] For information on preventive care for chronic conditions, see Notice 2019-45, 2019-32 I.R.B. 593.
[23] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.

benefits. The MHPAEA directly applies to large-group health insurance, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law described previously,[24] although the state law applies to some plans and policies not captured in the MHPAEA. In addition, MHPAEA prohibits separate financial requirements and treatment limitations that apply only to mental health and/or substance use disorder benefits.

AB 298 could interact with federal mental health parity requirements if costs for mental health and substance use disorder care exceed those of medical/surgical care within a classification, as calculated under the law. (For more information on possible considerations, see the *Benefit Coverage, Utilization, and Cost Impacts* section).

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 298 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[25,26]

Essential health benefits

In California, nongrandfathered[27] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[28] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[29]

AB 298 would not require coverage for a new state benefit mandate and instead modifies cost sharing terms and conditions of already covered services. Therefore, AB 298 does not exceed the definition of EHBs in California.

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[24] HSC Section 1374.72; INS Section 10144.5 and 10123.15.
[25] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[26] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[27] A grandfathered health plan is “a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their ‘grandfathered’ status if they make certain significant changes that reduce benefits or increase costs to consumers.”
[28] For more detail, see CHBRP’s issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[29] See CHBRP’s resource, *Sources of Health Insurance in California*.

Background on the Impact of Cost Sharing on Health Utilization and Outcomes

AB 298 addresses cost sharing for a wide array of services for enrollees younger than 21 years under a plan or policy's medical benefit. The impact of the elimination of cost sharing on individual health or health outcomes, however, is difficult to measure as there is insufficient evidence on the topic, particularly among children. CHBRP therefore breaks down available information, beginning with health insurance coverage of Californians younger than 21 year and how they generally interact with the health care system. CHBRP then describes how changes in cost-sharing impact utilization among persons younger than 21. And finally, CHBRP presents available research on how changes in utilization may impact health outcomes for persons younger than 21 years.

Health Insurance Coverage of Californians Younger than 21

As mentioned in the *Introduction*, AB 298 would apply to DMHC-regulated plans and CDI-regulated policies. In 2026, among the 7.47 million Californians younger than 21 years enrolled in plans or policies subject to AB 298's cost-sharing requirements, 49% are in commercial and CalPERS plans and policies. The remaining 51% are enrolled in DMHC-regulated Medi-Cal plans, which are already compliant with AB 298.[30]

Types of Health Care Used Among Persons Younger than 21

People younger than 21 years are relatively healthy compared to an older population and have distinct health care needs, driven by developmental, congenital, and acute conditions (HCCI, 2022). In 2020, persons 18 and younger accounted for 23% of the U.S. population but only 10% of personal health care spending (CMS, 2024). AB 298 applies broadly to all medical services for persons aged 0 to 20. As such, below is a broad overview of how people younger than 21 year interact with the health care system.

Top 10 Conditions for Largest Personal Health Spending Among Youth Aged 0–19, 2013

Spending Rank	Care Category
1	Well-newborn (e.g., routine newborn care)
2	ADHD
3	Well-dental (e.g., routine oral surgery such as filings, crowns, extraction, and dentures)
4	Asthma
5	Oral disorders
6	Well-child
7	Upper respiratory tract infections
8	Other long-term respiratory diseases (e.g., sleep apnea, allergic rhinitis, and chronic sinusitis)
9	Skin and subcutaneous diseases
10	Exposure to mechanical forces (e.g., falling object, striking other object, cuts, and being crushed)

Source: Bui et al., 2017

Care utilized by those younger than 21 years can fall under the following nonexclusive, nonexhaustive common categories:

- **Neonatal and infant care.** The neonatal period is the most vulnerable time for child's survival, with higher risk of death compared to later childhood. Care delivered at this stage generally occurs at the hospital setting; inpatient newborn care accounts for 60.5% of infant spending (Weiss, 2019). Other common reasons for care for infants aged 0 to 1 years include treatment for respiratory distress and congenital anomalies.
- **Preventive care.** Health care use among persons younger than 21 years is commonly centered around routine preventive care. Pediatric care places an emphasis on well-child visits, vaccinations, and developmental screenings.

[30] Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, persons younger than 21 years enrolled in Medicaid receive medically necessary covered Medi-Cal services and items without cost sharing. must have coverage for a broad array of age-appropriate preventive services, including screening for medical, dental, vision, hearing, and mental health, and for substance use disorders, as well as receiving developmental and specialty services.

Among children aged 0 to 17 in California, nearly 3 in 4 (72%) reported receiving one or more preventive care visit in the past year (CAHMI, 2024). Among youth, reproductive care becomes a need for many older adolescents and young adults, accounting for the largest share of spending among adolescents aged 15 to 19 (Bui et al., 2017).

- **Chronic care.** Common chronic conditions impacting persons younger than 21 years can span the range of physical and behavioral health conditions. Common chronic conditions among persons younger than 18 years include asthma and diabetes. Among children younger than 18 years in California, 6.4% have asthma (CAHMI, 2024). One in 6 children with asthma visits the emergency department in a given year, and 1 in 20 are hospitalized for it (CDC, 2021). To note, children with special health care needs (CSHCN) make up roughly one in seven Californians aged 0 to 17 (HHS, 2024). They have physical, developmental, behavioral, or emotional conditions that require additional health and support services compared to peers who do not have special health care needs.[31]
- **Acute care.** People younger than 21 years may seek acute care for an array of reasons, including to address severe life-threatening conditions, such as accidental ingestions or injuries, or to address short-term medical conditions including sports injuries, respiratory illnesses, appendicitis, ear infections, or asthma flare-ups. Acute care can be delivered in a variety of settings, such as clinics and hospital emergency departments. Approximately 12.2% of people aged 0 to 17 in California visited the emergency department at least once in the past 12 months (CAHMI, 2024).
- **Behavioral health.** Mental health disorders begin in early childhood and sharply rise between 10 and 18 years of age (CDC, 2025; Kuo et al., 2015). Mental health conditions and outcomes related to substance use have increased in recent years and the adolescent population in particular has experienced an uptick in drug-related deaths (CDC, 2024; Panchal, 2024). Unmet need persists; 60% of children aged 3-17 with mental, behavioral, and developmental disorders received services each year from 2016-2021 (Leeb et al., 2024).

As explained in the *Policy Context* section, behavioral health care providers are more frequently out of network, and therefore may pose additional cost-related barriers to care.[32] Increasing access overall increases use of behavioral health care (Sen et al., 2019).

Impact of Cost Sharing on Utilization of Health Services

In 2022, 7.4% of Californians younger than 21 years delayed or did not get health care, and over one-third (37%) of those people listed cost, lack of insurance, or other insurance-related reasons as the main reason for delaying or forgoing care (CHIS, 2022). For mental health care specifically, nearly four in ten families (39.3%) report cost as a reason they did not get needed mental health care for children (Meng and Wiznitzer, 2024). Missed pediatric care could delay or prevent critical preventive care, diagnoses of medical conditions, developmental delays, physical disabilities and more, and missed vaccinations could have serious health consequences for children and the public health of communities (Teasdale et al., 2022). Meanwhile, evidence shows that timely diagnosis and effective treatment for various conditions (including, for example, mental health and cochlear implantation), can improve outcomes for children (Bear et al., 2020; McGorry and Mei, 2018; Peterson et al., 2024; Spittle and Treyvaud, 2016; Tercyak et al., 2024).

Much of the existing research was conducted prior to the implementation of the Affordable Care Act which drastically changed the landscape of health insurance coverage and costs for children's health services. In a seminal large-scale analysis of more than 1,000 children, the RAND Health Insurance Experiment (HIE) analyzed how utilization and cost are affected by varying levels of coverage by insurance (Leibowitz et al., 1985). Overall, increasing cost sharing via increased coinsurance and applying individual deductibles was associated with decreased outpatient care for children aged 0 to 13, and decreased inpatient care for children aged 0 to 4. The research finds increased cost sharing decreased use of both

[31] Children with special health care needs (CSHCN) are more likely to be limited in their ability to participate and function in daily activities (HHS, 2024). In 2021, 3.8% of Californians aged 0 to 17 had major disabilities, meaning one or more or more serious impairments in hearing, vision, cognition, walking, or self-care. CSHCN may be eligible for additional community-based services and coordinated care through Title V funding, Medi-Cal through special eligibility pathways as well as home- and community-based services waivers, and many other programs.

[32] Mental health and behavioral health care is provided in traditional provider settings such as outpatient offices and hospitals but may also be covered by school districts. Under federal and state law, public school districts are required to cover mental and behavioral health services as related to a child's Individualized Education Program (IEP) or Section 504 plan and as necessary for their educational development.

effective and appropriate, and ineffective care for children. Declines were observed in care for acute and chronic conditions.

A study of more than 25,000 children younger than 18 years found that eliminating cost sharing for well-child primary care visits for children enrolled in private insurance resulted in increased primary care visits and increased uptake of four recommended vaccines as well as decreases in emergency department and specialist visits that had a higher out-of-pocket cost (Sepúlveda et al., 2016). The study further found that overall, this change in out-of-pocket cost had no impact on health care costs. To note, families may prefer ER care for nonurgent care for a variety of reasons, including access in areas with low supply of providers, perceived higher quality of care, perceived urgency, and referrals, among others (Berry et al., 2008; Ziemnik et al., 2024).

There is limited research in the United States on the effect of eliminating all cost sharing for persons younger than 21 years alone, while keeping family financial obligations unchanged. However, one study in Sweden may provide insight into the impact of age-based policy on cost sharing. The study utilized policy changes that eliminated copayments for persons younger than 20 years in Sweden (first for younger than 7 years, and then two years later, for those younger than 20 years), finding free care led to a 5% to 10% increase in doctor's visits among both age groups. The effect was concentrated among persons from lower income families, while persons in families in the top 25% of income did not significantly change behavior based on copayments (Nilsson and Paul, 2018). Given that families in Sweden experience little cost for health care and do not have deductibles, this study may inform how smaller amounts of cost impact use.

Utilization of Health Care Services in High Deductible Health Plans

Health insurance–specific research on high deductible health plans (HDHPs) may provide insight into the effect of high upfront costs for health care on decision-making and utilization. Families in HDHPs are more likely to delay nonurgent surgeries (such as tonsillectomies, adenoidectomies, and certain types of hernia repairs) for children to the end of the calendar year, when the deductible is closer to being met, compared to those who on public insurance who receive care throughout the year (Gil et al., 2023). Additionally, families with HDHPs are more likely to reduce use of disease monitoring for diabetes and routine care (Jiang et al., 2021), reduce use of care for substance use disorders and mental health care (Meiselbach et al., 2022; Schilling et al., 2023), and generally forgo medical care compared to those in traditional private plans (Larson et al., 2021). However, when preventive care (specifically well-child visits) is exempt from the application of a deductible in HDHPs, there is no change in utilization when families switch from employer-sponsored traditional health plans to HDHPs (Galbraith et al., 2014).

Impact of Cost Sharing of Health Care on Clinical Outcomes

There is limited available research examining the impact of reduced cost sharing on clinical outcomes for persons younger than 18. Research from the HIE (described above) also found that cost sharing had no discernable impact on health outcomes among children, including at-risk children (Burciaga Valdez, 1986). Existing research finds that enrollment in Medicaid and the Children's Health Insurance Program (CHIP), which provides coverage without cost sharing to children in low- to middle-income families, can improve access to care. Enrollees experienced reductions in unmet need, increased perceptions of quality of care, and reduced possibility of asthma attacks (Davidoff et al., 2005; Szilagyi et al., 2007; Thompson, 2017). Research in Japan finds that elimination of health care costs for children 0 to 6 years old resulted in increased access to care and improved health outcomes (as measured by parent-reports of symptoms, physician reporting discharge outcomes, and mortality rates) (Kang et al., 2022).

A systematic literature review of studies published between 2000 and 2021 with study populations including children found that HDHPs were associated with declines in routine care and medication adherence for diabetes, and increased incidence in acute care use, indicating potential negative health consequences (Jiang et al., 2021).

There is little research available on if and how clinical outcomes change as a result of changes to cost sharing, since many other noncontrollable variables may confound findings. However, research examining how cost impacts medication

adherence, and how that medication adherence impacts clinical outcomes may provide some insight into how outcomes change due to changes in cost sharing. There are a number of studies examining the impact of medication adherence on outcomes for the intended population, though studies specific to children, adolescents, or youth are not as common (Cong et al., 2021; Mattke et al., 2010). Research shows that increased adherence for anti-inflammatory medications improves disease control among children younger than 18 years, as evidenced through reductions in emergency department visits (Herndon et al., 2015). And, initiation of medication for attention-deficit/hyperactivity disorder (ADHD) is correlated with significantly lower mortality rates, for children and adults (Li et al., 2024).

Disparities[33]

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

There is limited literature examining disparities in utilization or outcomes based on cost-sharing requirements for persons younger than 21 years. There are differences in California between groups listing cost or other insurance related reasons as the main reason for delaying or forgoing care in California.

Income

As described earlier in the *Background* section, in general, low-income families who have cost-sharing expenses are more price sensitive than higher-income families with cost sharing, but the differences vary based on insurance design, the type of cost sharing, and specific income group. When examining the impact of cost sharing on decision-making for children aged 4-11 with asthma, research shows that higher-income families at or above 250% federal poverty level (FPL) as well as those with Medicaid are less likely to forgo or delay care due to cost than low-income families below 250% FPL with cost sharing (Fung et al., 2014). Results from the California Health Interview Survey (CHIS) show no statistical difference across income groups among those who list cost as the main reason for delaying or forgoing care for persons younger than 21 years (ranging from the lowest percentage at 35.2% of total in the 200–299% FPL group to the highest percentage of 42.7% in the 0–99% FPL group) (CHIS, 2022).[34]

Race and Ethnicity

The California Health Interview Survey (CHIS) found disparities by race and ethnicity among the share of persons younger than 21 years listing cost or insurance as the main reason for delayed or forgone care, with 46.8% for Black or African American respondents, 40.2% of Latino respondents, 33.0% of White respondents, and 18.0% of Asian respondents reporting delaying or forgoing care due to cost or insurance. Data on Native Americans or Pacific Islanders was not available (CHIS, 2022).

Sex or Gender[35]

A higher share of persons younger than 21 years who identified as female listed cost or other insurance reasons as the main cause for delaying or forgoing care when compared to people who identify as male (39.8% vs 33.3%, respectively) (CHIS, 2025). A higher share of persons younger than 21 years who identified as female listed cost or other insurance

[33] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).
[34] The California Health Interview Survey was sent to the sampled adult of the household. If present, one adolescent (12-17) and one child (younger than 12 years) would be randomly selected for an interview. The adolescent would be interviewed directly via CATI or Web and the child interview would be completed by the parent or guardian.
[35] CHBRP uses the National Institutes of Health (NIH) distinction between "sex" and "gender": "'Sex' refers to biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles. 'Gender' refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time." (NIH, 2019).

reasons as the main cause for delaying or forgoing care when compared to people who identify as male (38.5% vs. 34.7%, respectively) (CHIS, 2022).

Age

The percentage of persons younger than 21 years by age subgroups that listed cost or other insurance-related reasons as the main case for delayed or forgone care also varied. Among families reporting delayed or forgone care, 38.3% of the 0- to 4-year-old group, 51.4% of the 5- to 11-year-old group, 19.3% of the 12- to 14-year-old group, 29.2% of the 15- to 17-year-old group, and 39.6% of the 18- to 21-year-old group listed cost or other insurance-related reasons as the primary reason for delaying or forgoing care (CHIS, 2022).

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Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Introduction* section, AB 298 would prohibit health plans and health policies regulated by DMHC or CDI cost sharing (including deductibles, copays, or coinsurance) for health services provided to enrollees younger than 21 years. AB 298 would not affect current benefit coverage but rather the cost sharing currently associated with services provided through existing coverage.

This section reports the potential incremental impacts of AB 298 on estimated baseline benefit coverage, utilization, and overall cost. Increases in utilization are expected in most categories of care for enrollees younger than 21 years, including outpatient office visits, mental health, and emergency department care, as cost sharing is reduced to zero for all medical services.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Analytic Approach and Key Assumptions

As stated in the *Introduction*, AB 298 includes all in-network medical services, including doctor visits, mental health care, and any specialty care.

To analyze the benefit coverage, cost, and utilization impacts of AB 298, CHBRP has assumed that AB 298 does not apply to pharmacy benefit coverage or to coverage for durable medical equipment (DME). AB 298 applies to services under a DMHC-regulated plan or CDI-regulated policy's medical benefit coverage.

Due to the broad nature of the mandate under AB 298, CHBRP's Cost and Coverage Model provides aggregated reports of utilization increases by showing aggregated cost increases per member per month (PMPM) charges for all health services combined, by market segment. Since the unit cost of services is not assumed to change postmandate due to the AB 298, changes in PMPM charges reflect changes in utilization of services by enrollees.

In establishing the approach, CHBRP considered how AB 298's cost-sharing requirements could impact plans or policies differentially depending on their specific plan benefit design. Given that CHBRP is unable to model the differential behavior of each unique insurance plan or policy, CHBRP took the approach of modeling the impact of AB 298 for aggregate market segments (see Appendix B). Specifically, this modeling of the commercial insurance landscape informs the approach applied to the interaction of AB 298 with 1) metal-level tier requirements for plans and policies sold on and off Covered California's Marketplace, 2) mental health parity requirements (please see *Other Considerations for Policymakers* for a fuller discussion).

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

Baseline and Postmandate Benefit Coverage

As discussed in the *Introduction* section, AB 298 would apply to state-regulated health insurance, including commercial enrollees, enrollees with insurance through the California Public Employees' Retirement System (CalPERS), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans. It should be noted that DMHC regulates the plans and policies of

approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[36]

Enrollees younger than 21 years in DMHC-regulated Medi-Cal managed care plans currently have coverage that is compliant with AB 298. All other DMHC-regulated plans and CDI-regulated policies have some cost sharing associated with medical benefits, and therefore are not currently compliant with AB 298. CHBRP estimates that at baseline, 13,570,000 Californians (61%) with state-regulated insurance subject to the mandate are enrolled in plans or policies with cost sharing for services for enrollees younger than 21 year, and 8,637,000 (39%) are enrolled in plans or policies that are compliant.

Postmandate, 100% of DMHC-regulated plans and CDI-regulated policies would be compliant with AB 298.

Below, Table 1 provides estimates of how many Californians have health insurance that would have to comply with AB 298 in terms of cost sharing for existing benefit coverage.

Table 1. Impacts of AB 298 on Cost Sharing for Existing Benefit Coverage, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,207,000	22,207,000	0	0.00%
Total enrollees with health insurance subject to AB 298	22,207,000	22,207,000	0	0.00%
Percentage of enrollees with coverage without cost sharing for enrollees younger than 21 years	39%	100%	61%	157.11%
Number of enrollees with coverage without cost sharing for enrollees younger than 21 years	8,637,000	22,207,000	13,570,000	157.11%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[37]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Baseline and Postmandate Utilization and Unit Cost

Commercial and CalPERS

CHBRP estimated the impact of AB 298 using the Milliman Health Care Guidelines (see Appendix B for a full explanation). At baseline, CHBRP finds that there are 3,368,000 enrollees younger than 21 years in DMHC-regulated plans or CDI-regulated policies that are not HSA-qualified, including CalPERS plans. In this market, the estimated PMPM charges for all medical services averaged $685.34 for all ages. At baseline, there are 264,000 enrollees younger than 21 years in HSA-qualified HDHPs regulated by DMHC or CDI. For this market, the estimated PMPM charges for all ages for all medical services averaged $610.17. Finally, there are the 3,839,000 enrollees younger than 21 years that have DMHC-regulated Medi-Cal managed care coverage. In this market segment, the estimated PMPM charges averaged $285.51 for all medical services for all ages.

[36] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[37] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Postmandate, eliminating cost sharing for enrollees younger than 21 years would increase utilization of some medical services. In plans or policies that are not HSA-qualified, the estimated increase in PMPM charges for all ages would be 0.57% ($3.90) postmandate. For enrollees in HSA-qualified HDHPs, PMPM charges would increase by 0.28% ($1.73).

Below, Table 2 provides estimates of the impacts of AB 298 on average utilization and PMPM charges for all medical services for which cost sharing would be eliminated postmandate for enrollees younger than 21 years.

Table 2. Impacts of AB 298 on Utilization and Average PMPM Charges, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Commercial/CalPERS enrollees in plans or policies that are not HSA-qualified				
Number of enrollees younger than 21 years in non–HSA-qualified plans and policies	3,368,000	3,368,000	0	0.00%
Average allowed PMPM charges for all ages in non–HSA-qualified plans and policies	$685.34	$689.24	$3.90	0.57%
Commercial Enrollees in HSA-qualified HDHPs				
Number of enrollees younger than 21 years in HSA-qualified HDHP	264,000	264,000	0	0.00%
Average allowed PMPM charges for all ages in HSA-qualified HDHPs	$610.17	$611.90	$1.73	0.28%
Managed Care Medi-Cal				
Number of enrollees younger than 21 years	3,839,000	3,839,000	0	0.00%
Average allowed PMPM charges	$285.51	$285.51	$0.00	0.00%

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.

Medi-Cal

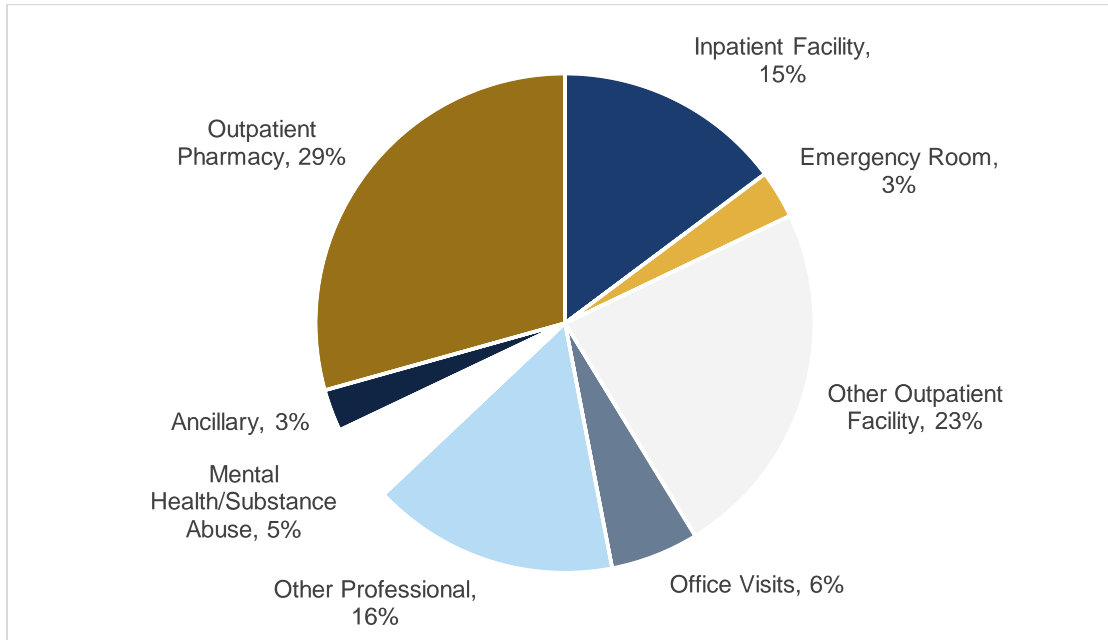
There is no impact estimated for enrollees in DMHC-regulated Medi-Cal plans, as they are compliant with AB 298 at baseline.

Change in Utilization and Unit Cost by Types of Services in a Sample Plan

To illustrate the estimated utilization impacts by types of services covered under the medical benefit, CHBRP estimated the effects of eliminating cost sharing for enrollees younger than 21 years for a sample health plan.[38] In order to create this illustrative analysis, CHBRP identified a sample DMHC-regulated small-group gold plan (see Figure 2 and Table 3). In this sample plan, enrollee cost sharing decreases by $5.90 PMPM postmandate. In general, cost-sharing amounts at baseline vary by service category.

[38] CHBRP's Cost and Coverage Model could not break out these categories of medical services for all plans combined, since benefit coverage varies among DMHC-regulated plans and CDI-regulated policies.

Figure 2. Share of Costs of Services by Type of Service in a Sample Small-Group Gold Plan, 2026



Source: California Health Benefits Review Program, 2025

Table 3. Impact of AB 298 on Cost of Services in a Sample Small-Group Gold Plan, 2026

Service Category	Baseline Total Cost of Services PMPM	Postmandate Total Cost of Services PMPM	Change in Total Cost of Services PMPM (a)	Baseline Enrollee Share of Cost PMPM	Postmandate Enrollee Share of Cost PMPM	Change in Enrollee Cost Share
Inpatient facility	$98.39	$98.39	$0.00	$0.89	$0.38	-$0.51
Emergency room	$20.74	$21.28	$0.53	$1.43	$0.86	-$0.58
Other outpatient facility	$155.06	$155.53	$0.47	$8.84	$7.79	-$1.05
Office visits	$38.04	$38.90	$0.85	$7.11	$5.52	-$1.58
Other professional	$106.36	$107.17	$0.82	$15.57	$13.67	-$1.90
Mental health/ Substance use	$33.15	$34.30	$1.15	$4.14	$2.90	-$1.24
Ancillary	$18.04	$18.04	$0.00	$2.96	$2.81	-$0.15
Outpatient pharmacy	$194.99	$195.53	$0.55	$7.86	$8.99	$1.12
Total PMPM	**$664.77**	**$669.14**	**$4.37**	**$48.80**	**$42.91**	**-$5.90**

Source: California Health Benefits Review Program, 2025
Notes: This table demonstrates AB 298's impact on utilization using a 2025 small-group gold plan.
(a) Change in total cost of services is due to increased utilization from the elimination of enrollee cost share.
Key: PMPM = per member per month

In this sample small-group gold plan, average enrollee cost sharing would decrease across nearly all service categories postmandate due to the prohibition of cost sharing for enrollees younger than 21 years under AB 298. This decrease in cost sharing would increase utilization, as measured by the increase in total cost PMPM. Total PMPM costs could increase across most types of care, except inpatient facility care and ancillary care, which tend not to be cost sensitive (see Table 3). Mental health/substance use, emergency room care, and office visits would experience the highest increases in PMPM costs postmandate (3.5%, 2.6%, and 2.2% respectively) as cost sharing would no longer be a barrier to enrollees younger than 21 years, and there would be fewer cost-related delays in accessing care. Outpatient pharmacy cost sharing is not covered under AB 298 but would increase overall postmandate due to the increase in doctor visits leading to increased number of prescribed medications.

Baseline and Postmandate Expenditures

For 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 (Table 4). Individual premium and group insurance expenditures would also increase. Meanwhile, enrollee expenses for covered benefits would decrease, and expenses for noncovered benefits would remain the same. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure 3).

Below, Table 4 provides detailed estimates of the impacts of AB 298 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

Figure 3. Expenditure Impacts of AB 298

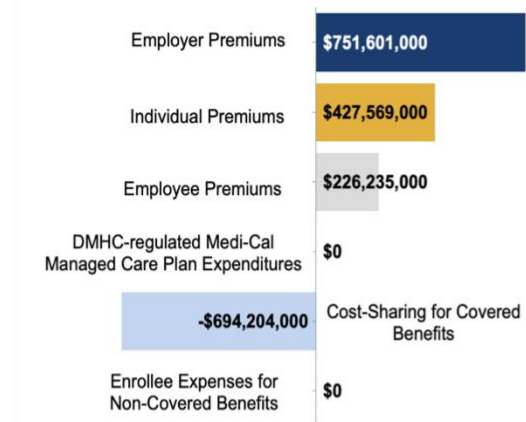


Table 4. Impacts of AB 298 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$69,439,562,000	$686,924,000	1.00%
CalPERS employer (b)	$7,881,873,000	$7,946,550,000	$64,677,000	0.82%
Medi-Cal (excludes COHS)	$31,818,731,000	$31,818,731,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,757,790,000	$22,185,359,000	$427,569,000	1.97%
Outside Covered California	$6,011,399,000	$6,216,152,000	$204,753,000	3.41%
Through Covered California	$15,746,391,000	$15,969,207,000	$222,816,000	1.42%
Enrollees, group insurance (c)	$21,712,866,000	$21,939,101,000	$226,235,000	1.04%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copayments, etc.)	$18,992,422,000	$18,298,218,000	-$694,204,000	-3.66%

Expenses for noncovered benefits (d) (e)	$0	$0	$0	0.00%
Total expenditures	$170,916,320,000	$171,627,521,000	$711,201,000	0.42%

Source: California Health Benefits Review Program, 2025.
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.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, 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 will 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; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Premiums

At the end of this section, Table 7 and Table 8 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums plus enrollee expenses).

Changes in premiums as a result of AB 298 would vary by market segment.[39] Note that such changes are related to the number of enrollees (see Table 2, Table 7, and Table 8), with health insurance that would be subject to AB 298.

Premium increases postmandate stem from three factors: increase in utilization (accounting for 44% of the premium increase), shift in cost sharing from point-of-service to premiums (49%), and administrative costs (7%).

Commercial

PMPM premium increases in DMHC-regulated commercial plans range from 0.85% ($5.98 PMPM) for large-group plans to 1.95% ($15.96 PMPM) for individual plans. Among CDI-regulated policies, PMPM increases range from 1.29% ($10.79 PMPM) for large-group policies to 2.92% ($22.74 PMPM) for individual policies. These increases are due in part from a shift in costs to insurers, with reductions in enrollee expenses for covered benefits, ranging from reductions of $2.69 PMPM for DMHC-regulated large-group plans to $11.84 PMPM for CDI-regulated individual policies. Combined, total expenditures are expected to increase postmandate by a range of 0.43% PMPM for DMHC-regulated large-group plans to 1.15% PMPM for CDI-regulated individual policies.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, PMPM premiums are expected to increase by 0.82% ($7.04 PMPM) postmandate.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there would be no impact as coverage at baseline is already compliant with AB 298.

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 4, Table 11, and Table 8) with health insurance that would be subject to AB 298 expected to use medical services during the year after enactment.

[39] 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 7 and 8.

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 different types of plans among all market segments (see Table 5).

Average enrollee out-of-pocket expenses per user

For enrollees younger than 21 years in DMHC-regulated Medi-Cal managed care plans, there is no change postmandate in cost sharing. For enrollees younger than 21 years in DMHC- and CDI-regulated large-group HSA-qualified HDHPs, average cost sharing PMPM is expected to decrease by $15.04, while for enrollees younger than 21 years in non–HSA-qualified HDHPs, average cost sharing PMPM is expected to decrease by $10.31 (see Table 5). Enrollees younger than 21 years in DMHC- and CDI-regulated small-group HSA-qualified HDHPs have average cost-sharing reductions of $9.50 PMPM, and among enrollees in non–HSA-qualified HDHPs, an average reduction of $23.72 in PMPM cost sharing. Among enrollees younger than 21 years in DMHC- and CDI-regulated individual HSA-qualified HDHPs, reductions in cost sharing are estimated to be $1.17 PMPM on average, but for enrollees younger than 21 years in non–HSA-qualified HDHPs, reductions in cost sharing are estimated to be $43.71 PMPM.

Table 5. Impact of AB 298 on Average Annual Enrollee Out-of-Pocket Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal (b)
Number of enrollees younger than 21 years in HSA-qualified plans	163,000	61,000	40,000	0	0
Avg. cost sharing PMPM impact for enrollees in HSA-qualified plans (a)	-$15.04	-$9.50	-$1.17	$0.00	$0.00
Number of enrollees younger than 21 years in non–HSA-qualified plans	2,158,000	539,000	408,000	263,000	3,839,000
Avg. cost sharing PMPM impact for enrollees in non–HSA-qualified plans (a)	-$10.31	-$23.72	-$43.71	-$4.11	$0.00

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.
(b) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.
Key: CalPERS = California Public Employees' Retirement System; 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 5 reflect 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, the postmandate impact of eliminating cost sharing for enrollees younger than 21 years will vary by family in relation to how many covered enrollees in that household are under the age limitation under AB 298. Finally, CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to plans and insurers negotiating discounted rates that are unavailable to patients and their families.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of 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

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 exceeds 1% for some market segments (see Table 7 and Table 8), CHBRP would expect measurable changes in the number of uninsured persons due to the enactment of AB 298.[40] These impacts would vary by market segment. Premium increases are larger for enrollees in DMHC-regulated individual plans and CDI-regulated individual policies than for small- and large-group markets. The aggregate premium increases of more than 1% in the individual markets would lead to an estimated increase in the uninsured of 0.42%. Due to an estimated premium increase of greater than 1% due to AB 298 (Table 8), CHBRP estimates that the increases in premiums would cause 6,430 enrollees in the 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.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP is aware that cost-sharing requirements may induce enrollees younger than 21 years to obtain medical services by other means that would have been lower cost for the enrollees at baseline. For example, the public program FamilyPACT covers reproductive health services for no cost, while the private group Planned Parenthood also offers similarly low-cost or free services. If a teenager faced cost sharing through their DMHC-regulated plan or CDI-regulated policy for a doctor visit for reproductive health at baseline, they may have chosen to use either the public or private option for medical services instead. However, CHBRP is unable to quantify the potential impact of the shift in utilization for enrollees younger than 21 years using their medical benefit coverage postmandate with no cost sharing.

Actuarial Value Considerations and Compliance

CHBRP is aware that there are different impacts of the elimination of cost sharing for enrollees younger than 21 years by market segment that may affect insurer behavior postmandate. In some market segments, most notably individual-market DMHC-regulated plans and CDI-regulated policies sold through Covered California, cost sharing is a key component of how enrollees make their purchasing choice. ACA-compliant plans and policies are assigned to a metal tier of comparable actuarial value (bronze, silver, gold, platinum, or catastrophic), with subsidies and eligibility for purchase varying by metal tier. Under the ACA, plans at each designated metal tier must fall within an actuarial value range set annually by the Centers for Medicare & Medicaid Services (CMS). This range reflects the percentage of total average costs of covered benefits that a plan is expected to cover to remain within that tier, which impacts cost-sharing levels for enrollees.

Plan design changes such as that proposed by AB 298 may push the actuarial value of certain plans outside of that range depending on the plan's current benefit design and its current actuarial value, thereby disqualifying such plans from being sold at that metal tier. In order to remain at a designated metal tier, plan designs may be adjusted to increase cost sharing for enrollees aged 21 and over to balance the elimination of cost sharing for enrollees younger than 21 years as a result of AB 298. Such a situation could have downstream impacts on utilization and cost. Should insurers increase cost sharing for enrollees aged 21 years and older, premiums would not change substantially and therefore the number of uninsured would remain unchanged, and utilization for enrollees younger than 21 years would decrease. CHBRP is unable to model either differential behavior of individual insurance carriers by market segment or differential purchasing choices of

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

individual enrollees and therefore took the approach of modeling the impact of AB 298 for aggregate market segments (see Appendix B).

Mental Health Parity Considerations

Commercial and CalPERS DMHC-regulated plans and CDI-regulated policies in California covering mental health and substance use disorder (MH/SUD) benefits are subject to federal and California's state MH/SUD parity laws (see *Policy Context* section for more information). These requirements apply to DMHC- regulated plans and CDI-regulated policies without regard to enrollee age. The elimination of cost sharing for enrollees younger than 21 years as proposed in AB 298 could shift the "predominant financial requirements" for medical/surgical benefits for all enrollees in a given plan or policy, potentially requiring the elimination of cost-sharing requirements for MH/SUD benefits for all enrollees. Modeling the effects of AB 298 on mental health parity laws was beyond the scope of this analysis. However, were AB 298 to interact with mental health parity laws, then the impacts of AB 298 could vary (see Appendix B).

Alternate Cost Sharing Scenario

At the request of the Assembly Committee on Health, CHBRP also examined the potential impacts of an alternate cost sharing reduction scenario, in which cost sharing for most services covered under the medical benefit for enrollees younger than 21 years would be limited to $10, except for cost sharing for emergency care, which would be limited to $100.

Under this scenario, total expenditures would increase by $373,195,000 or 0.22% (see Table 10). This is approximately half the impact of eliminating all cost sharing, as discussed in depth above. For enrollees in HSA-qualified HDHPs, the average allowed PMPM would increase by 0.25% ($1.55 PMPM) (see Table 6). For commercial/CalPERS enrollees in plans or policies that are not HSA-qualified, the average PMPM would increase by 0.28% ($1.92 PMPM) (see Table 6). For enrollees in HSA-qualified HDHPs, the impacts between the two scenarios are similar. But for commercial/CalPERS enrollees not enrolled in HSA-qualified HDHPs, again, these increases constitute roughly half the impacts of AB 298. For several market segments, premium increases would also exceed 1% (small-group and individual market) and because the overall impact is approximately half the size of elimination of all cost sharing for enrollees younger than 21 years, CHBRP estimates that roughly 3,000 people would become uninsured postmandate under this alternate cost sharing scenario.

Additional tables regarding the alternate cost sharing scenario are included in Appendix D.

Table 6. Alternate Cost Sharing Scenario — Impacts of AB 298 on Utilization and Average PMPM, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Commercial/CalPERS enrollees in plans or policies that are not HSA-qualified				
Number of enrollees younger than 21 years in non–HSA-qualified plans or policies	3,368,000	3,368,000	0	0.00%
Average allowed PMPM for all ages in non–HSA-qualified plans or policies	$685.34	$687.26	$1.92	0.28%
Commercial enrollees in HSA-qualified HDHPs				
Number of enrollees younger than 21 years in HSA-qualified HDHP	264,000	264,000	0	0.00%

Average allowed PMPM for all ages in HSA-qualified HDHPs	$610.17	$611.72	$1.55	0.25%
Managed Care Medi-Cal				
Number of enrollees younger than 21 years	3,839,000	3,839,000	0	0.00%
Average allowed PMPM	$285.51	$285.51	$0.00	0.00%

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.

Table 7. Baseline 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 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)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 298	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Premiums										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0.00	$718.62	$276.79	$583.72	$609.11	$567.83	$0.00	$108,453,242,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$151,923,898,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0.00	$0.00	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$767.33**	**$884.75**	**$1,091.05**	**$939.30**	**$276.79**	**$583.72**	**$956.34**	**$1,002.63**	**$951.40**	**$170,916,320,000**

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 51.6% are state retirees, state employees, or their dependents.
(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.[4]
(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 will 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 8. 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 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)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 298	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Premiums										
Average portion of premium paid by employer (e)	$4.7435	$7.9404	$0.0000	$5.8969	$0.0000	$0.0000	$7.8851	$8.7496	$0.0000	$751,601,000
Average portion of premium paid by enrollee	$1.2391	$3.3251	$15.9616	$1.1413	$0.0000	$0.0000	$2.9030	$2.8582	$22.7400	$653,804,000
Total premium	$5.9825	$11.2655	$15.9616	$7.0382	$0.0000	$0.0000	$10.7881	$11.6078	$22.7400	**$1,405,405,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$2.6948	-$5.7531	-$9.5141	-$1.3174	$0.0000	$0.0000	-$5.7378	-$5.5560	-$11.8449	-$694,205,000
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	$3.2877	$5.5124	$6.4475	$5.7208	$0.0000	$0.0000	$5.0503	$6.0518	$10.8950	**$711,201,000**
Percent change										
Premiums	0.8511%	1.5638%	1.9501%	0.8206%	0.0000%	0.0000%	1.2945%	1.5409%	2.9249%	0.9251%
Total expenditures	0.4285%	0.6231%	0.5909%	0.6091%	0.0000%	0.0000%	0.5281%	0.6036%	1.1452%	0.4161%

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 51.6% are state retirees, state employees, or their dependents.
(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.[5]
(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 will 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.

Public Health Impacts

As discussed in the *Introduction* section, AB 298 would prohibit DMHC-regulated plans and CDI-regulated policies from imposing a deductible, coinsurance, copayment, or other cost sharing for covered, in-network services provided to enrollees younger than 21 years. For enrollees in DMHC- and CDI-regulated HSA-qualified HDHPs, AB 298 would prohibit cost sharing for certain preventive care services, and for other covered services, prevent cost sharing once the deductible is met. AB 298 applies to medical services, excluding services covered under the pharmacy benefit or durable medical equipment benefit.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[41] of AB 298 on utilization, outcomes, and potential disparities. See *Long-Term Impacts* for discussion of impact on cost, access to care, and outcomes.

Estimated Public Health Outcomes

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, at baseline, 100% of enrollees in state-regulated commercial and CalPERS plans and policies have some cost sharing for medical services. Enrollees younger than 21 years in DMHC-regulated Medi-Cal plans already have access to coverage without cost sharing. Postmandate, an additional 13,570,000 enrollees would be in plans or policies that eliminate cost sharing for enrollees younger than 21 years (a 157% increase over baseline), of whom 3,632,000 would be enrollees younger than 21 years.

It is estimated that as a result of AB 298, **enrollee out-of-pocket expenses would decrease** by an average of 3.66% postmandate. The elimination of cost sharing under AB 298 would reduce out-of-pocket expenses on average for enrollees across each market segment, but, as stated in the *Benefit Coverage, Utilization and Cost Impact* section, the amount cost sharing decreases as a result of AB 298 would vary by market type. For instance, annual out-of-pocket expenses would decrease, on average, by $43.71 for enrollees younger than 21 years in individual market plans or policies that are not HSA-qualified, and by $1.17 for individual market plans or policies that are HSA-qualified. Enrollees younger than 21 years in HSA-qualified HDHPs would still need to meet their deductible before being eligible for coverage without cost sharing for non-preventive care, and therefore would still have out-of-pocket cost sharing for deductibles.

CHBRP finds some evidence that 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 (see *Background* section). However, 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.[42] 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.

It is estimated that as a result of AB 298, **utilization would increase across services** overall and by service category.

- **Behavioral Health.** Mental health and substance use disorder (SUD) services would experience the highest level of increases in utilization postmandate. This increase in access and utilization would address at least some part of the unmet need of mental health/SUD care amongst persons under the age of 21.
- **Emergency Room.** While some enrollees may shift from ER care to lower levels of care, such as office visits, in general utilization of emergency room care would increase postmandate as enrollees would no longer be prohibited by cost.

[41] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.
[42] 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.

- **Office Visits.** Office visit utilization would increase postmandate. While there is little available evidence examining the extent to which changes in cost sharing directly improve outcomes through increased utilization, it *is* known that not delaying care may improve health due to earlier diagnosis, treatment, and alleviation of symptoms.
- **Outpatient Pharmacy.** While AB 298 would not change cost sharing for pharmacy benefits, CHBRP estimates that medication use among enrollees younger than 21 years would increase if AB 298 is enacted, driven by the increase in office visits and other types of care. Increased medication use would improve health outcomes and help manage symptoms chronic conditions.

In the first year postmandate, 3,632,000 enrollees younger than 21 years would be eligible to receive medical services without cost sharing due to AB 298. Overall, enrollee out-of-pocket costs would decrease by $694,205,000, resulting in an increase in utilization across most types of care. To the extent that increased utilization results in improved health outcomes, there would be a public health impact.

Impact on Disparities[43]

AB 298 could have a differential impact by income level to the extent that enrollees younger than 21 years experience reduced cost sharing and increased utilization. As discussed in the *Background* section, CHBRP finds evidence that lower-income families who experience cost sharing are more likely to delay and forgo care due to cost than either higher-income families or those with insurance that already limits cost sharing. The elimination of cost sharing under AB 298 could thereby have a greater impact on care-seeking among lower-income families, particularly those in non–HSA-qualified plans or policies. As a result of increased access, utilization across services could increase for persons younger than 21 years in these families.

Yet, to the extent that the increase in premiums due to AB 298 presents a financial barrier for lower-income families with high health care costs, they may choose to forgo insurance altogether. This may exacerbate existing disparities in access to care for lower-income families who are not eligible for Medi-Cal or premium subsidies.

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[43] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of AB 298, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

Because of the broad impact of AB 298, CHBRP is unable to estimate utilization impacts past the first year. Utilization of medical services would be expected to increase in similar proportion to the first year postmandate, and there is a potential of reductions of higher-cost services and treatments of downstream health services. Enrollees younger than 21 years would be more likely to receive appropriate and timely care if there are no longer delays due to cost of health services.

Cost Impacts

With the broad impacts of AB 298, CHBRP is unable to estimate cost impacts past the first year. There is the potential for overall health costs to reduce over time as enrollees younger than 21 years receive appropriate and timely health care with no cost sharing for medical services leading to healthier outcomes for the entire population. There may also be some increase in out-of-pocket costs for baseline enrollees that become uninsured due to premium increases from AB 298. Additionally, there could be increases in the unit cost of services with the expected increases in utilization postmandate as well as with time, as unit cost of health care services tends to increase with time.

Long-Term Public Health Impacts

CHBRP is unable to estimate public health impacts past the first year. Additionally, long term impacts beyond those projected in the analysis are uncertain. There are a number of competing and potential impacts on enrollment, utilization, and provider access that make determining long-term impacts for a given group of people difficult to capture.

The elimination of cost sharing under AB 298 would lower the cost barrier to care, particularly for families in plans that are not HSA-qualified, potentially driving utilization up in the long term. With increased access to no-cost care, persons younger than 21 years may receive more timely access to care, treatments, and medication, potentially leading to improved health outcomes.

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Appendix A. Text of Bill Analyzed

On March 30, 2025, the California Assembly Committee on Health requested that CHBRP analyze AB 298, as introduced on January 23, 2025, as amended on March 4, 2025.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL
NO. 298

Introduced by Assembly Member Bonta

January 23, 2025

An act to add Section 1367.55 to the Health and Safety Code, and to add Section 10123.187 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 298, as introduced, Bonta. Health care coverage cost sharing.

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's requirements a crime. Existing law provides for the regulation of ~~disability~~ *health* insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.

This bill would prohibit a health care service plan contract or ~~disability~~ *health* insurance policy issued, amended, or renewed on or after January 1, 2026, from imposing a deductible, coinsurance, copayment, or other cost sharing requirement for ~~services~~ *in-network health care services, as defined,* services provided to an enrollee or insured under aged 21 years, except as otherwise specified. The bill would prohibit an individual or entity from billing or seeking reimbursement for *in-network health care* services provided to an enrollee or insured under aged 21 years, except as otherwise specified. Because a willful violation of these provisions by a health care service plan would be a crime, the 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.

DIGEST KEY

Vote: MAJORITY   Appropriation: NO   Fiscal Committee: YES   Local Program: YES

BILL TEXT

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

SECTION 1. Section 1367.55 is added to the Health and Safety Code, to read:
1367.55. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall not impose a deductible, coinsurance, copayment, or other cost sharing requirement for *in-network health care* services provided to an enrollee under 21 years of age, except as provided in subdivision (c).

(b) An individual or entity shall not bill or seek reimbursement from an enrollee or contractholder for *in-network health care* services provided to an enrollee under 21 years of age, except as provided in subdivision (c).

(c) In the case of a health care service plan contract that is a high deductible health plan qualifying as eligible for use in combination with a health savings account under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the health care service plan contract shall not impose either of the following:

(1) A deductible, coinsurance, copayment, or other cost sharing requirement for preventive care services, as defined for purposes of Section 223(c)(2) of Title 26 of the United States Code, provided to an enrollee under 21 years of age.

(2) Coinsurance, a copayment, or other cost sharing requirement for *in-network health care* services provided to an enrollee under 21 years of age once a health care service plan contract's deductible has been satisfied for the plan year.

(d) For purposes of this section, "in-network health care services" means all of the following:
(1) Covered services provided by a contracting provider.
(2) Covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting provider.
(3) Covered emergency services.
(4) Covered services provided to an enrollee by a noncontracting provider when a contracting provider is not available to provide the service in accordance with the timely access requirements described in Section 1367.03.
(e) This section does not expand or otherwise affect the scope of required coverage for out-of-network emergency services, except to the extent that cost sharing requirements for covered out-of-network emergency services shall not be imposed on an enrollee under 21 years of age pursuant to subdivision (a).

SEC. 2. Section 10123.187 is added to the Insurance Code, to read:

10123.187. (a) A ~~disability~~ *health* insurance policy issued, amended, or renewed on or after January 1, 2026, shall not impose a deductible, coinsurance, copayment, or other cost sharing requirement for *in-network health care* services provided to an insured under 21 years of age, except as provided in subdivision (c).

(b) An individual or entity shall not bill or seek reimbursement from an insured or policyholder for *in-network health care* services provided to an insured under 21 years of age, except as provided in subdivision (c).

(c) In the case of a ~~disability~~ *health* insurance policy that is a high deductible health plan qualifying as eligible for use in combination with a health savings account under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the ~~disability~~ *health* insurance policy shall not impose either of the following:

(1) A deductible, coinsurance, copayment, or other cost sharing requirement for preventive care services, as defined for purposes of Section 223(c)(2) of Title 26 of the United States Code, provided to an insured under 21 years of age.

(2) Coinsurance, a copayment, or other cost sharing requirement for *in-network health care* services provided to an insured under 21 years of age once a ~~disability~~ *health* insurance policy's deductible has been satisfied for the plan year.

(d) For purposes of this section, "in-network health care services" means all of the following:

(1) Covered services provided by a contracting provider.

(2) Covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting provider.

(3) Covered emergency services.

(4) Covered services provided to an enrollee by a noncontracting provider when a contracting provider is not available to provide the service in accordance with the timely access requirements described in Section 10133.54.

(e) This section does not expand or otherwise affect the scope of required coverage for out-of-network emergency services, except to the extent that cost sharing requirements for covered out-of-network emergency services shall not be imposed on an enrollee under 21 years of age pursuant to subdivision (a).

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.

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Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., 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.[44] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[45]

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

Analysis-Specific Data Sources

Health Cost Guidelines

The Milliman Health Cost Guidelines (HCGs) are a health care pricing suite used by actuaries in many of the major health plans in the United States. This analysis relied on the Managed Care Rating Model (MCRM) within the HCGs. The MCRM is a rating tool that calculates estimated utilization, allowed, and paid costs of over 100 different service categories based on the actuary's benefit design input. This tool consists of utilization, claims costs, and claim probability distributions adjusted to account for geographical and demographic differences in utilization and cost. Values are also adjusted for provider reimbursement and the degree of health care management. The utilization is also adjusted to account for the induced utilization associated with different cost-sharing amounts.

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 by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Across the California insurance landscape, there are hundreds of different health plans from different insurance carriers with different benefit designs. For this analysis, CHBRP did not exhaustively model all plans. Instead CHBRP used the carrier Premium and Enrollment Survey responses to summarize enrollees into plans by metal tiers for nongrandfathered individual and small-group plan enrollees and by deductible level for large-group and grandfathered plan enrollees. For each market, metal, and deductible tier, a representative plan was selected and assumed to be the benefit design for all enrollees with a plan of that market, metal and deductible tier. A total of 26 plans were selected by deductible and actuarial metal tier as representative of the California commercial insurance landscape. Details about the representative plans can be found in

[44] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[45] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

Table 9, below. Medi-Cal plans do not have enrollee cost sharing and are already compliant with AB 298.

Table 9. Representative Plans Used to Model the Impact of AB 298

Market	Plan Tier	Plan selected
Small Group	Platinum	Kaiser PCP 0/20 PCP (HMO)
Small Group	Gold	Kaiser 250/35 PCP (HMO)
Small Group	Silver	Kaiser 1900/65 ALT PCP (HMO)
Small Group	Bronze	Blue Shield Trio 7000/70 PCP ALT (HMO)
Small Group	Gold HSA qualified	Kaiser HDHP 1750/15% ALT PCP (HMO)
Small Group	Silver HSA qualified	Kaiser HDHP 2850/25% PCP (HMO)
Small Group	Bronze HSA qualified	Kaiser HDHP 6650/0% PCP (HMO)
Individual	Platinum	Individual-only Platinum Copay Plan
Individual	Gold	Individual-only Gold Copay Plan
Individual	Silver 70	Individual-only Silver Plan
Individual	Silver 73	CA Enhanced CSR Silver 73 Plan
Individual	Silver 87	CA Enhanced CSR Silver 87 Plan
Individual	Silver 94	CA Enhanced CSR Silver 94 Plan
Individual	Bronze	Bronze Plan
Individual	Bronze, HSA qualified	Bronze HDHP Plan
Individual	Catastrophic	Catastrophic Plan
Large Group (and GF)	$0 Deductible	$0 deductible, $1,500 MOOP, $100 per admit inpatient, $50 emergency room visit, $10 PCP visit, $15 specialist visit, $5 generic pharmacy, $10 brand pharmacy, $50 specialty, and 5% coinsurance for other services.
Large Group (and GF)	$1 - $799 deductible	$400 deductible, $2,500 MOOP, $350 per admit inpatient, $100 emergency room visit, $10 PCP visit, $15 specialist visit, $5 generic pharmacy, $10 brand pharmacy, $75 specialty, and 10% coinsurance for other services.
Large Group (and GF)	$800 - $1,599 deductible	$1,200 deductible, $3,500 MOOP, 10% coinsurance inpatient, $150 emergency room visit, $20 PCP visit, $30 specialist visit, $10 generic pharmacy, $35 brand pharmacy, $150 specialty, and 10% coinsurance for other services.
Large Group (and GF)	$1,600 - $3,999 deductible	$2,800 deductible, $5,500 MOOP, 20% coinsurance inpatient, $250 and 20% coinsurance emergency room visit, $25 PCP visit, $35 specialist visit, $15 generic pharmacy, $40 brand pharmacy, $250 specialty, and 20% coinsurance for other services.

Large Group (and GF)	$4,000 - $5,999 deductible	$5,000 deductible, $6,500 MOOP, 30% coinsurance inpatient, 30% coinsurance emergency room visit, $30 PCP visit, $40 specialist visit, $20 generic pharmacy, $45 brand pharmacy, $250 specialty, and 30% coinsurance for other services.
Large Group (and GF)	$6,000 deductible or greater	$6,000 deductible, $8,000 MOOP, 30% coinsurance inpatient, 30% coinsurance emergency room visit, $40 PCP visit, $55 specialist visit, $25 generic pharmacy, $55 brand pharmacy, $500 specialty, and 30% coinsurance for other services.
Large Group (and GF)	$1,600 - $3,999 deductible, HSA qualified	$2,800 deductible, $5,500 MOOP, and 20% coinsurance after deductible
Large Group (and GF)	$4,000 - $5,999 deductible, HSA qualified	$5,000 deductible, $6,500 MOOP, and 30% coinsurance after deductible
Large Group (and GF)	$6,000 deductible or greater, HSA qualified	$6,000 deductible, $8,000 MOOP, and 30% coinsurance after deductible
CalPERS	DMHC Regulated	CalPERS Kaiser Traditional HMO Plan

Source: California Health Benefits Review Program, 2025.
Key: CalPERS = California Public Employees' Retirement System; DMHC = Department of Managed Health Care; HSA = health savings account; HDHP = high deductible health plan; MOOP = maximum out of pocket; PCP = primary care physician; PMPM = per member per month.

Methodology and Assumptions for Baseline Cost, Utilization, and Cost Sharing

The Managed Care Rating Model (MCRM) was used to model the allowed claims, paid claims, and enrollee share of cost for each of the representative plans listed above. Values were adjusted for the California region and provider reimbursement values from Milliman's Commercial Reimbursement Benchmarking Model. Plan costs were trended to 2026 using an annual inpatient cost trend of 1%, an annual outpatient cost trend of 7% and outpatient utilization trend of 0.5%, an annual professional cost trend of 4.5%, and an annual outpatient pharmacy cost trend of 11.5% and outpatient pharmacy utilization trend of 2.5%.

- Plans costs and patient cost sharing were modeled separately for enrollees younger than 21 years and enrollees 21 and over.
- Plan costs and patient cost sharing for each of the representative plans were aggregated by line of business using the deductible and metal tier enrollment distribution by line of business from the 2024 premium and enrollment survey.

Methodology and Assumptions for Postmandate Cost, Utilization, and Cost Sharing

- CHBRP modeled the postmandate cost and cost sharing similar to the baseline cost and cost sharing.
- CHBRP assumed all cost sharing was eliminated for enrollees younger than 21 years in non–HSA-qualified plans and all cost sharing beyond the deductible was eliminated for enrollees younger than 21 years in HSA-qualified plans. CHBRP modified the representative plans for this change in cost sharing for enrollees younger than 21 years.
- CHBRP assumed the costs that would have been paid by patient cost sharing in the baseline would shift to the insurer postmandate.
- CHBRP assumed no change in the average cost of services for enrollees younger than 21 years postmandate.
- CHBRP used the induced utilization factors in the MCRM to adjust for the increase in services for enrollees younger than 21 years as a result of the elimination of all cost sharing for enrollees in non–HSA-qualified plans and the

elimination of cost sharing beyond the deductible for enrollees in HSA-qualified plans.

Methodology and Assumptions for Calculating the AB 298 Impact

- The 2026 baseline allowed costs were developed by removing administrative costs and profit from projected 2026 premiums in the Cost Model.
- CHBRP modeled the percentage increase in allowed costs as postmandate allowed as calculated by the MCRM for the representative plans divided by baseline allowed as calculated by the MCRM for the representative plans. This increase was dampened by 5% to adjust for AB 298 only applying to in-network services.
- This impact adjustment was applied to the 2026 baseline allowed costs from the Cost Model to determine 2026 postmandate allowed costs.
- CHBRP applied baseline and postmandate paid to allowed ratios to the baseline and postmandate allowed costs to determine insurer paid and enrollee share of cost.

Methodology and Assumptions for the Alternate Cost Sharing Scenario

- Postmandate, representative plans were adjusted to reflect a scenario with all cost sharing eliminated for enrollees younger than 21 years with the exception of $10 office visit copayments and $100 emergency department visit copayments. For enrollees younger than 21 years in HSA qualified health plans, cost sharing would be eliminated after the deductible is reached with the exception of $10 office visit copayments and $100 emergency department visit copayments.
- The scenario under the alternate cost sharing scenario was modeled similarly to the scenario proposed under AB 298, with methodology described above.

Limitations and Considerations

Plans sold through Covered California's individual and small-group marketplace must be categorized into four different metal tiers (bronze, silver, gold, and platinum), as well as catastrophic plans. Plans are placed into metal tiers according to their actuarial value, as calculated by the Actuarial Value Calculator published by the department of Health and Human Services (HHS) and must be within the de minimis range set annually by CMS. The CMS 2025 Marketplace Integrity and Affordability Proposed Rule is seeking to establish a de minimis range of -4 to +2 percentage points and plans that fall outside the de minimis ranges cannot be sold.[46]

While HHS's Actuarial Value Calculator is not a pricing tool, plan design changes that add benefit richness such as AB 298 may increase the calculated actuarial value to outside of the de minimis range. In that situation, metal tier plan designs may be adjusted to increase cost sharing for enrollees aged 21 and over to balance the elimination of cost sharing for enrollees younger than 21 years as a result of AB 298. How Covered California and insurers would make those adjustments is unknown and modeling such a change was beyond the scope of this analysis.

Most plans in California both cover mental health and substance use disorder (MH/SUD) benefits and are subject to MH/SUD parity laws. According to CMS, "the Mental Health Parity and Addition Equity Act (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification. In addition, MHPAEA prohibits separate financial requirements and treatment limitations that apply only to MH/SUD benefits."

These requirements apply to plans without regard to enrollee age, and plans that do not pass these laws have financial requirements and treatment limitations removed for MH/SUD benefits. The elimination of cost sharing for enrollees younger than 21 years may shift the value of "predominant financial requirements" for medical/surgical benefits for all

[46] See the factsheet, 2025 Marketplace Integrity and Affordability Proposed Rule, published March 10, 2025 by CMS for more information.

enrollees and require cost sharing be removed from all MH/SUD benefits for all enrollees. Modeling the effects of AB 298 on mental health parity laws was beyond the scope of this analysis.

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

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 298 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of AB 298 would be substantially the same as the impacts in the first year (Table 4, Table 7, Table 8). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

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Appendix C. Cost Sharing and Utilization Management

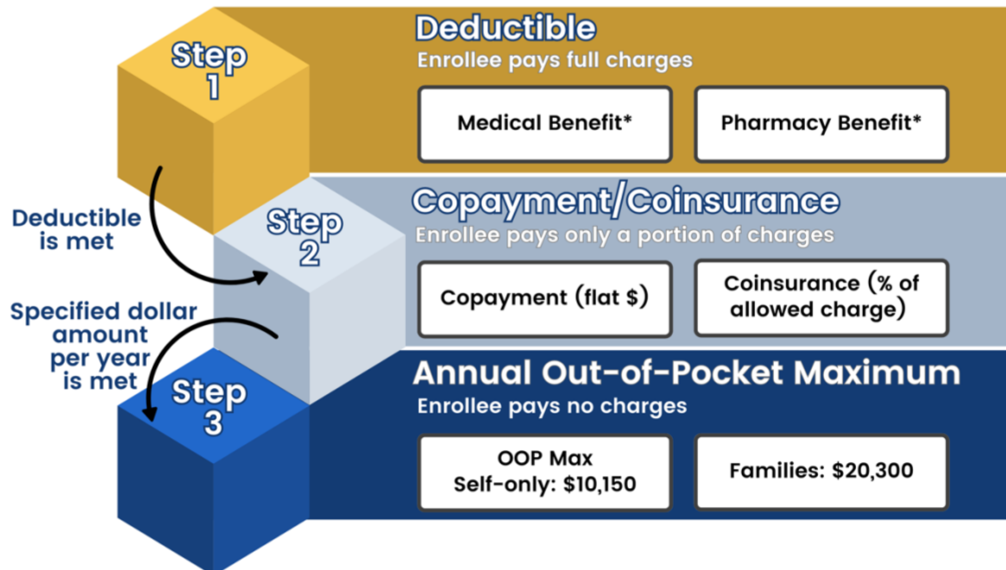
This section provides an overview of the cost sharing and utilization management structures used for health insurance benefits, including prescription drugs.

Cost Sharing

Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[47]). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (Figure 4). Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.[48]

Annual out-of-pocket maximums for covered benefits limit annual enrollee cost sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits.

Figure 4. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2025; CMS, 2024.
Notes: * Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also, copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2). The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2024).
There is variation in the type and source of the pharmacy benefit among commercial and CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies. While most enrollees have a pharmacy benefit that is regulated by DMHC or CDI, a small share of enrollees in the individual market have a pharmacy benefit that covers only generic medications, do not have a pharmacy benefit at all, or have a pharmacy benefit not subject to DMHC

[47] Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through the Covered California, or they receive benefits through Medi-Cal.
[48] Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percent of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.

or CDI regulation. Thus, the deductible paid by enrollees will vary depending on whether they have a medical and/or pharmacy benefit included in their plan or policy.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; OOP Max = annual out-of-pocket maximum.

Allowed Cost Amounts for Medical Services

Insurers usually negotiate how much they will pay for the costs of covered health care services with health care providers and suppliers (Center on Budget and Policy Priorities, 2018). These negotiated amounts are known as the "allowed cost amount." Health care providers, including hospitals and physicians, participating in a plan's network agree to accept these payment amounts when an enrollee covered by the plan uses covered services. The cost-sharing charges the enrollee owes (for example, a 20% coinsurance rate) are based on this allowed cost amount. If an enrollee uses a service that is not covered or sees a provider that is not within the insurer's network, the overall charge, including an enrollee's cost sharing, could be higher than the allowed amount.

Appendix D. Additional Tables for Alternate Cost Sharing Scenario

As described in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP was asked to model an additional scenario of limiting cost sharing to $10 for most services and $100 for emergency care. The below are additional tables that estimate this impact. See the overall discussion of this impact in the *Benefit Coverage, Utilization, and Cost Impacts* section.

Table 10. Alternate Cost Sharing Scenario: Impacts of AB 298 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$69,160,508,000	$407,870,000	0.59%
CalPERS employer (b)	$7,881,873,000	$7,912,266,000	$30,393,000	0.39%
Medi-Cal (excludes COHS)	$31,818,731,000	$31,818,731,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,757,790,000	$22,120,624,000	$362,834,000	1.67%
Outside Covered California	$6,011,399,000	$6,188,157,000	$176,758,000	2.94%
Through Covered California	$15,746,391,000	$15,932,467,000	$186,076,000	1.18%
Enrollees, group insurance (c)	$21,712,866,000	$21,850,867,000	$138,001,000	0.64%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copayments, etc.)	$18,992,422,000	$18,426,519,000	-$565,903,000	-2.98%
Expenses for noncovered benefits (d) (e)	$0	$0	$0	0.00%
Total expenditures	$170,916,320,000	$171,289,515,000	$373,195,000	0.22%

Source: California Health Benefits Review Program, 2025.
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.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, 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 will 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 11. Alternate Cost Sharing Scenario: Small-Group Gold Example ($100 ER Visits and $10 PCP/Specialist Visits Postmandate for Services) (a)

Service Category	Baseline Total Cost of Services PMPM	Postmandate Total Cost of Services PMPM	Change in Total Cost of Services PMPM (b)	Baseline Enrollee Share of Cost PMPM	Postmandate Enrollee Share of Cost PMPM	Change in Enrollee Cost Share
Inpatient facility	$98.39	$98.39	$0.00	$0.89	$0.38	-$0.51
Emergency room	$20.74	$20.83	$0.09	$1.43	$1.12	-$0.31
Other outpatient facility	$155.06	$155.49	$0.43	$8.84	$7.78	-$1.05
Office visits	$38.04	$38.51	$0.47	$7.11	$5.98	-$1.13
Other professional	$106.36	$106.92	$0.56	$15.57	$13.77	-$1.80
Mental health/ Substance use	$33.15	$33.81	$0.66	$4.14	$3.24	-$0.90
Ancillary	$18.04	$18.04	$0.00	$2.96	$2.79	-$0.17
Outpatient pharmacy	$194.99	$195.49	$0.50	$7.86	$8.88	$1.01
Total PMPM	**$664.77**	**$667.48**	**$2.71**	**$48.80**	**$43.94**	**-$4.87**

Source: California Health Benefits Review Program, 2025.
Notes: (a) AB 298 impact and service category distribution from a 2025 Small Business Gold plan. Assumes allowed PMPM costs from DMHC-regulated small-group other nongrandfathered gold plans.
(b) Change in total cost of services is due to increased utilization from the reduction of enrollee cost share.

Table 12. Alternate Cost-Sharing Scenario: Baseline 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 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)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 298 - Scenario 2	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Premium costs										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0.00	$718.62	$276.79	$583.72	$609.11	$567.83	$0.00	$108,453,242,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$151,923,898,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0.00	$0.00	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$767.33**	**$884.75**	**$1,091.05**	**$939.30**	**$276.79**	**$583.72**	**$956.34**	**$1,002.63**	**$951.40**	**$170,916,320,000**

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 51.6% are state retirees, state employees, or their dependents.
(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.[4]
(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 will 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 13. Alternate Cost Sharing Scenario: 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 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)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 298 - Scenario 2	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Premium Costs (postmandate change)										
Average portion of premium paid by employer (e)	$2.4545	$5.9434	$0.0000	$2.7711	$0.0000	$0.0000	$5.5837	$7.0268	$0.0000	$438,264,000
Average portion of premium paid by enrollee	$0.6412	$2.4888	$13.5464	$0.5363	$0.0000	$0.0000	$2.0557	$2.2954	$19.2066	$500,834,000
Total Premium	$3.0957	$8.4323	$13.5464	$3.3074	$0.0000	$0.0000	$7.6393	$9.3222	$19.2066	**$939,098,000**
Enrollee Expenses (postmandate change)										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$1.9108	-$4.8670	-$8.8524	-$0.4460	$0.0000	$0.0000	-$4.8310	-$4.8905	-$10.9926	-$565,903,000
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	$1.1849	$3.5653	$4.6940	$2.8615	$0.0000	$0.0000	$2.8083	$4.4317	$8.2140	**$373,195,000**

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 51.6% are state retirees, state employees, or their dependents.
(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.
(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 will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
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CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH Principal Policy Analyst
Karen Shore, **PhD,** Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

Faculty Task Force

Paul Brown, PhD, University of California, Merced
Timothy T. Brown, PhD, University of California, Berkeley
Shana Charles, PhD, MPP, University of California, Los Angeles, and California State University, Fullerton
Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness,* University of California, San Francisco
Todd Gilmer, PhD, University of California, San Diego
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Elizabeth Magnan, MD, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, Davis
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Joy Melnikow, MD, MPH, University of California, Davis
Aimee Moulin, MD, University of California, Davis
Jack Needleman, PhD, University of California, Los Angeles
Mark A. Peterson, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Dylan Roby, PhD, University of California, Irvine
Marilyn Stebbins, PharmD, University of California, San Francisco
Jonathan Watanabe, PharmD, MS, PhD, University of California, San Francisco

Task Force Contributors

Bethney Bonilla-Herrera, MA, University of California, Davis
Danielle Casteel, MA, University of California, San Diego
Margaret Fix, MPH, University of California, San Francisco
Carlos Gould, PhD, University of California, San Diego
Julia Huerta, BSN, RN, MPH, University of California, Davis
Michelle Keller, PhD, MPH, University of California, Los Angeles, and University of Southern California
Thet Nwe Myo Khin, MPH, University of California, San Diego
Xenia Mendez, MPH, University of California, San Francisco
Jacqueline Miller, University of California, San Francisco
Marykate Miller, MS, University of California, Davis
Katrine Padilla, MPP, University of California, Davis
Kyoko Peterson, MPH, University of California, San Francisco
Amy Quan, MPH, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego

National Advisory Council

Lauren LeRoy, PhD, Strategic Advisor, L. LeRoy Strategies, *Chair*
Stuart H. Altman, PhD, Professor of National Health Policy, Brandeis University, Waltham, MA
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Charles "Chip" Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President Emeritus, ECRI Institute Headquarters, Plymouth Meeting, PA; Adjunct Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
Donald E. Metz, Executive Editor, *Health Affairs,* Washington, DC
Dolores Mitchell, (Retired) Executive Director, Group Insurance Commission, Boston, MA
Marilyn Moon, PhD, (Retired) Senior Fellow, American Institutes for Research, Washington, DC
Rachel Nuzman, MPH, Senior Vice President for Federal and State Health Policy, The Commonwealth Fund, New York, NY
Carolyn Pare, (Retired) President and CEO, Minnesota Health Action Group, Bloomington, MN
Osula Evadne Rushing, MPH, Senior Vice President for Strategic Engagement, KFF, Washington, DC
Ruchika Talwar, MD, MMHC, Assistant Professor Department of Urology and Medical Director Episodes of Care, Population Health, Vanderbilt University Medical Center
Alan Weil, JD, MPP, Senior Vice President for Public Policy, AARP*,* Washington, DC

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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 chbrp.org.

Garen Corbett, MS Director

Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.