TECHNICAL BRIEF

SB 1199

Prescription Drug Cost Sharing

CHBRP

About the Technical Brief

This document provides details on the analytical foundation for CHBRP's analysis of SB 1199. While the main report synthesizes key findings for immediate policy consideration, this document is designed to support a deeper understanding of the background of the topic of the legislation and CHBRP's methodology and research in conducting its analysis. It contains the data sources, methods, assumptions, and other bill-specific considerations necessary for legislative staff, fiscal analysts, and other stakeholders to fully understand the scope and impact of the proposed measure.

Table of Contents

List of Figures

Acronyms and Terminology

Acronyms

ACA – Affordable Care Act

CA – California

CalPERS – California Public Employees' Retirement System

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

EHBs – essential health benefits

OOP – out-of-pocket

PBM – pharmacy benefit manager

PMPM – per member per month

SB – Senate Bill

Terminology

CHBRP uses the following terminology throughout this analysis:

- **Copayment adjustment program:** a pharmacy benefit design that excludes certain contributions made by a third party, such as drug copay assistance, from counting towards the enrollee's out-of-pocket (OOP) maximum. Includes copay accumulators and copay maximizers.
- **Copay accumulator:** a type of copayment adjustment program that excludes any amounts collected at the point of sale when using copay assistance for a prescription drug from counting towards the enrollee's deductible or annual OOP maximum.
- **Copay maximizer:** a program, typically implemented in conjunction with copay accumulators, that adjusts the cost sharing at the point-of-sale to an amount that utilizes the entire amount of the financial assistance available from a third party. This approach ensures that: (1) the plan captures the full value of the available manufacturer copay assistance, (2) the member does not pay OOP for the targeted drugs, but (3) none of the copay assistance counts towards deductibles or OOP maximums. For maximizers that use an accumulator functionality, once a member hits their OOP maximum (e.g., through receiving other health care services), the plan can no longer collect copay assistance. Some programs, referred to as "non-EHB maximizers," avoid this by classifying certain drugs as non-essential health benefits (non-EHBs). Non-EHBs can continue to collect copay assistance after the member hits their OOP maximum because copay assistance is not required to count towards the OOP maximum for them.
- **Drug copay assistance:** financial assistance provided to patients by drug manufacturers or nonprofit organizations (i.e., foundations and independent charities) to aid in reducing the cost of prescription drugs by covering all or a portion of a member's cost share, generally up to a pre-defined limit. These may also be referred to as drug coupons or drug manufacturer coupons. Most copay assistance is available from drug manufacturers rather than independent charities (Wreschnig, 2022).
- **Pharmacy benefit managers (PBMs):** entities that manage and administer prescription drug benefits for health plans and insurers.

Legislative Text Analyzed

CHBRP analyzed SB 1199 Prescription Drug Cost Sharing, as introduced February 19, 2026 per the request of the California Senate Committee on Health. The text analyzed is copied below.

SECTION 1. Section 1399.852 is added to the Health and Safety Code, to read:

1399.852. (a) (1) When calculating an enrollee's overall contribution to an out-of-pocket maximum or cost sharing requirement under the enrollee's health care service plan contract, a health care service plan shall count any amount paid by the enrollee or on behalf of the enrollee for a drug toward an enrollee's cost sharing, including any form of direct support offered by drug manufacturers when permitted under Division 114 (commencing with Section 132000).

(2) Amounts described in paragraph (1) shall be counted toward the annual limit on cost sharing and the applicable in-network deductible.

(b) (1) This section shall apply to all nongrandfathered health care service plan contracts that are subject to Section 1367.006.

(2) This section shall not apply to a grandfathered health plan, a specialized health care service plan contract that does not provide essential health benefits, a Medicare supplement plan contract, or accident-only, specified disease, or hospital indemnity plan contracts.

(c) Direct support offered by a drug manufacturer to an enrollee to reduce or eliminate immediate out-of-pocket expenses is subject to the limitations under Sections 132000 and 132002.

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

(1) "Annual limitation on cost sharing" means the limit described in Section 1367.006.

(2) "Cost sharing" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits. As set forth under Section 155.20 of Title 45 of the Code of Federal Regulations, cost sharing includes deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for nonnetwork providers, and spending for noncovered services.

(3) "Essential health benefits" has the same meaning as set forth under Section 1367.005.

SEC. 2. Section 10112.283 is added to the Insurance Code, to read:

10112.283. (a) (1) When calculating an insured's overall contribution to an out-of-pocket maximum or cost sharing requirement under the insured's health insurance policy, a health insurer shall count any amount paid by the insured or on behalf of the insured for a drug toward an insured's cost sharing, including any form of direct support offered by drug manufacturers when permitted under Division 114 (commencing with Section 132000) of the Health and Safety Code.

(2) Amounts described in paragraph (1) shall be counted toward the annual limit on cost sharing and the applicable in-network deductible.

(b) (1) This section shall apply to all nongrandfathered health insurance policies that are subject to Section 10112.28.

(2) This section shall not apply to a grandfathered health insurance policy, a specialized health insurance policy that does not provide essential health benefits, Medicare supplement insurance, or accident-only, specified disease, or hospital indemnity policies.

(c) Direct support offered by a drug manufacturer to an insured to reduce or eliminate immediate out-of-pocket expenses is subject to the limitations under Sections 132000 and 132002 of the Health and Safety Code.

(d) In addition to any other remedies that are available to the commissioner for a violation of this code, the commissioner may enforce this section pursuant to Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. After appropriate notice and opportunity for hearing in accordance with either of those provisions, the commissioner shall, by order, assess an administrative penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

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

(1) “Annual limitation on cost sharing” means the limit described in Section 10112.28.

(2) “Cost sharing” means any expenditure required by or on behalf of an insured with respect to essential health benefits. As set forth under Section 155.20 of Title 45 of the Code of Federal Regulations, cost sharing includes deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for nonnetwork providers, and spending for noncovered services.

(3) “Essential health benefits” has the same meaning as set forth under Section 10112.27.

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.

Background on Copayment Adjustment Programs

Prescription Drug Costs in California

Between 2017 and 2024, prescription drug costs increased 70.4% for Department of Managed Health Care (DMHC)-regulated health plans (DMHC, 2025). In 2024, DMHC-regulated health plans in California paid approximately $14.9 billion for prescription drugs – an increase of 9.5% ($1.3 billion) from the previous year – which accounted for 12.1% of total DMHC-regulated health plan premiums (DMHC, 2025).[1] Specialty drugs (which typically include high-cost brand-name drugs delivered by specialty pharmacies) accounted for only 1.8% of all prescription drugs dispensed yet represented 63% of total annual spending on prescription drugs (DMHC, 2025).

California has laws intended to increase prescription drug cost transparency. For example, existing law requires health plans and insurers that were already required under state law to report rate information to DMHC and California Department of Insurance (CDI) to also report prescription drug–specific information to the departments, including the most frequently prescribed drugs, the costliest drugs by total annual spending, and the drugs with the highest year-over-year increase in total annual plan spending.[2]

Types of Financial Assistance for Prescription Drugs

Drug manufacturers, other for-profit entities, nonprofit organizations, and state governments have established several strategies to reduce some of the high out-of-pocket (OOP) costs patients face when purchasing prescriptions. SB 1199 addresses financial assistance for prescription drugs from any third-party that operate with health insurance:

- **Pharmaceutical manufacturer foundation:** a nonprofit, 501(c)(3) organization directly or indirectly operated or controlled in any manner by a pharmaceutical manufacturer or its affiliates.[3] These foundations distribute or offer subsides for prescription drugs associated with the pharmaceutical manufacturer.
- **Independent charity:** a nonprofit organization that provides financial support to patients for prescription drugs that is typically funded through cash donations from multiple benefactors, including from pharmaceutical manufacturers.

These nonprofit organizations operate two types of financial assistance programs – drug copay assistance programs and patient assistance programs – and are described in the following bullet points. SB 1199 is concerned only with drug copay assistance programs outside of those provided by nonprofit organizations and charities. Other programs are included to provide context and clarification on other financial assistance excluded from CHBRP's analysis.

- **Drug copay assistance programs:** programs administered by nonprofit organizations to provide financial support for prescription drugs – particularly specialty drugs[4] – to underinsured[5] populations. Patients eligible for these programs typically have insurance coverage but have trouble affording specialty medications due to deductibles and OOP maximums. Eligibility for drug copay assistance grants is often based on poverty guidelines, which take family size into account, to help assess financial need. Eligible applicants are awarded annual grants that must be used to pay for drugs specific to their condition or disease. The grants may be distributed through either a card that must be

[1] Total health plan premium was calculated as the total amount paid by the health plan for medical and prescription drug benefits, administrative expenses, taxes and fees, profits, and adjustments for manufacturer rebates.
[2] Health and Safety Code (HSC) §1367.243.
[3] Office of Inspector General (OIG). (2014) Supplemental Special Advisory Bulletin: Independent Charity Patient Assistance Programs. Federal Register. 79(104):31120-31123.
[4] Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs often cost $1,000 or more per month, and spending on them is growing 15% to 20% per year. Many prescription drug plans that cover specialty drugs have a separate "tier" that specifies how much an individual has to pay for specialty drugs.
[5] Underinsurance is a measure of how an insured adult's reported OOP costs and deductible compare to their household income (excluding premiums). The Commonwealth Fund considers an adult underinsured if (a) their OOP costs, excluding premiums, over the prior 12 months are equal to 10% or more of household income; or (b) OOP costs, excluding premiums, are equal to 5% or more of household income if income is under 200% FPL; or (c) their deductible is 5% or more of household income (Collins et al., 2015).

processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient).

- **Patient assistance programs:** similar to drug copay assistance programs, however their financial assistance is targeted towards the uninsured population. Patient assistance programs are not applicable to SB 1199, as the bill addresses only state-regulated insurance.
- **State pharmaceutical assistance programs:** programs administered by some states to provide financial assistance to certain populations. Depending on the program, drug costs may be subsidized with state or federal funds, or both. California has one state patient assistance program, the AIDS Drug Assistance Program (ADAP), to assist uninsured and underinsured persons living with HIV and AIDS access medications (CDPH, 2025). Individuals enrolled in ADAP may be eligible for other programs administered by California's Office of AIDS that assist with premium and medical OOP benefits. The latter covers OOP costs that count towards the health insurance policy's annual OOP maximum (CDPH, 2025); therefore, ADAP would not be impacted by SB 1199, if enacted, due to compliance at baseline.
    - State discount programs: a subcategory of state pharmaceutical assistance programs, sometimes referred to as "prescription buying clubs" or "discount cards" (NCSL, 2022). The primary difference between these programs and state pharmaceutical assistance programs is that they do not rely on state or federal funds to pay for the prescription drugs. Instead, states use their purchasing power to buy medications in bulk. The patient then pays the discounted price at the pharmacy (NCSL, 2022). California currently administers one such program, called the Prescription Drug Discount Program for Medicare Recipients.
- **Cash card programs:** prescription discounts administered typically by online prescription discount programs. Enrollees pay a discounted amount for their prescription because of the card, then pharmacies pay a transaction fee to the prescription discount card program for processing the claim; thus, pharmacies do not receive the original retail price for these drugs. Cash cards are not used in conjunction with health insurance and would not be impacted by SB 1199.

Copayment Adjustment Programs

Copayment adjustment programs are a type of pharmacy benefit design that offset the impacts of certain pharmaceutical financial assistance; they operate by excluding the contributions made by a third party from counting towards the enrollee's OOP maximum. They may be designed to target specific drugs. Copayment adjustment programs are used to encourage the use of lower-cost prescription drugs, drive down drug prices, and reintroduce price sensitivity to enrollees who use financial assistance for OOP costs. There are two types of copayment adjustment programs: copay accumulator programs and copay maximizer combination programs.

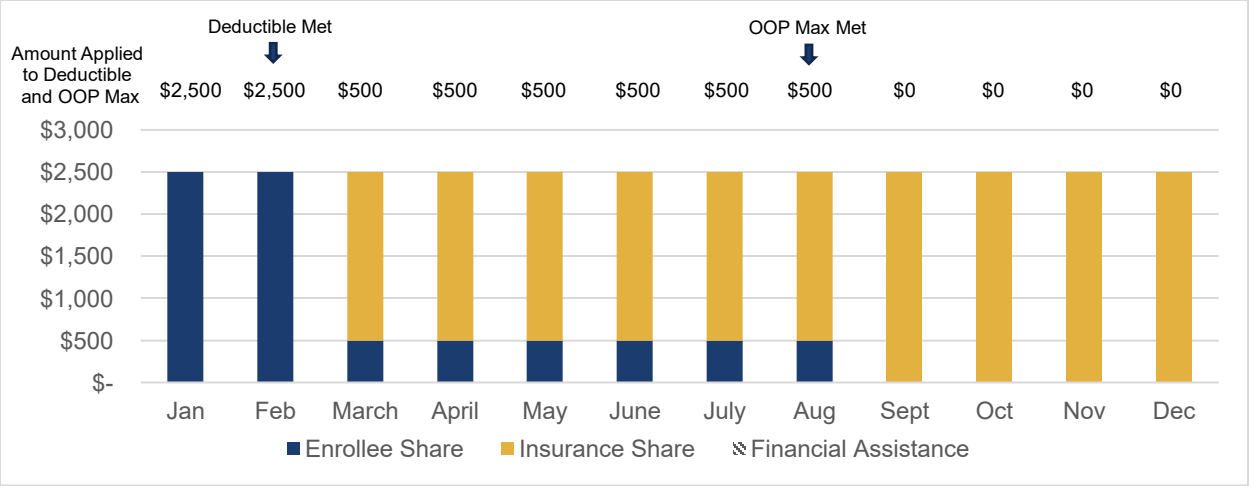
- **Copay accumulators:** programs that exclude any amounts collected at the point of sale when using financial assistance from a third party for a prescription drug from counting towards their deductible or annual OOP maximum.
- **Copay maximizers:** programs that adjust the cost sharing at the point-of-sale to an amount that utilizes the entire amount of the financial assistance available from a third party for each claim. This approach ensures that: (1) the plan captures the full value of the manufacturer's copay assistance, and (2) the member does not pay OOP for the targeted drugs, but (3) none of the copay assistance counts towards deductibles or OOP maximums. Copay maximizers are typically implemented in conjunction with copay accumulators. For maximizers that use an accumulator functionality, once a member hits their OOP maximum (e.g., through receiving other health care services), the plan can no longer collect copay assistance. Some programs, referred to as "non-EHB maximizers," avoid this by classifying certain drugs as non-essential health benefits (non-EHBs). Non-EHBs can continue to collect copay assistance after the member hits their OOP maximum because copay assistance is not required to count towards the OOP maximum for them.

Although these programs may result in lower premiums due to actual or projected savings in drug spending, they may also maintain the affordability challenges that enrollees originally faced in their plan design (MHPC, 2020). Other unintended consequences may include increased nonadherence or discontinuation of therapies and confusion by enrollees due to insufficient transparency on implementation of the copayment adjustment programs (Fein, 2018).

To better understand how copayment adjustments work, consider the following four examples, demonstrating monthly copayments with no financial assistance, financial assistance via a drug manufacturer coupon (with no copayment adjustment programs), implementation of a copayment accumulator program, and implementation of a copayment maximizer program.

First, consider the example of an enrollee with a 20% coinsurance, a deductible of $5,000, and an annual OOP maximum of $8,000. They are prescribed a drug costing $2,500 a month[6] and do not participate in a patient assistance program and do not use drug manufacturer coupons. Typically, an enrollee would pay the full $2,500 until they met their deductible, after month 2. In the following months, the patient would be responsible for covering $500 of the total (20% coinsurance of $2,500), and their health plan or policy would contribute the remaining $2,000, until they met their annual OOP maximum. The health plan or policy would then pay the full monthly cost of the drug for the remainder of the year (Figure 1).

Figure 1. Example of Monthly Copayments With No Financial Assistance



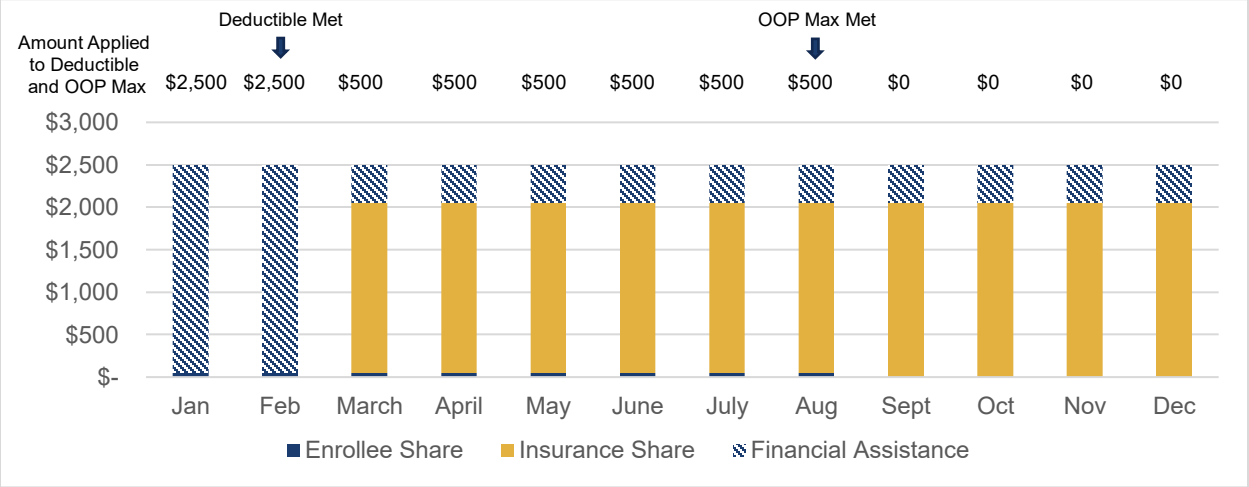
Source: **California Health Benefits Review Program, 2026.**

Key: OOP Max = out-of-pocket maximum.

[6] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copayments and coinsurance is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; Insurance Code [INS] 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible. The examples in this section are for illustrative purposes only.

If the enrollee instead had a drug manufacturer coupon to assist with their coinsurance and limited their monthly OOP expense to $50, and if the contributions of both the enrollee and the drug manufacturer coupon counted towards the enrollee's OOP maximum, the enrollee would still meet their deductible after month 2 and their OOP maximum a few months later. However, their monthly costs would be significantly reduced (Figure 2).

Figure 2. Example of Monthly Copayments With a Drug Manufacturer Coupon (No Copayment Adjustment Program)



Source: California Health Benefits Review Program, 2026.

Key: OOP Max = out-of-pocket maximum.

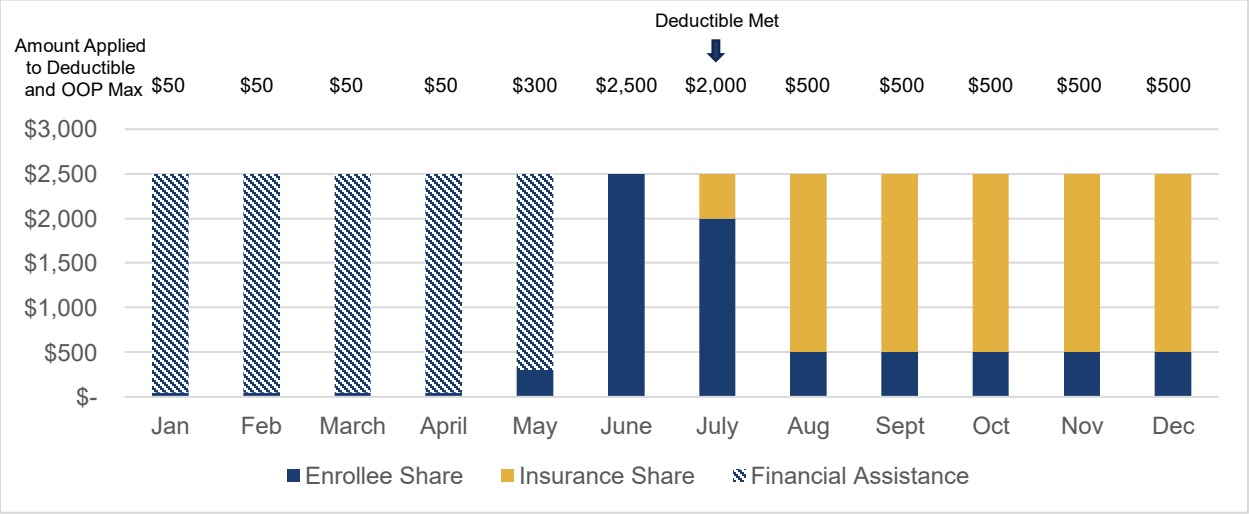
Copayment adjustment programs come in the form of either a copayment accumulator or a copayment maximizer program. As mentioned previously, throughout this report, references to a copayment maximizer program are always in reference to a copayment maximizer program combined with a copayment accumulator program. The following sections use this example to provide explanations of how a simple accumulator and maximizer program would work.

Copayment Accumulator Programs

In copayment accumulator programs, any amounts collected at the point-of-sale when using drug manufacturer coupons do not count towards their deductible or annual OOP maximum. In 2021, 80% of commercially insured beneficiaries were enrolled in plans with copayment accumulators available in the plan design; 43% of covered lives were under plans or policies that had implemented copayment accumulator programs (Fein, 2022).

In copayment accumulator programs, any amounts collected at the point-of-sale when using drug manufacturer coupons do not count towards the enrollee's deductible or annual OOP maximum. Using the same example as above, assume the enrollee is now eligible for a drug manufacturer coupon that provides $12,000 a year with a required enrollee contribution of $50 per fill. Under the copayment accumulator program, the enrollee would use $2,450 per month of the financial assistance and would initially only pay the monthly $50 required by the drug manufacturer to obtain the financial assistance. By month five, the assistance would be exhausted and the enrollee would be responsible for meeting their annual deductible[7] without financial assistance prior to their health plan or policy needing to pay any amount. After the deductible was met, although their health plan or policy would become responsible for 80% of the cost of the drug ($2,000), the enrollee would still be responsible for their 20% coinsurance, as they had not met the annual OOP maximum (Figure 3).

Figure 3. Example of Monthly Copayments Under a Copayment Accumulator Program



Source: California Health Benefits Review Program, 2026.

Key: OOP Max = out-of-pocket maximum.

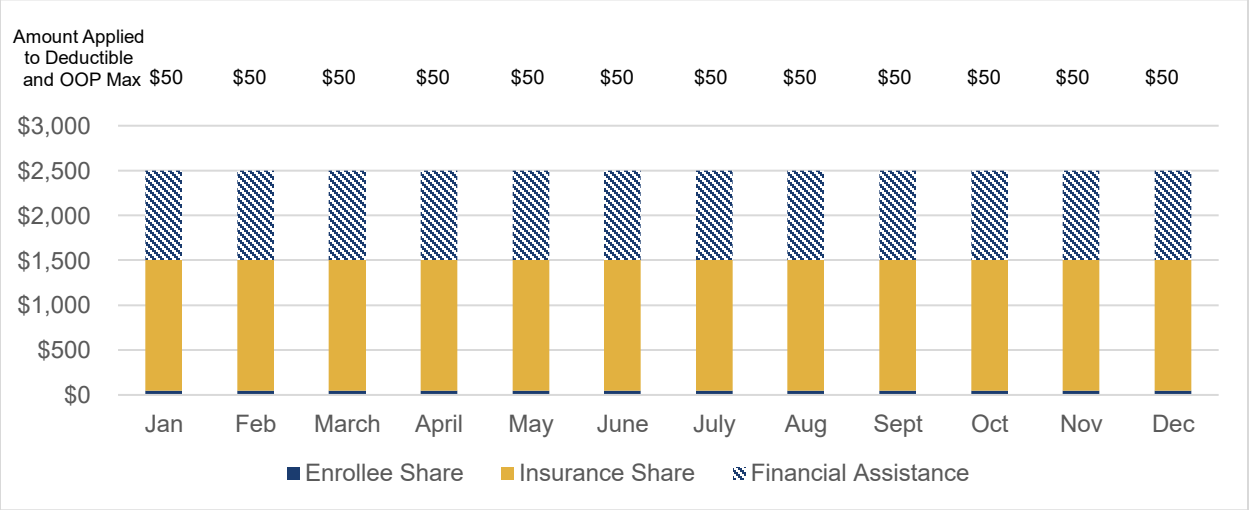
[7] In this example, assume the enrollee has contributed $0 towards their deductible from other medical or pharmacy expenses.

Copayment Maximizer Programs

Copayment maximizer programs are designed to use the total amount of financial assistance provided to an enrollee for a specific drug, typically over the course of a year. Under these programs, the enrollee's typical monthly cost-sharing maximums are inflated to equal the total amount of financial assistance, plus any required copayment for such assistance, divided into a monthly amount. Copayment maximizer programs are generally implemented in conjunction with a copayment accumulator program; therefore, the value of the financial assistance usually does not count toward the enrollee's deductible or annual OOP maximum.[8]

Consider, once again, the example from above where the enrollee is eligible for a drug manufacturer coupon that provides $12,000 a year with an enrollee contribution of $600 (i.e., $1,000 per month for the drug via coupon with an enrollee contribution of $50). The drug cost in this scenario remains $2,500 per month. In a copayment maximizer program, the benefit for the drug is redesigned to maximize the financial assistance; enrollee's monthly cost sharing for the drug would now be $1,050, with the enrollee responsible for $50, $1,000 contributed from the drug manufacturer coupon each month, and the health plan or policy covering a monthly total of $1,450. In this design, none of the contributions paid via the drug manufacturer coupon count towards the enrollee's OOP maximum or deductible. Because the benefit has been redesigned so that the enrollee's monthly benefit is still $50, the enrollee would not meet their deductible or OOP maximum in this example (Figure 4).

Figure 4. Example of Monthly Copayments Under a Copayment Accumulator and Maximizer Program



Source: California Health Benefits Review Program, 2026.
Key: OOP Max = out-of-pocket maximum.

Implementation of Copayment Adjustment Programs

Implementation of copayment adjustment programs involves complex claim processing that has requirements at the pharmacy. In addition, if a PBM, health plan, and/or insurer intends to impose a copayment adjustment program for a specific drug, the drug must be treated in the same manner for all pharmacies where the drug could be filled. These requirements make implementation of copayment adjustment programs through specialty pharmacies more attractive to PBMs. In general, PBMs either own or have exclusive contracts with specialty pharmacies to employ them.[9] In order to facilitate provision of these drugs through specialty pharmacies with the ability to process copayment adjustment program-

[8] Communication with T. Sloan, March 2023.
[9] Communication with T. Sloan, March 2023.

related claims, PBMs and health plans/insurers might use plan and network design to keep prescriptions for that drug within their specialty pharmacy network.

As noted in the *Policy Context* section of CHBRP's analysis of SB 1199, the 2020 version of the federal rule on copay adjustment programs is in effect as of the publication date of this report, which restricts health plans/insurers from applying drug manufacturer financial assistance to OOP maximums only if generic equivalents are available; if there is no generic equivalent, drug manufacturer financial assistance must be applied towards the enrollee's OOP maximum.

Additional Assumptions and Other Considerations for Policymakers

Additional Assumptions

- CHBRP assumed that if SB 1199 were enacted, there would be an increase in other medical utilization and plan expenses due to a portion of enrollees who use these programs hitting their OOP maximum earlier in the year and receiving full coverage without cost sharing for subsequent services. CHBRP assumed that for every $1 of cost sharing "saved," there would be $0.05 in additional spending due to utilization of other services. The rate of increase was determined by market segment using induced utilization[10] (IU) adjustment factors. For enrollees filling specialty drugs in plans where monthly cost-sharing requirements for the specialty drugs alone are high enough to satisfy the OOP maximum in the year, the postmandate IU factor was a blend of the baseline IU factor and the IU factor reflecting a plan with zero cost-sharing requirements. IU factors were blended based on the month in the year when enrollee OOP maximums would be satisfied using copay assistance–eligible specialty drug fills alone.
    - CHBRP assumed the portion of enrollees with induced utilization would be limited; patients with plans and policies in a copay maximizer program typically experience low cost sharing at baseline as these programs are often administered to eliminate enrollee cost sharing altogether. Postmandate, these enrollees are expected to continue to utilize copay assistance and therefore continue to experience low levels of cost sharing. Based on the nature of their medical conditions and the price of their prescriptions, many of these patients are expected to hit their annual OOP maximum regardless of the impact of SB 1199.
    - SB 1199 would not impact enrollees in high-deductible health plans (HDHPs) until they have paid the minimum deductible mandated by the IRS, therefore CHBRP does not anticipate SB 1199 to alter these enrollees' behavior as much as those enrollees without this requirement.
- For postmandate estimates, utilization was not adjusted for plans where specialty drug cost-sharing requirements were not high enough to meet the OOP maximum.
- CHBRP assumes that some drug copay assistance and drug manufacturer coupons are currently being used to help patients with cost-sharing requirements for drugs administered in a medical setting. CHBRP assumes that this financial assistance is provided through reimbursements and therefore currently counts towards enrollees' cost-sharing requirements. See the *Policy Context* section for additional information about claims for drugs under the medical benefit.

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

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

State Health Care Spending Target

In 2024, in an effort to slow health care spending growth and improve health care affordability for California families, California's Office of Health Care Affordability (OHCA) under the Department of Health Care Access and Information

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

approved a statewide target for maximum annual growth in health care spending for certain health care entities. The targets apply to per capita spending to specific entities, including health plans and insurers, provider organizations with at least 25 physicians, and hospitals (HCAI, 2022). The state is implementing this target with a phased-in approach, with a spending target of 3.5% for 2026, lowered to 3.2% in 2027 and 2028, and will be at 3% for 2029 and beyond (HCAI, 2025). Since health insurance benefit mandates may increase health care spending, such as increases to insurance premiums, administrative costs, and out-of-pocket costs, OHCA spending targets may be relevant considerations in benefit mandate policy decisions.

Postmandate Changes in the Number of Uninsured Persons

CHBRP assumes that if premiums increase by more than 1.7% in the small- or large-group market segments or 0.6% in the individual market, some enrollees will lapse their coverage. Because the change in average premiums do not exceed either of these thresholds (see Table 4, Table 8, and Table 9 of the Analysis of California Senate Bill 1199), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 1199.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 1199.

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.[11] 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.[12]

Key Uncertainties

The estimated impacts on premiums and enrollee cost sharing are based upon the approach discussed throughout this document, as well as baseline assumptions about compliance with SB 1199 from carrier surveys. This section highlights key uncertainties that may materially impact on premiums and enrollee cost sharing.

There are two main ways that copay maximizer programs operate in the commercial market, namely accumulator programs or non-essential health benefit (non-EHB) classification. Copay accumulators are discussed in the body of the report. Under the non-EHB classification approach, large-group plans that are not regulated by the Affordable Care Act (ACA) may utilize copay maximizer programs that identify drugs with manufacturer coupons available as non-essential health benefits in order to ensure copay assistance does not count towards enrollee maximum out-of-pocket amounts (Chevron, 2023; MHPNJ, 2021). Maximum out-of-pocket limits are not required to apply to non-essential health benefits (HHS, 2019). As such, these health plans may be able to continue to operate select copay maximizer programs after passage of SB 1199. Therefore, if non-EHB copay adjustment programs become more widely used by health plans and policies postmandate, the reduction on enrollee cost sharing may be overestimated. For the purposes of this analysis, CHBRP assumed that 41% of large group enrollees would not be impacted by SB 1199 based on the estimated market share of PBMs known to use non-EHB classifications for their maximizer programs.

In recent years, drug manufacturers have attempted to restrict access to manufacturer coupons/copay assistance when health plans operate copay accumulator programs or copay maximizer programs. To the extent that such coupons are not available, actual cost increases may be lower than what is estimated in this analysis. The availability and value of such coupons is a key factor in the impact of the mandate.

SB 41, effective January 1, 2026, limits PBM steering to affiliated pharmacies. To the extent that manufacturer drug coupon utilization is higher when dispensing is concentrated in affiliated specialty channels, this change could reduce future coupon use. However, the magnitude of any change is uncertain because the law does not directly regulate manufacturer coupon programs and PBMs may continue to influence pharmacy choice through permitted cost sharing incentives.

There is uncertainty related to each of the following, which may materially impact the scope and/or financial impact of copay assistance programs:

- The extent to which plans implement copay accumulator programs versus copay maximizer programs.
- The prevalence of maximizer designs focused on non-EHB relative to other maximizer designs.
- The adoption of exclusive specialty pharmacy networks, which often functions as a prerequisite for accumulator and maximizer programs.
- The specific drugs targeted by these programs, which may vary by PBM.
- The drug mix among health plans and policies affected by this mandate.

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

- The realized value of manufacturer copayment assistance during the experience period and in the future, including annual caps and eligibility criteria that are subject to change.

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

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

Analysis-Specific Data Sources

- The population subject to the mandated offering includes individuals covered by non-grandfathered DMHC-regulated commercial insurance plans and non-grandfathered CDI-regulated policies that include coverage of outpatient prescription drugs with broad formulary coverage as essential health benefits.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage that is already compliant with SB 1199.

Current coverage of prescription drugs that is compliant with SB 1199 for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to these surveys represent 84% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS plans were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies and previous surveys for similar mandates.

Health Cost Guidelines

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

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.

- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Analytic Approach and Key Assumptions

General Assumptions

SB 1199 would impact drug copay assistance used to reduce member cost share. For each of these programs, CHBRP takes the following approach:

- When a card is used and processed by the PBM to provide drug copay assistance, the PBM may have a copayment adjustment program in place. These programs are typically used for high-cost drugs that can only be filled by specialty pharmacies with a relationship with the PBM. These specialty pharmacies may be owned by the PBM or have an exclusive contractual relationship with the PBM. Many health plans and policies have an exclusive specialty pharmacy network, directing all of their specialty pharmacy claims to the affiliated specialty pharmacy, in order to utilize the copay accumulator and copay maximizer programs.
- Reimbursement to enrollees after the point of sale is not tracked by health plans or insurers and therefore is not part of any copayment adjustment program. For example, if a patient goes to a pharmacy to fill a prescription and their copayment amount is $1,500 for any prescription drug through their health plan or insurer, the patient will pay that amount directly to the pharmacy. If that amount is later reimbursed by a drug copay assistance program, this will generally result in patients getting "credit" for $1,500 of spending toward their deductible or OOP maximum regardless of SB 1199.

CHBRP also makes the following general assumptions:

- SB 1199 would impact all copayment adjustment programs targeting essential health benefits, including copay accumulator programs and copay maximizer programs.
- For all non-compliant plans other than health savings account (HSA)-qualified HDHPs, CHBRP assumes that copay maximizer programs are always implemented in conjunction with copay accumulator programs.
- For non-compliant HDHPs with a qualified HSA, CHBRP assumes that copay adjustment programs are the primary program in place.
- Almost all (95.3%) commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications.[13] Of the remaining commercial/CalPERS enrollees, 0.99% do not have a pharmacy benefit and 3.7% have a pharmacy benefit that is not regulated by DMHC or CDI. For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and administered by the Department of Health Care Services (DHCS) under the Medi-Cal Rx program; therefore, it is not subject to DMHC regulation. Because SB 1199 would not require the creation of a pharmacy benefit – only compliant benefit coverage when a pharmacy benefit is present – baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is compliant. In addition, due to federal anti-kickback regulations, Medicare and Medicaid are prohibited from having copay assistance. Therefore Medi-Cal would not be impacted by legislation related to copay assistance.

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

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

and findings may not be directly comparable. A prior CHBRP analysis of copay accumulator bills included a restriction that the mandate would apply only to those enrollees with chronic disease or terminal illness (CHBRP, 2024). Also, high trends in specialty drug utilization, the rise of biosimilars, and manufacturer actions to limit coupon availability to enrollees in health plans with copay adjustment programs have all changed the landscape of specialty drugs, which is highly relevant to SB 1199. Furthermore, copay adjustment programs have evolved over the last few years. Therefore, the methodology and results of SB 1199 cost analysis are not comparable to results of prior bills.

Methodology and assumptions for baseline utilization and cost

Prescription drugs relevant to the bill included those used in drug copay assistance programs. CHBRP used publicly available lists of drugs included in copay adjustment programs to identify drugs to include in this analysis. The 2025 pharmacy claims data from Milliman's MyRxConsultant for a national self-insured employer was used to estimate the utilization and unit cost of (1) specialty drugs and (2) the subset of specialty drugs with available copay assistance. Utilization and cost were trended to 2027 based on therapeutic class trend factors from Milliman's Commercial Drug Trend Study.

CHBRP assumed that 70% of claims for drugs with available copay assistance used copay assistance (Kang et al., 2023).

Drugs with a generic equivalent available were excluded from this list. CHBRP determined that roughly 9% of prescription drugs with coupons and a generic equivalent have a generic drug covered on a lower tier of the formulary, and would not be impacted by SB 1199, due to existing restrictions on drug coupons in California law.

CHBRP estimated that pharmaceutical manufacturers and copay assistance programs would provide coupons or support of up to 15% of the ingredient cost of the drug.

Prescription drugs in a medical setting

CHBRP assumed that no prescription drugs administered in a medical setting would be impacted by SB 1199. While the grants available from nonprofits and drug coupons would be available to cover drugs administered in a medical setting, these drugs are generally not subject to copayment adjustment programs because these claims are not typically submitted to pharmacy benefit managers (PBMs) or to the specialty pharmacy associated with the PBM. Therefore, CHBRP currently assumes all third-party assistance provided for drugs administered in a medical setting already count towards deductibles and out-of-pocket (OOP) maximums.

Methodology and assumptions for baseline cost sharing

For all plans other than HSA-qualified HDHPs, CHBRP assumed the following cost-sharing requirements:

- The deductible and maximum out-of-pocket amounts are an average of representative non-HDHP plan types based upon carrier surveys.
- Copay adjustment programs apply, and therefore, the enrollee is subject to the entire maximum out-of-pocket amount.
- Based on the prescription drug copay cap set forth under Senate Bill 1021 (2018), CHBRP set the maximum copay amount for non-HDHPs to $250 after the deductible period.[14]

For HSA-qualified HDHPs, CHBRP assumed the following cost-sharing requirements:

- The deductible and maximum out-of-pocket amounts are an average of representative HDHP plan types based upon carrier surveys.
- Copay accumulator programs apply, and therefore, no copay assistance amounts apply towards cost sharing until such amounts are exhausted. The enrollee is subject to the entire maximum out-of-pocket amount.

[14] HSC 1342.73; INS 10123.1932.

- Based on the prescription drug copay cap set forth under Senate Bill 1021 (2018), CHBRP set the maximum copay amount for HDHPs to $500 after the deductible period.

Methodology and assumptions for postmandate utilization

Patients impacted by accumulator programs are likely to recognize the positive impact during the first year of enactment, as copay assistance now counts towards their deductible and maximum out-of-pocket amount. This can have a material impact on their cost-sharing obligations and can impact their behavior and health care utilization.

CHBRP notes that patients impacted by maximizer programs, on the other hand, are less likely to recognize the impacts due to SB 1199. Under many copay maximizer programs, enrollees would experience low levels of member cost sharing at baseline as often these programs are administered to eliminate enrollee cost sharing altogether. Postmandate, these enrollees are expected to continue to utilize copay assistance and continue to experience low levels of cost sharing.

For all noncompliant plans other than HSA-qualified HDHPs, CHBRP assumed that copay maximizer programs are always implemented in conjunction with copay accumulator programs. For noncompliant HDHPs with a qualified HSA, CHBRP assumed that copay accumulator programs are the primary program in place.

CHBRP assumed that changes in funding would lead to an increase in the total number of specialty prescriptions for HSA-qualified HDHPs as well as an increase in medical expenses for enrollees in plans other than HSA-qualified HDHPs. CHBRP assumed that patients using the drugs affected by this mandate each fill the equivalent of 12 30-day scripts at baseline and postmandate.

Methodology and assumptions for postmandate cost

CHBRP assumed the average cost per prescription would not change as a result of SB 1199.

CHBRP assumed that if SB 1199 were enacted, there would be an increase in other medical utilization and plan expenses due to a portion of enrollees who use these programs hitting their OOP maximum earlier in the year and receiving full coverage without cost sharing for subsequent services.

- The rate of increase was determined by market segment using induced utilization[15] (IU) adjustment factors. For enrollees filling specialty drugs in plans where monthly cost-sharing requirements for the specialty drugs alone are high enough to satisfy the OOP maximum in the year, the postmandate IU factor was a blend of the baseline IU factor and the IU factor reflecting a plan with zero cost-sharing requirements. IU factors were blended based on the month in the year when enrollee OOP maximums would be satisfied using copay assistance-eligible specialty drug fills alone.
- CHBRP assumed the average per enrollee per month (PMPM) allowed cost of total services would increase proportionally to the increase in utilization described above and did not assume a change in the average cost per service.

Methodology and assumptions for postmandate cost sharing

To estimate postmandate cost sharing, CHBRP continued to assume that all impacted enrollees filled prescriptions 12 times per year at a 30-day supply. Separately, CHBRP made an adjustment to utilization discussed above.

The OOP maximum is handled independently in determining the impact of drug copay assistance programs on specialty prescription drug costs and total enrollee costs. Because enrollees may receive more than one medication with coupons or drug copay assistance, the accumulation of these fills in combination with their use of other prescription drugs and medical services may cause the enrollee to exceed the out-of-pocket maximum at a faster rate than implied by this

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

analysis. This analysis does not account for the interaction between the services and could overstate the cost sharing, thereby understating premium impact.

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 the 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.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Danielle Casteel, MA, of the University of California, San Diego, supported the medical effectiveness analysis. Stephen L. Clancy, MLS, (retired) of the University of California, Irvine, conducted the literature search. Timothy T. Brown, PhD, of the University of California, Berkeley prepared the cost impact analysis. Andy Dressler, ASA, MAAA, and John Rogers, ASA, MAAA, of Milliman provided actuarial analysis. An-Chi Tsou, PhD, of CHBRP staff prepared the Overview and Policy Context, the public health impact analysis, and synthesized the individual sections into a single report. Abby Choy, Project Assistant with CHBRP, prepared the infographic. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and members of the CHBRP Faculty Task Force, Mark Peterson, PhD, of the University of California, Los Angeles; Jonathan H. Watanabe, PharmD, MS, PhD, of the University of California, San Francisco, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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.

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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.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. 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. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

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. An independent actuarial firm 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.

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This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

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Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). *Technical Brief: Senate Bill 1199 Prescription Drug Cost Sharing.* Berkeley, CA.