CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

# Abbreviated Analysis

# California Senate Bill 568: Deductibles: Chronic Disease Management

Summary to the 2021–2022
California State Legislature
April 19, 2021

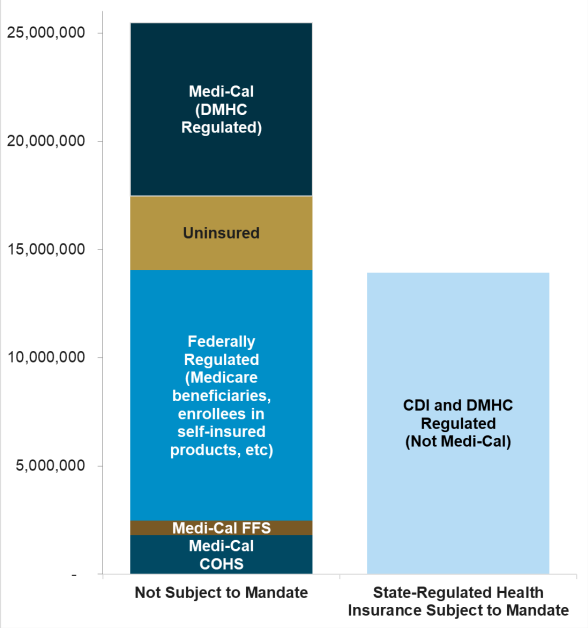
# SUMMARY

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of California Senate Bill (SB) 568 Deductibles: Chronic Disease Management. [1]

For enrollees in group and individual plans and policies regulated by the California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) SB 568 would prohibit some application of a deductible. For enrollees in health savings account (HSA)-qualified plans and policies, SB 568 would prohibit application of a deductible to covered preventive services. For enrollees in non-HSA plans and policies, SB 568 would prohibit application of a deductible to covered outpatient prescription drugs used to treat chronic diseases or to covered diabetes equipment and supplies. SB 568 would not, however, prohibit application of other forms of cost sharing, such as copayments and coinsurance, which are often applicable after a deductible has been met.

As noted in Figure A, SB 568 would apply to the benefit coverage of commercial and California Public Employees' Retirement System (CalPERS) enrollees in group and individual health plans[2] and health insurance policies regulated by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

**Figure A. Health Insurance in CA and SB 568**




*Source:* California Health Benefits Review Program, 2021.

SB 568 would affect the benefit coverage of commercial enrollees in plans and policies regulated by DMHC[3] or CDI that include a deductible (no CalPERS enrollees are in DMHC-regulated plans that include a deductible).

Covered services subject to a deductible are generally also subject to other forms of cost sharing (copayments or coinsurance) once the deductible is met. Postmandate, when application of the deductible is prohibited by SB 568, a portion of the cost sharing that had been paid by users of the covered service in the form of a deductible would shift to copayments or coinsurance. Among these users, user-specific decreases in total cost sharing would vary by enrollee depending on the cost of the service, the size of the deductible, the applicable out-of-pocket maximum, and the use of any services not subject to SB 568 (through which the enrollee may meet any applicable deductible). For all enrollees in the affected plans and policies, decreases in average total cost sharing would result in premium increases.

# APPROACH

Outpatient prescription drugs identified as maintenance drugs — typically used for a year or more to treat chronic disease — were included in this analysis.

[1] See next sections (beyond Summary) for full citations and references.
[2] Medi-Cal beneficiaries enrolled in DMHC-regulated plans would be not be subject to SB 568 because the bill specifies that it is applicable to group and individual plans and policies. Medi-Cal beneficiaries are enrolled in neither.
[3] Deductibles are present for some enrollees in DMHC-regulated health maintenance organization (HMO) as well as for some enrollees in DMHC-regulated preferred provider (PPO) plans.

Some diabetes equipment and supplies are covered through a medical benefit, and so potentially subject to a medical deductible. Others are covered through a pharmacy benefit, and so potentially subject to a pharmacy deductible. Both kinds of equipment and supplies were included in this analysis.

Preventive services for which the Affordable Care Act (ACA) already prohibits all cost sharing were excluded from this analysis. The remaining preventive services listed in the Social Security Act (the source identified by SB 568) were included. [4]

CHBRP cannot estimate the number of enrollees in family plans or policies (as opposed to self-only plans or policies). For this analysis, CHBRP has approached all enrollees as being in a self-only plan or policy.

# IMPACTS

## Benefit Coverage, Utilization, and Cost

For enrollees in plans and policies regulated by DMHC or CDI, postmandate compliance with SB 568's deductible prohibitions would require changes in benefit coverage for:

- 34% of commercial enrollees enrolled in a non-HSA plan that includes a medical deductible;
- 21% of commercial enrollees with pharmacy coverage enrolled in a non-HSA plan that includes a pharmacy deductible; and
- 6% of commercial enrollees enrolled in an HSA-qualified plan that includes a deductible.

### Utilization

For enrollees in non-HSA plans and policies, no postmandate increase in the number of users of prescription drugs for chronic diseases or of diabetes equipment and supplies is projected. However, utilization by current users would be affected by the projected decrease in total cost sharing. For every 10% reduction in cost sharing, CHBRP projects:

- A 4.0% increase in utilization of prescription drugs for chronic diseases per current user.
- A 5.3% increase in utilization of pharmacy benefit–covered diabetes equipment and supplies covered by a pharmacy benefit per current user.
- 0.7% increase in utilization of diabetes equipment and supplies covered by a medical benefit per current user.

For enrollees in HSA-qualified plans and policies, no postmandate increase in utilization by current users is projected. However, the number of users of preventive services would be affected by the projected decrease in total cost sharing. CHBRP projects:

- A 2% increase in users of preventive services.

### Expenditures

Deductibles in self-only plans and policies vary. Pharmacy deductibles generally range from $10 to $500. Medical deductibles generally range from $75 to $6,300. HSA-qualified plans have a combined medical and pharmacy deductible that generally ranges from $1,400 to $7,000.

Postmandate, some enrollees in plans and policies with deductibles would not experience a cost-sharing impact because they would meet their medical or pharmacy deductible through use of medical or pharmacy services not impacted by SB 568. CHBRP projects that this would be the case for:

- 66% of enrollees in non-HSA plans and policies with a $10 pharmacy deductible and 12% with a $500 pharmacy deductible using outpatient prescription drugs for a chronic disease.
- 99% of enrollees in non-HSA plans and policies with a $10 pharmacy deductible and 78% with a $500 deductible using

[4] For enrollees in grandfathered HSA-qualified plans and policies, SB 568's deductible prohibition would be more broadly applicable, as these enrollees' benefit coverage is not required to comply with the ACA's cost-sharing prohibition. However, as enrollees in grandfathered HSA-qualified plans and policies represent only about 0.4% of all enrollees in plans and policies subject to SB 568, the impact was not calculated for this analysis.

pharmacy benefit–covered diabetes equipment and supplies.

- 93% of enrollees in non-HSA plans and policies with a $75 medical deductible and 34% with a $6,300 deductible using medical benefit–covered diabetes equipment and supplies.
- 62% of enrollees in HSA-qualified plans and policies with a $1,400 combined medical and pharmacy deductible and 28% with a $7,000 combined deductible using preventive services.

Though SB 568 may change the timing of when these enrollees pay various cost-sharing amounts, it would not impact the annual spend for these enrollees.

Postmandate, for enrollees who do not meet their deductibles (through use of services not impacted by SB 568) and who use services that are impacted by SB 568, average total annual cost sharing would decrease.

For enrollees in non-HSA plans and policies with deductibles:

- Average total annual cost sharing for outpatient prescription drugs for chronic diseases would decrease by $57 (9.0%).
- Average total annual cost sharing for pharmacy benefit–covered diabetes equipment and supplies would decrease by $3 (4.9%).
- Average total annual cost sharing for medical benefit–covered diabetes equipment and supplies would decrease by $232 (16.0%).

For enrollees in HSA-qualified plans and policies:

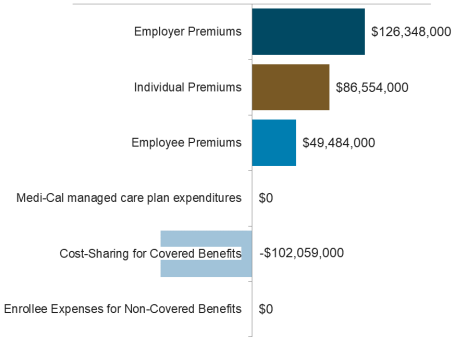
- Average total annual cost sharing for preventive services would decrease by $333 (37.3%).

These impacts include shifts of cost sharing (from paying towards a deductible to paying copayments and coinsurance) as well decreases in total cost sharing. Related increases in premiums are presented in Figure B.

The figures above are averages. Annual cost-sharing impacts would vary by enrollee — with variations depending on the cost of the service used, size of the deductible, out of pocket maximums, and/or use of other services subject to the deductible.

SB 568 would increase total net annual expenditures (premiums as well as enrollee cost sharing and any enrollee expenses for non-covered benefits) by $160,327,000 or 0.12% for enrollees with health insurance subject to state-level benefit mandates (see Figure B).

**Figure B. Expenditure Impacts of SB 568**




*Source:* California Health Benefits Review Program, 2021.

### CalPERS

SB 568 would have no impact on CalPERS CalPERS as no CalPERS enrollees are in HSA-qualified or non-HSA plans with deductibles.

### Medi-Cal

The benefit coverage of Medi-Cal beneficiaries in DMHC-regulated plans (which include no deductibles) is not subject to SB 568.

### Number of Uninsured in California

SB 568 would not increase premiums more than 1% for any affected market segment, so no increase in the number of uninsured is expected.

## Essential Health Benefits (EHBs) and the Affordable Care Act (ACA)

As it would alter terms and conditions benefit coverage but not require an additional benefit coverage, SB 568 would not exceed EHBs.

# REVISION HISTORY

| Date | Description of Revisions |
|---|---|
| April 23, 2021 | The analysis has been updated to include the additional preventive care benefits (beyond those listed in the Social Security Act) that have been identified by the Internal Revenue Service[5] as potentially not subject to a deductible for enrollees in health savings account (HSA)-qualified plans and policies. A refinement in actuarial approach has also been made to more closely estimate the number of enrollees who would meet their deductible through use of services not addressed by SB 568. |

[5] The IRS notice is available at https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

# ABBREVIATED ANALYSIS — SB 568

The California Senate Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[6] conduct an evidence-based assessment of Senate Bill (SB) 568, Deductibles: Chronic Disease Management.

For enrollees in group and individual plans and policies regulated by the California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI), this report estimates the incremental impacts of SB 568 on benefit coverage, utilization, and cost.

SB 568 would not require new benefit coverage but would specify the terms and conditions of existing benefit coverage for enrollees in plans or policies that include a deductible.

For enrollees in health savings account (HSA)-qualified plans and policies,[7] SB 568 would:

- Prohibit application of a deductible for covered preventive care. SB 568 would define preventive care through reference to Internal Revenue Service (IRS) specifications.[8] The IRS specifies preventive care (which includes tests, treatments, and services) through reference to the Social Security Act[9] and through IRS Notice 2019-45.[10]

For other enrollees in plans and policies with deductibles (but not for enrollees in HSA-qualified plans and policies, the exemption made through reference to California law[11]), SB 568 would make two prohibitions. SB 568 would:

- Prohibit application of a deductible for any covered prescription drug used to treat a chronic disease (defining as “chronic” any disease that is treated for a year or more).
- Prohibit application of a deductible to specified equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin–using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription. SB 568 would define diabetes equipment and services through reference to California law.[12]

SB 568 would not, however, prohibit application of other forms of cost sharing, such as copayments and coinsurance, which are often applicable after a deductible has been met. The full text of SB 568 can be found in Appendix A.

## California Policy Landscape

As noted in the description of SB 568, the bill includes references to current California law. One reference creates an exemption from compliance for the benefit coverage of enrollees in HSA-qualified plans and policies. The other reference defines the relevant set of diabetes-related medications and equipment for which application of a deductible would be prohibited for enrollees in non-HSA plans and policies.

[6] CHBRP’s authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.
[7] SB 568 addresses the benefit coverage of enrollees with HSAs, which can be opened by enrollees, regardless of employment status. SB 568 does not address health reimbursement arrangement (HRA) accounts, which must be opened through an employer.
[8] Section 223(c)(2)(C)of Title 26 of the United States Code.
[9] Section 1861 of the Social Security Act.
[10] The IRS notice is available at https://www.irs.gov/pub/irs-drop/n-19-45.pdf.
[11] Through the bill’s reference to current law, California Health and Safety Code Section 1342.73 and California Insurance Code Section 10123.1932, SB 568 would exempt from compliance (to this portion of the bill) the benefit coverage of enrollees in HSA-qualified plans and policies.
[12] Through the bill’s reference to current law, California Health and Safety Code Section 1367.51 and California Insurance Code Section 10176.61, SB 568 would specify the diabetes-relevant medications and equipment for which deductibles would be prohibited.

Other California laws may also interact with SB 568. Existing California law places these requirements on plans and policies regulated by DMHC or CDI:

- Plans and policies that provide a prescription drug benefit must cover insulin.[13]
- Cost sharing for prescription drugs to up to $250 for a 30-day supply.[14]
- Separate pharmacy deductibles are limited to $500 for nongrandfathered individual and small group plans and policies.[15]

### *Similar requirements in other states*

CHBRP is unaware of similar prohibitions on the application of deductibles in other states.

## Federal Policy Landscape

As noted in the description of SB 568, the bill references current federal law to define a list of tests, treatments, and services the preventive care for which application of a deductible would be prohibited for enrollees in HSA-qualified plans and policies.

In addition, a number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates.

### Essential Health Benefits

Nongrandfathered plans and policies sold in the individual and small group markets are required to meet a minimum standard of benefits defined by the ACA as essential health benefits (EHBs).[16,17] In California, EHBs are related to the benefit coverage available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs.[18,19] CHBRP estimates that approximately 4.2 million Californians (11%) have insurance coverage subject to EHBs in 2022.[20]

As SB 568 would not require coverage for a new state benefit mandate, it would not exceed the definition of EHBs in California.

### Federally Selected Preventive Services

The ACA requires that nongrandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing (including deductibles) when delivered by in-network providers and as soon as 12 months after a recommendation appears in any of a number of federal lists.[21]

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[13] H&SC 1367.51; IC 10176.61.
[14] H&SC 1342.73; IC 10123.1932.
[15] Ibid.
[16] The ACA requires nongrandfathered small group and individual market health insurance — including but not limited to QHPs 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: www.chbrp.org/other_publications/index.php.
[17] 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.
[18] CCIIO, Information on Essential Health Benefits (EHB) Benchmark Plans. Available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html.
[19] H&SC Section 1367.005; IC Section 10112.27.
[20] CHBRP, *Estimates of Sources of Health Insurance in California in 2021*. Available at: www.chbrp.org/other_publications/index.php.
[21] See CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at www.chbrp.org/other_publications/index.php.

The list of preventive services relevant to SB 568 is drawn from the Social Security Act, which, in addition to listing particular test, treatments, and services, references United States Preventive Services Task Force (USPSTF) A and B recommendations, one of the lists referenced by the ACA's preventive services mandate.

## Relevant Populations

SB 568 would apply to the benefit coverage of the 13.9 million commercial and CalPERS enrollees in group and individual health plans and health insurance policies regulated by DMHC or CDI (see Figure A in the *Summary* section). Medi-Cal beneficiaries enrolled in DMHC-regulated plans would be not be subject to SB 568 because the bill specifies that it is applicable to group and individual plans and policies, and Medi-Cal beneficiaries are enrolled in neither.[22] Therefore, SB 568 would apply to the benefit coverage of 64% of Californians in plans or policies regulated by DMHC or CDI.

Postmandate, SB 568 would affect cost sharing for enrollees in HSA-qualified plans and policies as well as the cost sharing for enrollees in non-HSA plans and policies that include a deductible.

Tables 1 and 2, below indicate the presence of commercial/CalPERS enrollees with one or more deductibles in the various market segments regulated by DMHC[23] or CDI. It should be noted that many enrollees in plans and policies regulated by DMHC or CDI have no deductibles, and so are compliant with SB 568 at baseline.

Table 1 presents enrollment in plans with a medical deductible[24]

Table 2 presents enrollment in plans and policies with a pharmacy benefit and a pharmacy deductible. Most of these enrollees would have a separate medical deductible as well. The total number of enrollees is smaller than in Table 1 because some enrollees have no pharmacy benefit, and some have a pharmacy benefit from a source other than their DMHC- or CDI-regulated plan or policy. [25] Such enrollees may be present in Table 1 but not in Table 2.

[22] DMHC and healthcare.gov specify that individual health plans are plans that you buy on your own, for yourself, or for your family, and group health plans are obtained through your job, union, or as a retiree for employees/retirees and their families (see https://www.dmhc.ca.gov/HealthCareinCalifornia/TypesofCoverage.aspx and https://www.healthcare.gov/glossary/group-health-plan/). Enrollment of Medi-Cal beneficiaries in DMHC-regulated plans seems to fit neither definition.

[23] Deductibles are present for some enrollees in DMHC-regulated health maintenance organization (HMO) as well as for some enrollees in DMHC-regulated preferred provider (PPO) plans.

[24] Coverage for equipment and supplies for diabetes treatment vary, some generally covered under a medical benefit and some generally under a pharmacy benefit.

[25] See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage, 2022*, available at https://chbrp.org/other_publications/index.php.

**Table 1. Enrollment in Plans/Policies with a Medical Deductible, 2022**

| Market Segment | Enrollment | No Deductible | Low (<$1,400) | High (a) (>=$1,400) | HSA Qualified |
|---|---|---|---|---|---|
| CDI/DMHC Large Group | 8,789,000 | 73% | 20% | 1% | 6% |
| CDI/DMHC Small Group (b)(c) | 2,129,000 | 28% | 37% | 27% | 9% |
| CDI/DMHC Individual | 2,133,000 | 16% | 22% | 52% | 10% |
| DMHC CalPERS | 889,000 | 100% | 0% | 0% | 0% |
| **Total** | **13,940,000** | **59%** | **21%** | **13%** | **6%** |

*Source:* California Health Benefits Review Program, 2021.

*Notes:* (a) Does not include enrollees in HSA-qualified plans or policies.

(b) For this analysis, small group Platinum plans are assumed to have $0 deductible. In 2021, as only one of eight plans offered in this metal tier has a deductible ($250) and CHBRP is unable to estimate the number of enrollees in that plan.

(c) Small group Gold plans have an average deductible of $370, placing them all in the "Low Deductible" category. In 2021 designs, three of 13 plans offered in this tier have $0 deductible.

*Key:* CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

**Table 2. Enrollment in Plans/Policies with a Pharmacy Benefit and a Pharmacy Deductible, 2022**

| Market Segment | Enrollment | No Deductible | Low (<$500) | High (a) (>=$500) | HSA Qualified |
|---|---|---|---|---|---|
| CDI/DMHC Large Group (e) | 8,097,000 | 81% | 13% | 0% | 6% |
| CDI/DMHC Small Group (b)(c)(d)(f) | 2,129,000 | 64% | 23% | 5% | 9% |
| CDI/DMHC Individual | 2,093,000 | 39% | 27% | 24% | 10% |
| DMHC CalPERS(g) | 672,000 | 100% | 0% | 0% | 0% |
| **Total** | **12,991,000** | **72%** | **16%** | **5%** | **7%** |

*Source:* California Health Benefits Review Program, 2021.

*Notes:* (a) Does not include enrollees in HSA-qualified plans or policies.

(b) For this analysis, small group Gold plans are assumed to have no pharmacy deductible. In 2021, two of 13 plans offered in this metal tier have a $250 pharmacy deductible and CHBRP is unable to estimate the number of enrollees in those two plans.

(c) For this analysis, small group Silver plans are assumed to be in the "Low Deductible" category. In 2021, nine of 13 plans offered in this tier have a $300-$350 pharmacy deductible, three have $0 deductible, and one has a deductible of $500 and CHBRP is unable to estimate the varied enrollment among these plans.

(d) For this analysis, small group Bronze plans are assumed to have a $500 pharmacy deductible. In 2021, four of five plans offered in this tier have a $500 pharmacy deductible and one plan has no pharmacy deductible. CHBRP is unable to estimate enrollment in that plan.

(e) Large group distribution between no deductible and a deductible is from the Kaiser Family Foundation's 2019 Employer Health Benefits Survey (KFF, 2019), which reports the average pharmacy deductible of large groups with a pharmacy deductible is $190. For this analysis, all large group enrollees with a deductible are in the “Low Deductible” category.

(f) The average pharmacy deductible of small groups with a pharmacy deductible is $160 (KFF, 2015). For this analysis, all grandfathered small group enrollees with a deductible are assumed to be in the "Low Deductible" category.

(g) A portion of CalPERS enrollees have a pharmacy benefit, but one for which CalPERS separately contracts with a pharmacy benefit manager — so the benefit is not through the enrollee’s DMHC-regulated plan.

*Key:* CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high deductible health plan; HSA = health savings account.

## Background on Cost Sharing (including Deductibles)

For each test, treatment, or service that is a benefit covered by a plan or policy that includes a deductible, one or more of the following cost-sharing requirements may be applicable.

- Deductible: The enrollee is responsible for paying the full cost of covered benefits subject to the deductible until the full value of the deductible is paid by the enrollee. The enrollee's payments towards the deductible accumulates over the course of the plan/policy year. For example, if an enrollee has a $750 deductible, and uses four $250 services that are subject to the deductible throughout the course of the year, the enrollee would pay for the first three services ($250 x 3 = $750) in full. At that point, the deductible would be met and a different form of cost sharing such as a copayment or coinsurance may be applied to the fourth visit, depending on the plan/policy.
- Copayment: A copayment is a flat dollar amount paid by the enrollee per service for services subject to a copayment. Copayments may be applied on their own or to services subject to deductible after the deductible is met.
- Coinsurance: Coinsurance is the percentage of the total cost of a service that will be paid by the enrollee. For example, on a $250 service subject to a 10% coinsurance, the enrollee cost sharing would be $25. Coinsurance may be applied on its own or to services subject to deductible after the deductible is met.
- Out-of-pocket maximums: Out-of-pocket maximums are the maximum an enrollee will spend on cost sharing for covered services in the form of deductibles, copayments, and coinsurance during the plan/policy year.[26] For plans and policies available through Covered California, out-of-pocket maximums for in-network essential health benefits are applicable. In 2021, the out-of-pocket maximum limit for self-only coverage is $8,550 (Covered CA, 2021a). If an enrollee has a high-cost hospital stay in the first month of their plan/policy year (whether or not that plan or policy includes a deductible) and reaches their out-of-pocket maximum, the enrollee would not have any other cost sharing for covered services for the remaining 11 months of the plan/policy year.

The deductible and out-of-pocket maximum cost-sharing requirements described above can vary between self-only and family plans and policies. For self-only plans and policies, the enrollee must meet the deductible and out-of-pocket maximum from their own use of medical and pharmacy services. For family plans and policies, there may be a family deductible and family out-of-pocket maximums that may depend on any or all of the family members' use of medical and pharmacy services.

## Analytic Approach and Key Assumptions

CHBRP's approach to this analysis has required several assumptions regarding aspects of enrollees' benefit coverage, including:

- The preventive services and medical benefit–covered diabetes equipment and supplies addressed by SB 568 are commonly covered medical benefits. For this analysis, CHBRP has assumed that all enrollees in plans and policies regulated by DMHC or CDI have such benefit coverage.
- The outpatient prescription drugs for chronic diseases and pharmacy benefit–covered diabetes equipment and supplies addressed by SB 568 are commonly covered for enrollees that have a pharmacy benefit.[27] For this analysis, CHBRP has assumed that all enrollees in plans and

[26] This limit doesn't apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies – note on "table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2020" available at https://www.irs.gov/publications/p969

[27] Pharmacy benefit coverage is not required for all enrollees in plans and policies regulated by DMHC or CDI. As a result, some enrollees in plans and policies have no pharmacy benefit and some have a pharmacy benefit that is provided from a source other than their DMHC- or CDI-regulated plan or policy. See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage, 2022*, available at https://chbrp.org/other_publications/index.php

policies regulated by DMHC or CDI that have a pharmacy benefit regulated by DMHC or CDI have such benefit coverage.

- Enrollees in HSA qualified plans and policies generally have a deductible and it is generally a combined (medical and pharmacy) deductible. For this analysis, CHBRP has approached all enrollees in HSA-qualified plans and policies as having a combined deductible.
- For enrollees in non-HSA plans and policies deductibles (if present) may vary. For this analysis CHBRP has estimated the portion of these enrollees with a medical deductible and the portion with a pharmacy deductible (see Tables 1 and 2).
- CHBRP cannot estimate the number of enrollees in family plans or policies (as opposed to self-only plans or policies). For this analysis, CHBRP has approached all enrollees as being in a self-only plan or policy.

## Examples of SB 568 Impacts on Cost Sharing

Typically, services that are subject to a deductible are also subject to copayments or coinsurance once the deductible is met.

It should be noted that not all enrollees with a deductible using services subject to SB 568 would experience cost sharing savings - because some enrollees will meet their deductibles or out-of-pocket maximums through use of services not subject to SB 568.

For enrollees who do experience cost sharing savings, SB 568 would shift a portion of cost sharing paid in the form of deductibles (at baseline) to copayments or coinsurance (postmandate). Resulting decreases in total cost sharing would vary by enrollee depending on the cost of the service, the size of the deductible, the applicable out-of-pocket maximum, and the use of any services not subject to SB 568 (through which the enrollee may meet any applicable deductible). The examples below are provided to illustrate some of the varied impacts SB 568 may have, depending on all of these factors.

The examples in Table 3 and Table 4 (below) represent potential cost sharing impacts of SB 568 for enrollees have a pharmacy benefit and a pharmacy deductible and who meet the deductibles, baseline and postmandate. As noted above, decreases in cost sharing could vary depending on use of services not subject to SB 568, so the examples, to clarify SB 568's potential impact for a single drug, assume use of only that one drug.

The hypothetical example in Table 3 demonstrates a possible impact of SB 568 on cost sharing for an enrollee who uses a single high-cost drug and meets their deductible. In the example, the user has a pharmacy benefit regulated by DMHC or CDI, a pharmacy deductible of $300 per year, and a $1,200 monthly drug cost. Coverage of the high-cost drug is subject to 30% coinsurance (up to $250 per prescription). Postmandate, annual cost sharing for the high-cost drug would decrease by $300 (9%) as a result of the first month's filled prescription not being subject to the deductible.

**Table 3. High-Cost Drug Example – Enrollee Cost Sharing Per Prescription By Month***

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Baseline Enrollee Cost Sharing | $550 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $3,300 |
| Postmandate Enrollee Cost Sharing | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $250 | $3,000 |

*Source*: California Health Benefits Review Program, 2021

*Notes:* *Example assumes the plan or policy year is on a calendar year basis.

The hypothetical example in Table 4 demonstrates the possible impact of SB 568 on cost sharing for an enrollee who uses a single lower cost generic drug. In the example, the user has a pharmacy benefit regulated by DMHC or CDI, a pharmacy deductible of $300 per year, and a $30 monthly drug cost. Coverage of the generic drug is subject to a copayment of $15 per prescription. At baseline, the low-cost drug user is paying the full cost of the drug each month until full deductible is met in October. Postmandate, annual cost sharing for the generic drug would decrease by $150 (45%)

**Table 4. Low-Cost Drug Example – Enrollee Cost Sharing Per Prescription By Month***

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Baseline Enrollee Cost Sharing | $30 | $30 | $30 | $30 | $30 | $30 | $30 | $30 | $30 | $30 | $15 | $15 | $330 |
| Postmandate Enrollee Cost Sharing | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $15 | $180 |

*Source*: California Health Benefits Review Program, 2021

*Notes:* *Example assumes the plan or policy year is on a calendar year basis.

Because of the way deductibles function over time (applicable only until the point in the year at which they are met), the impact of SB 568 on cost sharing for the low-cost drug (Table 4) would be greater than the impact for the high-cost drug (Table 3). This would be true because the use of the high-cost drug would, at baseline, have met the deductible after the first month. Therefore, SB 568's deductible prohibition would decrease only the first month's cost sharing. In contrast, use of the low-cost drug would, at baseline, take many months to meet the deductible. Therefore, SB 568's deductible prohibition would decrease many months' cost sharing. By year's end, many months' impact for the low-cost drug would add up to the greater total decrease in cost sharing.

The hypothetical examples in Table 3 and Table 4 illustrate possible variations in SB 568's impact due to drug cost, applicable coinsurance or copayments, and deductibles. SB 568's impacts for any one drug would also vary by enrollee depending on that use of other drugs and services (which have their own varied costs and variations as to applicable cost sharing). For example,[28] among insulin users with cost sharing impacted by SB 568, the average insulin specific cost sharing reduction would be $2. However, that average would include greater impact for some enrollees:

- 9.5% of insulin users would experience a reduction of more than $20;
- 7.7% of insulin users would experience a reduction of more than $100;
- 3.3% of insulin users would experience a reduction of more than $250; and
- 1.5% of insulin users would experience a reduction of more than $500.

The figures in Table 8 (at the end of this section) present average decreases for all users of all outpatient prescription drugs for chronic diseases.

## Baseline and Postmandate Benefit Coverage

For commercial/CalPERS enrollees in non-HSA plans and policies, SB 568 would impact application of deductibles for the following sets of covered benefits:

- Outpatient prescription drugs used to treat chronic diseases
- Diabetes equipment and supplies

For commercial/CalPERS enrollees in HSA-qualified plans and policies, SB 568 would impact application of deductibles for the following set of covered benefits:

[28] See CHBRP's 2021 analysis of AB 97 (Nazarian) Insulin Affordability, available at https://chbrp.org/completed_analyses/index.php.

- Preventive services

## Outpatient prescription drugs used to treat chronic diseases

SB 568's prohibition on the application of a deductible to outpatient prescription drugs used to treat chronic disease would require benefit coverage change for the 21% of commercial enrollees with a pharmacy benefit regulated by DMHC or CDI[29] in non-HSA plans and policies that includes a pharmacy deductible (see Table 2).

Outpatient prescription drugs used to treat chronic diseases were identified using the Medi-Span[30] identifier of maintenance drugs, which are typically for self-administered therapy, with low probability for dosage changes, and for which the drug's most common use is to treat chronic disease. Maintenance drugs are usually administered continuously and typically for a period of 12 months or longer.[31] Over 1,500 outpatient prescription drugs for chronic diseases (including drugs relate to behavioral health) were so identified and included in this analysis.

## Diabetes equipment and supplies

SB 568's prohibition on the application of a deductible to diabetes equipment and supplies would require benefit coverage change for the 21% of commercial enrollees with a pharmacy benefit regulated by DMHC or CDI[32] in non-HSA plans and policies that includes a pharmacy deductible.

SB 568's prohibition on the application of a deductible to diabetes equipment and supplies would also require benefit coverage change for the 34% of commercial enrollees in non-HSA plans and policies that include a medical deductible.

As noted in Table 5 (below), diabetes equipment and supplies vary as to whether they are generally covered as a medical benefit or as a pharmacy benefit.

**Table 5. Medical or Pharmacy Benefit Coverage for Diabetes Equipment and Supplies**

| Medical Benefit | Pharmacy Benefit |
|---|---|
| • Glucose monitors and supplies, including subcutaneous monitoring devices, test strips, lancets, and external monitors<br>• Insulin pumps and supplies including needles, syringes, cannula, and various insulin pumps<br>• Equipment for the treatment of diabetic foot including molded foot inserts and inlays and pressure wraps | • Insulin administration supplies<br>• Insulin infusion pumps and supplies<br>• Insulin infusion disposable pump kit and supplies<br>• Blood glucose calibration<br>• Blood glucose monitoring devices and supplies<br>• Blood glucose meter disposable device with test strips<br>• Continuous blood glucose monitor, system receiver, system sensor, system transmitter, and supplies<br>• Blood glucose monitoring software<br>• Urine glucose monitoring kit and supplies<br>• Lancets |

[29] Pharmacy benefit coverage is not required for all enrollees in plans and policies regulated by DMHC or CDI. As a result, some enrollees in plans and policies have no pharmacy benefit and some have a pharmacy benefit that is provided from a source other than their DMHC- or CDI-regulated plans or policies. See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage, 2022*, available at https://chbrp.org/other_publications/index.php
[30] Medi-Span is a collection of databases providing information on prescription and over-the-counter drugs.
[31] It is possible that the SB 568 prohibition could be interpreted as also applicable to nonmaintenance drugs for the treatment of chronic disease — drugs taken for finite period or in an episodic fashion. Nonmaintenance drugs have not been included in this analysis.
[32] See footnote #26.

- Blood glucose/ketone monitoring devices
- Blood glucose and blood pressure monitoring device
- Blood glucose and cholesterol monitoring device
- Blood ketone calibration solution

*Source:* California Health Benefits Review Program, 2021

## Preventive Services

SB 568's prohibition on applying a deductible to preventive services is applicable to all enrollees in HSA-qualified plans and policies, a group that represents approximately 6% of commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI.

SB 568 would define preventive services through reference to the IRS definition, which defines preventive care through reference to the Social Security Act (SSA)[33] and IRS notice 2019-45. [34,35] For enrollees in nongrandfathered plans and policies, the federal preventive services mandate included in the Affordable Care Act (ACA), prohibits all cost sharing (including deductibles) for many preventive services. [36] For this analysis, the two lists were cross-referenced with the ACA (see Table 6). IRS defined preventive services for which cost sharing is already prohibited by the ACA were excluded. IRS defined preventive services for which SB 568's deductible prohibition would require a change in benefit coverage were included in this analysis.

**Table 6. Preventive Services and Current Cost Sharing Prohibitions**

| Preventive Services | Cost Sharing Prohibited by ACA |
|---|---|
| Initial Preventive Physical Exam | Yes |
| End of Life Planning | No |
| Opioid Medication Review | No |
| Pneumococcal, influenza, and hepatitis B vaccine and administration | Yes |
| Screening mammography | Yes |
| Screening pap smear and screening pelvic exam | Yes |
| Prostate cancer screening tests | No |
| Colorectal cancer screening tests | Yes |
| Diabetes outpatient self-management training services | No |
| Bone mass measurement | Yes |
| Screening for glaucoma | No |
| Medical nutrition therapy services | Yes |
| Cardiovascular screening blood tests | Yes |
| Diabetes screening tests | Yes |
| Ultrasound screening for abdominal aortic aneurysm | Yes |

[33] Social Security Act, Section 1861
[34] The IRS notice is available at https://www.irs.gov/pub/irs-drop/n-19-45.pdf.
[35] The list of preventive services, relevant to the benefit coverage of enrollees in HSA-qualified plans and policies, includes outpatient prescription drugs for chronic diseases and diabetes equipment and supplies. The list includes fewer such drugs than does the list of outpatient drugs for chronic diseases previously discussed as relevant to the benefit coverage of enrollees in non-HSA plans and policies. Similarly, the list includes fewer such items than does the list of diabetes equipment and supply previously discussed as relevant to the benefit coverage of enrollees in non-HSA plans and policies.
[36] See CHBRP's resource *Federal Preventive Services Mandates and California Mandates*, available at www.chbrp.org/other_publications/index.php.

| Preventive Services | Cost Sharing Prohibited by ACA |
|---|---|
| An electrocardiogram | No |
| Screening for potential substance use disorders | Yes |
| Services recommended with an A or B by USPSTF | Yes |
| Ace Inhibitors for enrollees diagnosed with congestive heart failure, diabetes, coronary artery disease | No |
| Antiresorptive therapy for enrollees diagnosed with osteoporosis / osteopenia | No |
| Beta-blockers for enrollees diagnosed with congestive heart failure/coronary artery disease | No |
| Blood pressure monitor for enrollees diagnosed with hypertension | Yes |
| Inhaled corticosteroids for enrollees diagnosed with asthma | No |
| Insulin and glucose lowering agents for enrollees diagnosed with diabetes | No |
| Retinopathy screening for enrollees diagnosed with diabetes | No |
| Peak flow meter for enrollees diagnosed with asthma | No |
| Glucometer for enrollees diagnosed with diabetes | No |
| Hemoglobin A1c testing for enrollees diagnosed with diabetes | No |
| International normalized ration (INR) testing for enrollees diagnosed with liver disease and/or bleeding disorders | No |
| LDL testing for enrollees diagnosed with heart disease | Yes |
| SSRIs for enrollees diagnosed with depression | No |
| Statins for enrollees diagnosed with heart disease | No |

*Source:* California Health Benefits Review Program, 2021.

*Key:* Affordable Care Act = ACA

For enrollees in grandfathered HSA-qualified plans and policies, SB 568's deductible prohibition would be more broadly applicable, as these enrollees' benefit coverage is not required to comply with the ACA's cost-sharing prohibition. However, as enrollees in grandfathered HSA-qualified plans and policies represent only about 0.4% of all enrollees in plans and policies subject to SB 568, the impact was not calculated for this analysis.

## Baseline and Postmandate Utilization

At baseline (see Table 8, at the end of this section), CHBRP estimates:

- 887,343 enrollees in a non-HSA plan or policy with a pharmacy benefit regulated by DMHC or CDI and a pharmacy deductible use outpatient prescription drugs for chronic disease.
- 19,381 enrollees in a non-HSA plan or policy with a pharmacy benefit regulated by DMHC or CDI and a pharmacy deductible use pharmacy benefit–covered diabetes supplies.
- 14,908 enrollees in a non-HSA plan or policy using medical benefit–covered diabetes supplies processed through the medical benefit and a medical deductible.
- 150,535 enrollees in an HSA-qualified plan or policy with a deductible who use preventive services.

### Utilization Impacts for Enrollees in non-HSA Plans and Policies

In literature establishing evidence of price elasticity of demand for prescription drugs (Goldman et al., 2004), the authors found use of generic drugs for chronic diseases decreased by 16% when copayments doubled and use of brand drugs decreased by 21% when copayments doubled. Applying these findings,

for enrollees whose cost sharing would decrease, postmandate, CHBRP has projected a 0.3% to 7.1% per user increase in utilization for outpatient prescription drugs used to treat chronic disease and a 0.3% to 10% per user utilization increase for pharmacy benefit–covered diabetes equipment.

Milliman's Health Cost Guidelines provide guidance regarding medical benefits and cost sharing. For enrollees whose cost sharing would decrease, postmandate, utilization of diabetes medical benefit–covered diabetes equipment and supplies would increase by 0.7% per user.

This analysis models increased adherence, and so increased utilization, among enrollees in non-HSA plans and policies for whom cost sharing decreases, postmandate. Cost sharing may be the sole barrier for some enrollees not using the drugs or items. However, the cost sharing threshold that would stimulate new use among these enrollees is not known. Although some among this group could become new users, postmandate, the number could be too few to substantially change the results of this analysis.

### Utilization Impacts for Enrollees in HSA-Qualified Plans and Policies

Milliman's Health Cost Guidelines provide guidance regarding preventive services and cost sharing. For enrollees whose cost sharing would decrease, postmandate, the number of users of preventive services per 1,000 would increase by 2.0%. It is likely that the reduction in cost sharing would result in a mix of greater prescription drug adherence for some enrollees while promoting new use of preventive services in others.

## Baseline and Postmandate Per-User Cost

For commercial/CalPERS enrollees, baseline average annual per-user costs are presented in Table 8, at the end of this section. The average annual per-user cost increases postmandate due to the greater postmandate utilization per user (not a greater cost per unit used).

## Baseline and Postmandate Expenditures

SB 568 would result in a per-user increase in utilization of chronic disease drugs and diabetes supplies and equipment as well as an increase in the number of users of preventive care services. As a result, SB 568 would increase total net annual expenditures by $160,327,000 or 0.12% (see Table 8 at the end of this section). This is due to a $262,386,000 increase in total premiums and a decrease of $102,059,000 in enrollee cost sharing for covered benefits.

Average enrollee cost sharing in the form of deductibles, copayments, and coinsurance would change from the baseline period to the postmandate period as a result of SB 568 (see Table 8 at the end of this section). Postmandate, a portion of cost sharing that had been paid in the form of deductibles at baseline would be paid as copayments or coinsurance postmandate. The remaining portion of the cost sharing decrease would result in premium increases.

Within the time available (60 days), CHBRP could not conduct a medical effectiveness analysis of the many preventive services, many items of diabetes supply and equipment, and over 1,500 outpatient prescription drugs for chronic disease that would be relevant to SB 568. Without a medical effectiveness analysis, impacts on health outcomes and possible offsets (decreased use of other health services) cannot be accurately projected. Due to the limited decreases in cost sharing and limited increase in utilization, measurable impacts at the population level for either may not occur. However, at the person-level, some enrollees who experience a decrease in cost sharing due to SB 568 and so increase adherence or begin use may see some improvement in health outcomes, some of which could result in reduced use of other health care services. Such impact would vary by the drug, item, or service as well as by enrollee.

The changes discussed above derive from the impact of SB 568 on the cost sharing of users who would not meet their deductibles through use of services not impacted by SB 568. Other users would meet their deductibles in this manner and so would have no cost sharing impacts from SB 568. As noted in Table 7, the percentage of users who would meet their deductibles in this manner varies by deductible amount.

**Table 7. Users Meeting Deductibles Through Use of Services Not Impacted by SB 568**

| Users | Deductible Amounts(a) | % Meeting Deductible (b) Through Use of Services Not Impacted by SB 568 |
|---|---|---|
| Users of outpatient prescription drugs used to treat chronic diseases who have a pharmacy benefit regulated by DMHC or CDI and who are enrolled in a non-HSA plan or policy with a pharmacy deductible | $10 pharmacy deductible | 66% |
| | $500 pharmacy deductible | 12% |
| Users of pharmacy benefit–covered diabetes equipment and supplies who have a pharmacy benefit regulated by DMHC or CDI and who are enrolled in a non-HSA plan or policy with a pharmacy deductible | $10 pharmacy deductible | 99% |
| | $500 pharmacy deductible | 78% |
| Users of medical benefit–covered diabetes equipment and supplies, enrolled in a non-HSA plan or policy with a medical deductible | $75 medical deductible | 93% |
| | $6,300 medical deductible | 34% |
| Users of preventive services enrolled in an HSA-qualified plan or policy, with a combined medical and pharmacy deductible | $1,400 combined medical and pharmacy deductible | 62% |
| | $7,000 combined medical and pharmacy deductible | 28% |

*Source:* California Health Benefits Review Program, 2021.

*Notes:* (a) Self-only deductible amounts are generally in the ranges indicated by the amounts listed in this table.

(b) The percentage of users with deductibles not impacted by SB 568 depends on a number of factors, including the deductible amount, which ranges depending on the terms and conditions of the enrollee's plan or policy. Other factors include the cost of drugs and services used.

**Table 8. SB 568 Impacts on Benefit Coverage, Utilization, and Cost, 2022**

| | Baseline (2022) | Postmandate Year 1 (2022) | Increase/ Decrease | Change Postmandate |
|---|---|---|---|---|
| **Benefit Coverage** | | | | |
| Total enrollees with health insurance subject to state-level benefit mandates (a) | 21,945,000 | 21,945,000 | 0 | 0.00% |
| Total enrollees with health insurance subject to SB 568 | 13,940,000 | 13,940,000 | 0 | 0.00% |
| Total percentage of enrollees with health insurance subject to SB 568 | 64% | 64% | 0% | 0.00% |
| **Utilization and Cost** | | | | |
| **Number of enrollees using…** | | | | |
| Outpatient prescription drugs for chronic disease with deductible | 887,343 | 0 | (887,343) | -100.00% |
| Outpatient prescription drugs for chronic disease without deductible | 2,844,998 | 3,732,341 | 887,343 | 31.19% |
| Pharmacy benefit diabetes supplies with deductible | 19,381 | 0 | (19,381) | -100.00% |
| Pharmacy benefit diabetes supplies without deductible | 62,139 | 81,520 | 19,381 | 31.19% |
| Medical benefit diabetes supplies with deductible | 14,908 | 0 | (14,908) | -100.00% |
| Medical benefit diabetes supplies without deductible | 22,564 | 37,472 | 14,908 | 66.07% |
| Preventive care with deductible – HSA only (e) | 150,535 | 0 | (150,535) | -100.00% |
| Preventive care without deductible – HSA only (f) | 0 | 153,545 | 153,545 | 0.00% |
| **Average Annual Cost for Services per user** | | | | |
| Outpatient prescription drugs for chronic disease | $2,237 | $2,266 | $29 | 1.31% |
| Pharmacy benefit diabetes supplies | $173 | $175 | $2 | 1.15% |
| Medical benefit diabetes supplies | $3,262 | $3,274 | $12 | 0.37% |
| Preventive care – HSA only (e) | $891 | $891 | $0 | 0.00% |
| **Average Annual Total Cost Sharing (Including Deductibles) per User** | | | | |
| Outpatient prescription drugs for chronic disease with deductible (g) | $625 | $569 | -$57 | -9.04% |
| Outpatient prescription drugs for chronic disease without Deductible | $112 | $112 | $0 | 0.00% |
| Pharmacy benefit diabetes supplies with deductible (g) | $69 | $66 | -$3 | -4.87% |
| Pharmacy benefit diabetes supplies without deductible | $36 | $36 | $0 | 0.00% |
| Medical benefit diabetes supplies with deductible (g) | $1,451 | $1,219 | -$232 | -16.02% |
| Medical benefit diabetes supplies without deductible | $334 | $334 | $0 | 0.00% |
| Preventive care with deductible – HSA only (e)(g) | $891 | $559 | -$333 | -37.32% |
| Preventive care without deductible – HSA only (f) | - | - | - | - |
| **Average Annual Cost Sharing Deductibles Only per User** | | | | |
| Outpatient prescription drugs for chronic disease with deductible | $138 | $0 | -$138 | -100.00% |

| | | | | |
|---|---|---|---|---|
| Outpatient Prescription drugs for chronic disease without deductible | $0 | $0 | $0 | 0.00% |
| Pharmacy benefit diabetes supplies with deductible | $48 | $0 | -$48 | -100.00% |
| Pharmacy benefit diabetes supplies without deductible | $0 | $0 | $0 | 0.00% |
| Medical benefit diabetes supplies with deductible | $950 | $0 | -$950 | -100.00% |
| Medical benefit diabetes supplies without deductible | $0 | $0 | $0 | 0.00% |
| Preventive care with deductible – HSA only (e) | $891 | $0 | -$891 | -100.00% |
| Preventive care without deductible – HSA only (f) | - | - | - | - |
| **Average Annual Cost Sharing Copays and Coinsurance Only per User** | | | | |
| Outpatient prescription drugs for chronic disease with deductible (g) | $487 | $569 | $82 | 16.85% |
| Outpatient prescription drugs for chronic disease without deductible | $112 | $112 | $0 | 0.00% |
| Pharmacy benefit diabetes supplies with deductible (g) | $22 | $66 | $45 | 206.79% |
| Pharmacy benefit diabetes supplies without deductible | $36 | $36 | $0 | 0.00% |
| Medical benefit diabetes supplies with deductible (g) | $501 | $1,219 | $717 | 143.07% |
| Medical benefit diabetes supplies without deductible | $334 | $334 | $0 | 0.00% |
| Preventive care with deductible – HSA only (e) (g) | $0 | $559 | $559 | 0.00% |
| Preventive care without deductible – HSA only (f) | - | - | - | - |
| **Expenditures** | | | | |
| *Premium (expenditures) by payer* | | | | |
| Private employers for group insurance | $55,032,803,000 | $55,159,151,000 | $126,348,000 | 0.23% |
| CalPERS HMO employer expenditures (b) (c) | $5,765,017,000 | $5,765,017,000 | $0 | 0.00% |
| Medi-Cal managed care plan expenditures | $24,150,529,000 | $24,150,529,000 | $0 | 0.00% |
| *Enrollee premiums (expenditures)* | | | | |
| Enrollees for individually purchased insurance | $15,847,507,000 | $15,934,061,000 | $86,554,000 | 0.55% |
| Individually purchased – outside exchange | $4,890,852,000 | $4,916,668,000 | $25,816,000 | 0.53% |
| Individually purchased – Covered California | $10,956,655,000 | $11,017,393,000 | $60,738,000 | 0.55% |
| Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal managed care (c) | $20,753,446,000 | $20,802,930,000 | $49,484,000 | 0.24% |
| *Enrollee out-of-pocket expenses* | | | | |
| Cost sharing for covered benefits (deductibles, copayments, etc.) | $13,168,032,000 | $13,065,973,000 | -$102,059,000 | -0.78% |
| Expenses for non-covered benefits (d) | - | - | - | - |
| **Total Expenditures** | $134,717,334,000 | $134,877,661,000 | $160,327,000 | 0.12% |

*Source:* California Health Benefits Review Program, 2021.

*Notes:* (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) There is no projected increase in CalPERS employer expenditures.

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

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not 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.

(e) For enrollees in HSA-qualified plans/policies. Prior rows are for all other enrollees (excluding enrollees in HSA-qualified plans/policies).

(f) At baseline, all enrollees in HSA-qualified plans/policies have deductibles applicable to some forms of preventive care.

(g) Plans and policies without deductibles tend to have lower copayments and coinsurance amounts than do those with deductibles.

*Key:* CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; COHS = County Operated Health Systems; HSA = Health Savings Account.

**Table 9. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022**

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Commercial Plans (by Market) (a) | | | Publicly Funded Plans | | | Commercial Policies (by Market) (a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS HMOs (b)* | *MCMC (Under 65) (c)(f)* | *MCMC (65+) (c)(f)* | *Large Group* | *Small Group* | *Individual* | **Total** |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 8,405,000 | 2,086,000 | 1,989,000 | 889,000 | 7,218,000 | 787,000 | 384,000 | 43,000 | 144,000 | 21,945,000 |
| Total enrollees in plans/policies subject to SB 568 | 8,405,000 | 2,086,000 | 1,989,000 | 889,000 | 0 | 0 | 384,000 | 43,000 | 144,000 | 13,940,000 |
| **Premiums** | | | | | | | | | | |
| Average portion of premium paid by employer | $426.28 | $374.49 | $0.00 | $540.40 | $226.61 | $478.87 | $530.80 | $421.81 | $0.00 | $84,948,349,000 |
| Average portion of premium paid by employee | $141.02 | $180.89 | $624.47 | $96.86 | $0.00 | $0.00 | $186.55 | $212.07 | $545.57 | $36,600,954,000 |
| Total premium | $567.30 | $555.38 | $624.47 | $637.27 | $226.61 | $478.87 | $717.35 | $633.88 | $545.57 | $121,549,303,000 |
| **Enrollee expenses** | | | | | | | | | | |
| Cost sharing for covered benefits (deductibles, copayments, etc.) | $43.61 | $121.70 | $173.51 | $50.75 | $0.00 | $0.00 | $134.75 | $197.13 | $184.11 | $13,168,032,000 |
| Expenses for non-covered benefits (e) | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0 |
| **Total expenditures** | $610.91 | $677.07 | $797.97 | $688.02 | $226.61 | $478.87 | $852.10 | $831.01 | $729.68 | $134,717,335,000 |

*Source:* California Health Benefits Review Program, 2021.

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

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

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

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

*Key:* CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

**Table 10. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022**

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Commercial Plans (by Market) (a) | | | Publicly Funded Plans | | | Commercial Policies (by Market) (a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS HMOs (b)* | *MCMC (Under 65) (c)(f)* | *MCMC (65+) (c)(f)* | *Large Group* | *Small Group* | *Individual* | **Total** |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 8,405,000 | 2,086,000 | 1,989,000 | 889,000 | 7,218,000 | 787,000 | 384,000 | 43,000 | 144,000 | 21,945,000 |
| Total enrollees in plans/policies subject to SB 568 | 8,405,000 | 2,086,000 | 1,989,000 | 889,000 | 0 | 0 | 384,000 | 43,000 | 144,000 | 13,940,000 |
| **Premiums** | | | | | | | | | | |
| Average portion of premium paid by employer | $0.6966 | $1.9044 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $1.4598 | $3.2818 | $0.0000 | $126,348,000 |
| Average portion of premium paid by employee | $0.2304 | $0.9199 | $3.3441 | $0.0000 | $0.0000 | $0.0000 | $0.5131 | $1.6499 | $3.8980 | $136,037,000 |
| Total premium | $0.9270 | $2.8242 | $3.3441 | $0.0000 | $0.0000 | $0.0000 | $1.9729 | $4.9317 | $3.8980 | $262,385,000 |
| **Enrollee expenses** | | | | | | | | | | |
| Cost sharing for covered benefits (deductibles, copayments, etc.) | -$0.3722 | -$0.9810 | -$1.2765 | $0.0000 | $0.0000 | $0.0000 | -$1.2903 | -$1.9027 | -$1.4857 | -$102,058,000 |
| Expenses for non-covered benefits (e) | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0 |
| **Total expenditures** | $0.5548 | $1.8432 | $2.0676 | $0.0000 | $0.0000 | $0.0000 | $0.6827 | $3.0290 | $2.4123 | $160,327,000 |
| **Percent change** | | | | | | | | | | |
| Premiums | 0.1634% | 0.5085% | 0.5355% | 0.0000% | 0.0000% | 0.0000% | 0.2750% | 0.7780% | 0.7145% | 0.2159% |
| **Total expenditures** | 0.0908% | 0.2722% | 0.2591% | 0.0000% | 0.0000% | 0.0000% | 0.0801% | 0.3645% | 0.3306% | 0.1190% |

*Source:* California Health Benefits Review Program, 2021.

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

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

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

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

*Key:* CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

# APPENDIX A TEXT OF BILL ANALYZED

On February 18, 2021, the California Senate Committee on Health requested that CHBRP analyze SB 568.

**SENATE BILL** **NO. 568**

**Introduced by Senator Pan**

**February 18, 2021**

An act to add Section 1342.75 to the Health and Safety Code, and to add Section 10123.1934 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 568, as introduced, Pan. Deductibles: chronic disease management.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law, in accordance with the federal Patient Protection and Affordable Care Act, requires a health care service plan or health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, includes preventive and wellness services and chronic disease management. Existing law, with respect to those individual or group health care service plan contracts and health insurance policies, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250, as specified. Existing law requires a health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for certain equipment and supplies for the management and treatment of various types of diabetes as medically necessary, even if those items are available without a prescription.

This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, from imposing a deductible requirement for a covered prescription drug and the above equipment and supplies, and would limit the amount paid for the benefit by an enrollee, subscriber, policyholder, or insured to no more than the amount of copayment or coinsurance specified in the applicable summary of benefits and coverage, as specified. This bill would prohibit a health care service plan contract or health insurance policy that meets the definition of a “high deductible health plan” under specified federal law from imposing a deductible requirement with respect to any covered benefit for preventive care, in

accordance with that law. Because a violation of the requirements of the bill 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.

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

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

**SECTION 1.** Section 1342.75 is added to the Health and Safety Code, to read:

**1342.75.** (a) Notwithstanding subdivision (a) of Section 1342.73 with respect to deductibles, an individual or group health care service plan contract issued, amended, or renewed on or after January 1, 2022, shall not impose a deductible requirement for a covered prescription drug and for a benefit described in subdivision (a) of Section 1367.51 used to treat a chronic disease. The amount of cost sharing, if any, paid by an enrollee or a subscriber for those drugs and benefits shall not exceed the amount of copayment or coinsurance specified in the summary of benefits and coverage and shall be consistent with other applicable provisions of this article.

(b) A state-regulated "high deductible health plan," under the definition set forth in Section 223 of Title 26 of the United States Code, shall not impose a deductible requirement with respect to any covered benefit for preventive care identified by the Internal Revenue Service, in accordance with Section 223(c)(2)(C)of Title 26 of the United States Code.

(c) This section does not require cost sharing for care that state or federal law otherwise requires to be provided without cost sharing.

(d) For purposes of this section, "chronic disease" means a condition that lasts one year or longer and requires ongoing medical attention, limits activities of daily living, or both.

**SEC. 2.** Section 10123.1934 is added to the Insurance Code, to read:

**10123.1934.** (a) Notwithstanding subdivision (a) of Section 10123.1932 with respect to deductibles, an individual or group health insurance policy issued, amended, or renewed on or after January 1, 2022, shall not impose a deductible requirement for any covered prescription drug and for a benefits described in subdivision (a) of Section 10176.61 used to treat a chronic disease. The amount of cost sharing, if any, paid by a policyholder or an insured for those drugs and benefits shall not exceed the amount of copayment or coinsurance specified in the summary of benefits and coverage and shall be consistent with other applicable provisions of this article.

(b) A state-regulated "high deductible health plan," under the definition set forth in Section 223 of Title 26 of the United States Code, shall not impose a deductible requirement with respect to any covered benefit for preventive care identified by the Internal Revenue Service, in accordance with Section 223(c)(2)(C)of Title 26 of the United States Code.

(c) This section does not require cost sharing for care that state or federal law otherwise requires to be provided without cost sharing.

(d) For purposes of this section, "chronic disease" means a condition that lasts one year or longer and requires ongoing medical attention, limits activities of daily living, or both.

**SEC. 3**. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

# APPENDIX B COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

The cost analysis presented in this report was prepared with the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, and reviewed by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[37] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impact analyses are available at CHBRP's website.[38]

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

## Analysis-Specific Data Sources

Enrollment in HSA-qualified and non-HSA–qualified plans and policies was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 89% of commercial enrollees with health insurance that can be subject to state benefit mandates.

Medi-Span — a collection of databases providing information on prescription and over-the-counter drugs primarily used for clinical decision-making support by health care professionals in a variety of contexts — was used as described below to identify drugs relevant to SB 568.

## Analysis-Specific Caveats and Assumptions

### Baseline Utilization and Cost

- The average cost for outpatient prescription drugs used to treat chronic diseases, diabetes supplies and equipment, and preventive services are based on the 2019 Consolidated Health Cost Guidelines Sources Database (CHSD). The data was limited to California commercial enrollees. The average allowed cost per user of each type of service was summarized. The diabetes supplies and equipment were separated into medical and pharmacy costs.
- Outpatient prescription drugs used to treat chronic diseases were identified using Medi-Span's identifier of maintenance drugs, which are typically for self-administered therapy, with low probability for dosage changes, where the drug's most common use is to treat chronic disease. Maintenance drugs are usually administered continuously and typically for a period of 12 months or longer.
- Diabetes supplies processed through the medical benefit were identified using claims categorized as supplies with a primary ICD-10 diagnosis of diabetes. The ICD-10 diagnosis codes were identified using Milliman's Health Cost Guidelines Affordable Care Act diabetes diagnosis indicator.
- Diabetes supplies processed through the pharmacy benefit were identified using the following Medi-Span minor sub-class categories:
    - Insulin Administration Supplies
    - Glucose Monitoring Test Supplies
    - Glucose/Ketone Monitoring Test Supplies
    - Glucose Monitor & Blood Pressure Monitor Combinations

[37] CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[38] See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2021 Cost Analyses: Data Sources, Caveats, and Assumptions*.

  - Glucose Monitor & Cholesterol Monitor Combinations
- Preventive services were identified by first cross-referencing the definition of preventive care under the Social Security Act and IRS Notice 2019-45 with the definition of preventive services under the Affordable Care Act (ACA). Services identified as preventive under the ACA and either the Social Security Act or IRS Notice 2019-45 were not included in CHBRP's analysis because they are already covered without cost sharing.
- Preventive services processed through the medical benefit were identified using the following CPT/HCPCS codes:

| HCPCS/CPT | Description |
|---|---|
| G0102 | Prostate cancer screening; digital rectal examination |
| G0103 | Prostate cancer screening; prostate specific antigen test (psa) |
| 84152 | Prostate specific antigen (PSA); complexed (direct measurement) |
| 84153 | Prostate specific antigen (PSA); total |
| 84154 | Prostate specific antigen (PSA); free |
| G0108 | Diabetes outpatient self-management training services, individual, per 30 minutes |
| G0109 | Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes |
| 99078 | Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions) |
| G0117 | Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist |
| G0118 | Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist |
| G0403 | Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report |
| G0404 | Electrocardiogram, routine ecg with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination |
| G0405 | Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination |
| 93000 | Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report |
| 93005 | Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report |
| 93010 | Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only |
| G8704 | 12-lead electrocardiogram (ecg) performed |
| 0178T | Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report |
| 0179T | Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report |
| 0180T | Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only |
| G0396 | Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes |
| G0397 | Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes |
| G2011 | Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes |
| 99408 | Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes |
| 99409 | Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes |
| G9380 | Patient offered assistance with end of life issues during the measurement period |
| S0257 | Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) |
| 4350F | Counseling provided on symptom management, end of life decisions, and palliation (DEM) |

| | |
|---|---|
| 4553F | Patient offered assistance in planning for end of life issues (ALS) |
| G9562 | Patients who had a follow-up evaluation conducted at least every three months during opioid therapy |
| G9578 | Documentation of signed opioid treatment agreement at least once during opioid therapy |
| G8428 | Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given |
| G8427 | Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications |
| G2076 | Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician qualified personnel |
| 99605 | Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient |
| 99606 | Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient |
| 1159F | Medication list documented in medical record (COA) |
| 1160F | Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record (COA) |
| 92227 | Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral |
| 92228 | Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral |
| 92250 | Fundus photography with interpretation and report |
| S8096 | Portable peak flow meter |
| 83037 | Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use |
| 93792 | Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results |
| 93793 | Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed |
| G0248 | Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results |
| G0249 | Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests |
| G0250 | Physician review, interpretation, and patient management of home inr testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests |
| 3555F | Patient had International Normalized Ratio (INR) measurement performed (AFIB) |
| A4233 | Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each |
| A4234 | Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4235 | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4236 | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips |
| A4255 | Platforms for home blood glucose monitor, 50 per box |

| | |
|---|---|
| A9276 | Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply |
| A9277 | Transmitter; external, for use with interstitial continuous glucose monitoring system |
| A9278 | Receiver (monitor); external, for use with interstitial continuous glucose monitoring system |
| E0607 | Home blood glucose monitor |
| E2100 | Blood glucose monitor with integrated voice synthesizer |
| E2101 | Blood glucose monitor with integrated lancing/blood sample |
| K0553 | Supply allowance for therapeutic continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service |
| S1030 | Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use cpt code) |
| S1031 | Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use cpt code) |

- Preventive services processed through the pharmacy benefit were identified using the following Medi-Span categories:
    - Major category: Beta-blockers
    - Major category: Antidiabetics
    - Major Subcategory: Hypertensives: Ace Inhibitors
    - Major Subcategory: Anti-asthmatic and bronchodilator agents: Steroid inhalant
    - Major Subcategory: Anti-depressants: SSRIs
    - Major Subcategory: Antihyperlipidemics: HMG-CoA reductase inhibitors
    - Minor Subcategory: Endocrine & metabolic agent: Bone density regulators: Bisphosphonates, RANK ligand inhibitor, calcitonin
    - Minor Subcategory: Medical devices and supplies: Respiratory therapy supplies: Peak flow meter
    - Minor Subcategory: Medical devices and supplies: Diabetic supplies: Glucose monitoring test supplies
- IRS Notice 2019-45 requires certain prescriptions for specific conditions be covered without a deductible or with a limited deductible. The pharmacy data used for this analysis does not have patient diagnosis information. CHBRP assumed the utilization of the drugs outlined above are for the specified conditions. This may over-estimate the utilization of drugs covered without deductible under SB 568.
- The utilization and cost per user were trended from 2019 to 2022 using the combined cost and utilization trends of 6.5% and 8.5% for medical and pharmacy services, respectively.
- Enrollee plan design information is not available in the data, preventing detailed analysis of when enrollees with specific benefit cost-sharing requirements meet their deductibles and out-of-pocket maximums. Due to these data limitations, CHBRP assumes medical diabetes equipment and supplies processed under the medical benefit and preventive services occur in the beginning of the year before other services impact the deductible. Baseline pharmacy cost sharing for outpatient prescription drugs used to treat chronic diseases and diabetes equipment and supplies processed under the pharmacy benefit considers all other outpatient prescription drug services throughout the entire year.

## Baseline Cost Sharing

- Non-HSA plan/policy in-network medical deductible information was summarized by regulator, line of business, and deductible or metal tier levels.
    - The large group and grandfathered plans/policies are by medical deductible ranges, as determined by results from CHBRP's survey of the largest (by enrollment) providers of health insurance in California. For plans in the $1 to $1,399 deductible range, a medical

deductible of $750 was assumed. For plans with a deductible of $1,400 or greater, a $2,000 medical deductible was assumed.
    - For small group plans/policies, the 2021 Covered California plan offerings (Covered CA, 2021b) were reviewed. The average medical deductible for the Silver tier plans was assumed to be applicable to all plans in that tier. For all other tiers, the mode was assumed applicable to all.
    - For individual plans/policies, the 2022 Covered California plan offerings (Covered CA, 2022) were reviewed. The non-HSA plan medical deductible at each tier was assumed to be applicable.
- Non-HSA plan/policy in-network pharmacy deductible information was summarized by regulator, line of business, and deductible or metal tier levels.
    - 14% of large group plans are assumed to have a pharmacy deductible based on the large group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
    - Large group plans with a pharmacy deductible are assumed to have a pharmacy deductible of $190 based on the average large group pharmacy deductible from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019).
    - 10% of the small group and individual grandfathered plans are assumed to have a pharmacy deductible based on the small group percentage of workers with a separate pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KF, 2015).
    - The small group and individual grandfathered plans with a pharmacy deductible are assumed have a pharmacy deductible of $160 based on the average small group pharmacy deductible from Kaiser Family Foundation's 2015 Employer Health Benefit Survey (KF, 2015). The 2015 report was used because grandfathered plans are allowed to offer benefits they had before the Affordable Care Act was signed in 2010 and are not allowed to significantly reduce coverage. The information needed was not available in the 2010-2014 reports.
    - For all nongrandfathered small group plans, the 2021 Covered California plan offerings were reviewed (Covered CA, 2021b). Platinum and Gold plans were assumed to have no pharmacy deductible. Silver and Bronze plans were assumed to have $300 and $500, respectively.
    - For all nongrandfathered individual plans, the 2022 Covered California plan offerings were reviewed (Covered CA, 2022). The non-HSA plan pharmacy deductible was assumed for each tier.
- Non-HSA plan/policy in-network medical coinsurance information was summarized by regulator, line of business, and deductible or metal tier levels.
    - 20% coinsurance was assumed for large group and grandfathered plans based on the average large group coinsurance for a hospital admission from Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KFF, 2019). Hospital admission was used because other coinsurances were not available and the hospital coinsurance is typically the same as most other services.
    - Nongrandfathered individual and small group plans were assumed to have the coinsurances as listed in the metal tiers in the Covered California plan designs.
- HSA-qualified plan/policy medical and pharmacy in-network deductibles were summarized using the 2021 individual and 2020 small group Covered California plans for individual and small group nongrandfathered plans (Covered CA, 2021). Individual silver metal tier off-exchange plans were assumed to have a $3250 deductible based on Kaiser Permanente's Silver 70 HDHP HMO plan. Large group and grandfathered plans are assumed to have a $2,500 deductible, based on the Kaiser Family Foundation's 2019 Employer Health Benefit Survey (KF, 2019).

- HSA-qualified plan/policy medical in-network coinsurance was estimated using assumed actuarial values for each population category based on deductible levels and metal tiers. The estimated coinsurances range from 30% to 40%.
- For chronic drugs and diabetes equipment and supplies covered through the pharmacy benefit, total cost share was developed using the paid-to-allowed ratios for the drugs from the CHSD database. To adjust for average plan benefit differentials by line of business, factors were calculated by comparing paid-to-allowed ratios of each line of business to the overall paid-to-allowed ratios of the California commercial population in the CHSD database. The paid-to-allowed ratios of outpatient prescription drugs for chronic diseases and diabetes equipment and supplies processed through the pharmacy benefit were multiplied by the line of business factors to calculate line of business and service specific paid-to-allowed ratios. One minus the line of business and service specific adjusted paid-to-allowed ratio were applied multiplicatively to the allowed costs to determine the enrollee share of cost for users of outpatient prescription drugs for chronic diseases and pharmacy diabetes equipment and supplies.
- For outpatient prescription drugs for chronic diseases and diabetes equipment and supplies (whether covered through a medical or pharmacy benefit), the cost and utilization of each service was summarized into claim probability distributions. The value of the deductible for each service was determined at each deductible level and multiplied by the membership count at each deductible level to determine an average deductible value for each population category.
- For diabetes equipment and supplies covered through a medical benefit, the coinsurance was calculated as the average cost of medical diabetes equipment and supplies net the value of the deductible multiplied by the coinsurance. This calculation was performed for each population category and deductible level or metal tier. Coinsurance values were multiplied by the membership count at each deductible level to determine an average coinsurance value for each population category. The sum of the deductible value and the coinsurance values are the total cost share for the medical diabetes equipment and supplies.
- For the preventive services, the deductible value was assumed equal to the total allowed amount of the service because HSA-qualified plan deductibles exceed the service cost.

## Postmandate Utilization

- CHBRP assumed the number of users of outpatient prescription drugs used to treat chronic diseases and diabetes equipment and supplies would not increase postmandate.
- CHBRP assumed the number of users of outpatient prescription drugs used to treat chronic diseases and diabetes equipment and supplies would not increase postmandate, but that their utilization would be affected by the decrease in cost sharing. CHBRP estimated that the number of drugs and diabetes equipment and supplies each user received would increase as a result of SB 568. For every 10% reduction in cost sharing, CHBRP increased utilization of outpatient prescription drugs used to treat chronic diseases by 4.0% and increased utilization of diabetes equipment and supplies processed under the pharmacy benefit by 5.3% based on Goldman et al., 2004. CHBRP increased utilization of diabetes equipment and supplies processed under the medical benefit by 0.7% per user based on Milliman's Health Cost Guidelines induced utilization factors.
- CHBRP assumed that the number of users of preventive services per 1,000 would increase by 1.25% as a result of SB 568, based on the Milliman Health Cost Guidelines induced utilization factors for preventive services. CHBRP assumed drug manufacturers and providers of diabetes supplies and preventative care services would not increase the cost of the services as a result of SB 568. The average cost of these supplies per user would increase postmandate due to the utilization per user increase postmandate.

## Postmandate Cost Sharing

- For all services, the postmandate cost share for enrollees without deductibles would not change.

- For each of the enrollees with deductibles using outpatient prescription drugs used to treat chronic diseases, diabetes equipment and supplies, and preventive services, the cost of their other medical and pharmacy services were summarized into claim probability distributions. The percentage of enrollees that would meet their medical or pharmacy deductible from the other services and not be impacted by SB 568 was then calculated. Their total cost sharing (deductibles as well as copayments and coinsurance) would not change from baseline to postmandate.
- For the percentage of enrollees that do not meet their deductible with services other than those impacted by SB 568, the postmandate cost share is equal to the baseline cost share minus the value of the deductible plus the value of the service if it were subject to copayments for pharmacy services or coinsurance for medical benefits. The methods used to calculate the copayment or coinsurance are outlined below:
    - For outpatient prescription drugs used to treat chronic diseases and pharmacy diabetes equipment and supplies, the prescriptions underlying the average cost per user were summarized by generic, preferred brand, nonpreferred brand, specialty, and preventive. For each population category and deductible level or metal tier, a pharmacy plan design based on the Covered California plan designs or the large group plan design in the Kaiser Family Foundation's 2019 Employer Health Benefits Survey (KF, 2019) was assumed. Cost sharing was determined by applying the assumed copayments to the prescriptions by pharmacy tier, assuming that each member only received prescriptions in a single tier.
    - For preventive services and medical diabetes equipment and supplies, the assumed coinsurance was multiplied by amount by the value of the deductible at baseline to determine the postmandate coinsurance.

# REFERENCES

Academy of Managed Care Pharmacy Professional Practice Committee. Prior Authorization and Utilization Management Concepts in Managed Care Pharmacy. *Journal of Managed Care & Specialty Pharmacy.* 2019;25(6):641-644.

Allen SN, Ojong-Salako M. Pharmacist-initiated prior authorization process to improve patient care in a psychiatric acute care hospital. *Journal of Pharmacy Practice.* 2015;28(1):31-34.

Covered California (Covered CA). Covered CA Plan Benefit Changes for 2021. 2021a. Available at: https://www.healthforcalifornia.com/blog/covered-ca-plan-benefit-changes-for-2021. Accessed April 2021.

Goldman DP, Joyce GF, Escarce JJ, et al. Pharmacy Benefits and the Use of Drugs by the Chronically Ill. *JAMA*. 2004;291(19):2344-2350.

Kaiser Family Foundation's 2015 Employer Health Benefits Survey (KFF 2015. Available at: https://www.kff.org/health-costs/report/2015-employer-health-benefits-survey/. Accessed March 2021.

Kaiser Family Foundation's 2019 Employer Health Benefits Survey (KFF 2019). Available at: https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/. Accessed March 2021.

Pharmacy Benefits Management Institute (PBMI). 2014-2015 Prescription Drug Benefit Cost and Plan Design Report. Plano, TX: PBMI; 2015.

Pharmacy Benefits Management Institute (PBMI). 2018 Trends in Specialty Drug Benefits Report. Plano, TX: PBMI; 2018.

# ABOUT CHBRP

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

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

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

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