A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Senate Bill 1199 Prescription Drug Cost Sharing

APRIL 20, 2026

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

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 1199 Prescription Drug Cost Sharing

Summary to the 2025–2026 California State Legislature, April 20, 2026

CHBRP

Summary

The version of California Senate Bill (SB) 1199 analyzed by the California Health Benefits Review Program (CHBRP) would prohibit "copayment adjustment programs," which are benefit designs that exclude third-party financial assistance from contributing towards a patient's in-network deductible or annual out-of-pocket (OOP) maximums. In 2027, of the 22.8 million Californians enrolled in state-regulated health insurance, 12.9 million of them would have insurance subject to SB 1199.

Background

Copayment adjustment programs originate from divergent economic interests between drug manufacturers and payers over high-cost specialty drugs. Rising specialty drug costs have increased patient OOP expenses, prompting drug manufacturers, nonprofits, and state governments to offer financial assistance such as coupons and patient assistance programs. Copayment adjustment programs – including copay accumulators and maximizers – emerged as a benefit design response, limiting how third-party financial assistance counts toward patient deductibles and OOP maximums.

Benefit Coverage

CHBRP estimates that approximately 5.8 million Californians have health insurance that is subject to SB 1199 but is not compliant at baseline. Postmandate, CHBRP assumes all would have health plans or policies compliant with the mandate. SB 1199 would not exceed essential health benefits (EHBs).

Medical Effectiveness

CHBRP found *some evidence* that copayment adjustment programs impact utilization of prescription drugs; the specific impacts, however, depend on multiple factors including drug type, patient condition, the type of copayment adjustment program, and other factors.

Cost Impacts

Postmandate, CHBRP estimates SB 1199 would result in approximately 44,300 enrollees having third-party financial assistance for 253,800 prescriptions applied to their annual cost sharing requirements. This would lead to an annual increase of approximately $355 million in total premiums paid by both those using and not using prescriptions impacted by SB 1199. Of this total premium increase, $9.5 million would be due to an increase of utilization of other health care services by enrollees who would likely hit their annual OOP maximum earlier in the year as a result of SB 1199. Enrollees using drugs impacted by SB 1199 would see a total decrease in cost sharing of $75.6 million, with an annual OOP savings ranging from $530 to $2,600 per utilizer, depending on the market segment.

Public Health Impacts

CHBRP found literature showing that copayment adjustment programs disproportionately affect non-White patient populations because these patients are significantly more likely to be enrolled in them than White patients. If SB 1199 were to be enacted, disparities related to enrollment in copayment adjustment programs would dissipate due to the elimination of these programs.

Long-Term Impacts

The global biologics market continues to experience significant growth. SB 1199 would not impose any requirements that would change the initial prices of biologics or other drugs; these would still be set by drug manufacturers. As these are high-cost specialty drugs, manufacturers would likely continue to offer coupons for new biologics to offset patient OOP costs. SB 1199 may compound this effect by removing a barrier to patient access. Combined, this may increase utilization of specialty drugs and premiums. To mitigate this, some health plans may remove certain specialty drugs from formularies or reclassify them as non-EHBs; federal rules requiring cost-sharing assistance to count toward OOP maximums only apply to EHBs. This allows insurers to avoid coverage requirements and OOP limits. Though plans and policies in the small-group and individual markets in California must cover prescription drugs as EHBs, those in the large-group market do not have the same requirement under existing law.

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Acronyms and Terminology

Acronyms

ACA – Affordable Care Act

CA – California

CalPERS – California Public Employees' Retirement System

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

OOP – out-of-pocket

PBM – pharmacy benefit manager

PMPM – per member per month

SB – Senate Bill

Terminology

CHBRP uses the following terminology throughout this analysis:

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

Overview: SB 1199 and Copayment Adjustment Programs

On February 20, 2026, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of the impacts of Senate Bill (SB) 1199 on prescription drug cost sharing, as introduced on February 19, 2026.

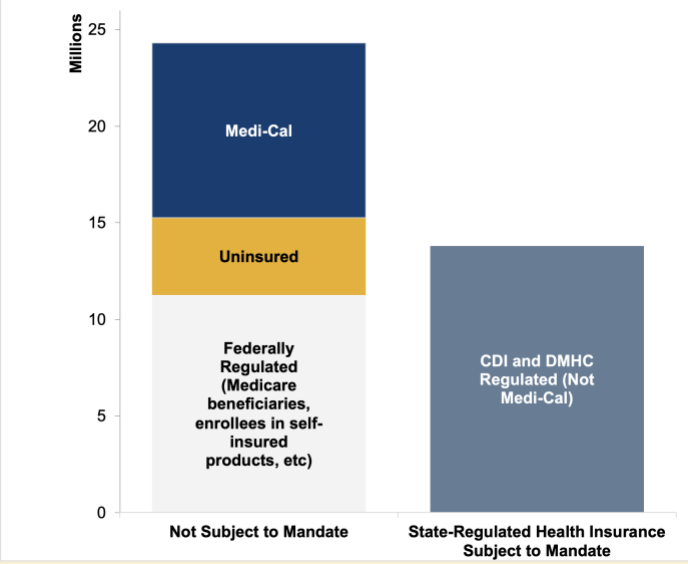
Bill Language of SB 1199

SB 1199 would require health plans regulated by the Department of Managed Health Care (DMHC) and health policies regulated by the California Department of Insurance (CDI) to count all third-party payments, including drug manufacturer copay assistance, toward a patient's annual cost sharing requirements. The measure would effectively prohibit "copayment adjustment programs" that exclude such assistance from contributing towards a patient's in-network deductible or annual out-of-pocket (OOP) maximum. See the bill's full text in CHBRP's Technical Brief on SB 1199.

If enacted, SB 1199 would apply to the health insurance of approximately 12.9 million enrollees (33.7% of all Californians) (see Figure 1).

- **Includes**: Enrollees in *nongrandfathered* commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).
- **Excludes**: Enrollees in *grandfathered* DMHC-regulated health plans or CDI-regulated insurance, Medi-Cal beneficiaries, Medicare supplement plan contracts, or accident-only, specified disease, or hospital indemnity plan contracts.

Figure 1. Health Insurance in CA and SB 1199



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

CHBRP provides an overview of cost sharing terms addressed by SB 1199 in its explainer, *What Is Cost Sharing?*

What Are Copayment Adjustment Programs?

Copayment adjustment programs exist, in part, because of divergent economic interests between drug manufacturers and health insurers and payers regarding high-cost specialty drugs.

The portion of California insurance premiums driven by prescription drug spending has grown from 12.7% in 2020 to 15.4% in 2024 (DMHC, 2025). One of the primary drivers of these increases is the rising cost of specialty drugs, which account for 63% of prescription drug spending but make up less than 2% of the total number of drugs dispensed in the state (DMHC, 2025). Studies point to a wide range of factors that influence the cost and prices of specialty drugs. These

[1] See CHBRP's authorizing statute.

include, among other factors, lack of competition in the biosimilar market, high drug development costs, regulatory challenges, and exclusive sales rights to manufacturers of newly approved brand-name drugs (Baker and Laughery, 2024; Ross and Barrueta, 2024; Waxman et al., 2020). Drug manufacturers and payers operate under different incentive structures: manufacturers generally seek to expand patient access to and utilization of specialty drugs, while payers seek to manage costs for employers and plan enrollees by encouraging lower-cost alternatives and stabilizing premiums.

Specialty and other high-cost drugs are typically assigned a coinsurance (a percentage of cost) regarding patient cost sharing responsibility, rather than a copay (a flat-rate amount) to help mitigate the costs to the health plan or insurer (Long et al., 2024). Thus, the high cost of specialty drugs increases OOP costs for patients. In response to these cost increases, nonprofit organizations, drug manufacturers and other for-profit entities, and state governments have established several strategies to reduce some of the OOP costs patients face when purchasing prescriptions. Examples include drug manufacturer coupons, which lower OOP costs at the pharmacy to encourage the use of specific drugs, and patient assistance programs, which provide direct financial aid to patients. See the *Background on Copayment Adjustment Programs* section in CHBRP's Technical Brief on SB 1199 for more information on types of financial assistance for prescription drugs.

Copayment adjustment programs emerged as a benefit design response to the potential for third-party financial assistance, such as drug manufacturer coupons, to affect how patient cost-sharing requirements function within a health plan (Long et al., 2024). They are a type of pharmacy benefit design that limits how third-party financial assistance counts towards a patient's OOP costs. Specifically, they exclude the contributions made by a third party (such as a drug manufacturer coupon) from counting towards the enrollee's OOP maximum or deductible. The programs typically target specialty drugs, which tend to have higher OOP costs and the most financial assistance from third parties (Fein, 2026). There are two types of copayment adjustment programs:

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

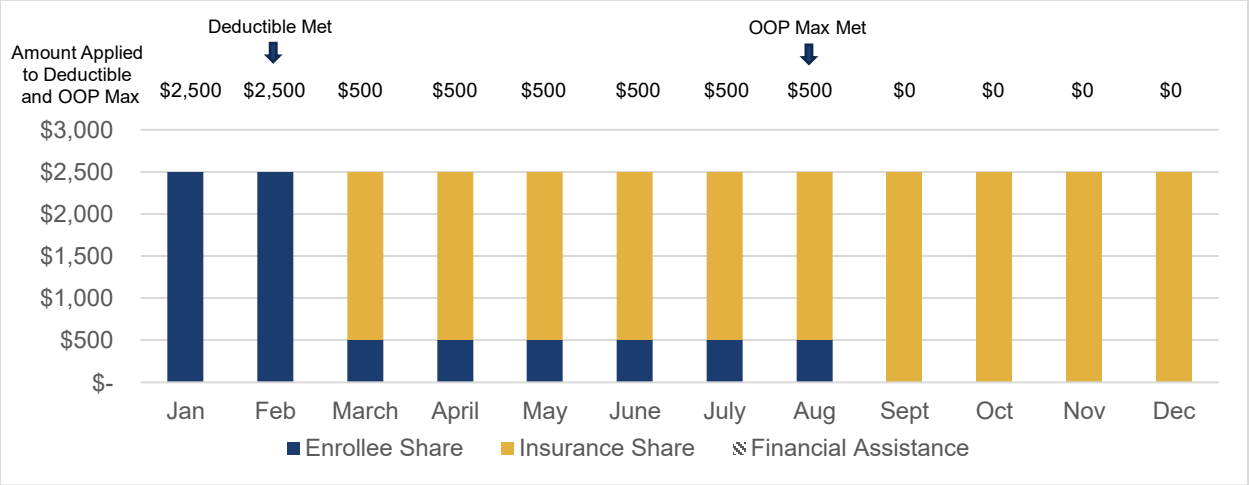
A noted consideration regarding both third-party financial assistance and copayment adjustment programs is that these benefit designs may influence patients toward filling higher-cost specialty drugs rather than pursuing other clinically appropriate therapeutic alternatives. If enacted, SB 1199 would curtail both copay accumulators and copay maximizers.

To better understand how copayment adjustments work, consider the following examples of a monthly copayment with no financial assistance, implementation of a copay accumulator program, and implementation of a copay maximizer program. Additional information and examples can be found in CHBRP's Technical Brief on SB 1199.

No Copay Assistance or Copayment Adjustment Program

First, consider the example of an enrollee with a 20% coinsurance, a deductible of $5,000, and an annual OOP maximum of $8,000. They are prescribed a drug costing $2,500 a month[2] and do not participate in a patient assistance program[3] and do not use drug manufacturer coupons. Typically, an enrollee would pay the full $2,500 until they met their deductible, after month 2. In the following months, the patient would be responsible for covering $500 of the total (20% coinsurance of $2,500), and their health plan or policy would contribute the remaining $2,000, until they met their annual OOP maximum. The health plan or policy would then pay the full monthly cost of the drug for the remainder of the year (Figure 2).

Figure 2. Example of Monthly Copayments With No Financial Assistance



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

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

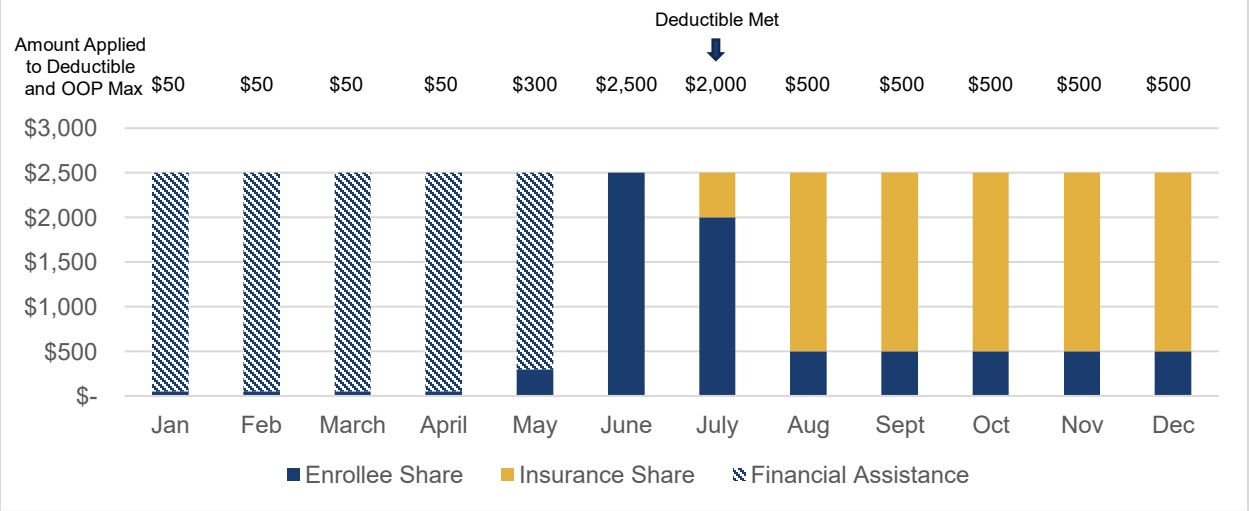
[2] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copayments and coinsurance is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; Insurance Code [INS] 10123.1932). Cost sharing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

[3] A financial assistance program run by a nonprofit organization. See CHBRP's Technical Brief on SB 1199 for more information.

Example of Copay Accumulator Program

In copayment accumulator programs, any amounts collected at the point-of-sale when using drug manufacturer coupons do not count towards the enrollee's deductible or annual OOP maximum. Using the same example as above, assume the enrollee is now eligible for a drug manufacturer coupon that provides $12,000 a year with a required enrollee contribution of $50 per fill. Under the copayment accumulator program, the enrollee would use $2,450 per month of the financial assistance and would initially only pay the monthly $50 required by the drug manufacturer to obtain the financial assistance. By month five, the assistance would be exhausted and the enrollee would be responsible for meeting their annual deductible[4] without financial assistance prior to their health plan or policy needing to pay any amount. After the deductible was met, although their health plan or policy would become responsible for 80% of the cost of the drug ($2,000), the enrollee would still be responsible for their 20% coinsurance, as they had not met the annual OOP maximum (Figure 3).

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



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

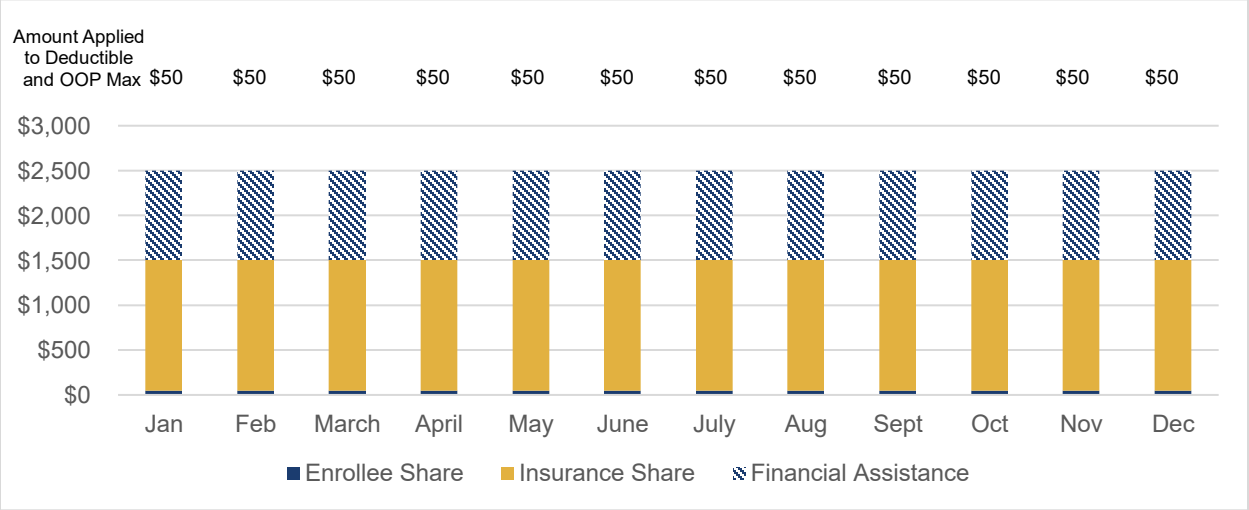
[4] In this example, assume the enrollee has contributed $0 towards their deductible from other medical or pharmacy expenses.

Example of Copayment Maximizer Program

Copayment maximizer programs are designed to use the total amount of financial assistance provided to an enrollee for a specific drug, typically over the course of a year. Under these programs, the enrollee's typical monthly cost-sharing maximums are inflated to equal the total amount of financial assistance, plus any required copayment for such assistance, divided into a monthly amount. Copayment maximizer programs are generally implemented in conjunction with a copayment accumulator program; therefore, the value of the financial assistance usually does not count toward the enrollee's deductible or annual OOP maximum.[5]

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

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



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

Disparities[6] Regarding Copayment Adjustment Programs

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

CHBRP found literature identifying disparities by race and ethnicity regarding copay adjustment programs. A 2023 retrospective, cross-section study examining the potential differences in their use by White and non-White patients found

[5] Communication with T. Sloan, March 2023.
[6] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

that copay adjustment programs disproportionately affect non-White[7] patient populations because these patients are significantly more likely to be enrolled in them than White patients (Ingham et al., 2023). Although there were no significant differences in the initial utilization of third-party financial assistance (copay cards) between non-White and White patients, non-White patients faced a much higher likelihood of their assistance being subject to insurer adjustment. In an adjusted analysis of commercially insured patients, non-White patients were significantly more likely to be exposed to copay adjustment programs compared to White patients. Specifically, non-White patients had a 27% higher likelihood of being in a copay maximizer program (OR = 1.27) and a 31% higher likelihood of being in a copay accumulator program (OR = 1.31) (Ingham et al., 2023).

If SB 1199 were to be enacted, disparities related to enrollment in copayment adjustment programs would dissipate due to the elimination of these programs. The bill would not impact other disparities by race and ethnicity that exist in the health care system or health insurance benefits.

What Are the Impacts of Cost Sharing on Prescription Drug Utilization?

It is well established in the literature that persons who face higher cost sharing use fewer services than persons with lower cost sharing (CHBRP, 2018). In addition, there is a preponderance of evidence across multiple health conditions that, as cost sharing increases, adherence to drug regimens decreases, with a majority of studies indicating that decreased adherence is associated with worse outcomes (CHBRP, 2014). Goldman et al. (2007) found that for every 10% increase in cost sharing, there was a 2% to 6% decrease in utilization. The results are clear for those with chronic conditions that increased cost sharing is associated with decreased adherence and worse health outcomes (Goldman et al., 2007). Similar results were found in a meta-analysis of publicly insured patients (Sinnott et al., 2013). However, there is also evidence that the effect of cost sharing may differ depending on the specific disease and the specific drug (CHBRP, 2018).

How Do Copayment Adjustment Programs Affect Prescription Drug Utilization?

CHBRP examined the literature to determine whether copay adjustment programs impact patient health outcomes or utilization of prescription drugs.

CHBRP identified no studies that examined the effects of copay adjustment programs on patient health outcomes. **There is *not enough research* regarding the impact of copayment adjustment programs to reach evidence-based conclusions on whether they affect patient health outcomes.** This does not mean that there is no impact, only that the impact is unknown.

CHBRP found two retrospective cohort studies that considered the impacts of these programs on prescription drug utilization. One study compared claims data of patients with different copay arrangements (accumulator, maximizer, or standard) and measured utilization of branded antidepressants and atypical antipsychotics for major depressive disorder or bipolar disorder (Baser et al., 2025). Patients in copay accumulators with either condition were found to have significantly lower adherence to antidepressants and higher discontinuation rates of atypical antipsychotics than those in standard copay plans.[8] In contrast, patients diagnosed with bipolar disorder in copay maximizers had significantly higher adherence and longer persistence[9] with atypical antipsychotics; those with major depressive disorder in a copay maximizer also had significantly higher persistence (Baser et al., 2025).

[7] Non-White patients in the study identified as African American, Central and Southwest Asian, Far Eastern Polynesian, Hispanic, Native American, Southeast Asian, and other (Ingham et. al., 2023).
[8] Adherence was measured using a standard industry metric known as the "proportion of days covered," by calculating the percentage of a time a patient possessed their medication during an observation period. Discontinuation was measured as a significant and prolonged break in a patient's medication supply or, specifically, 60 or more days for oral medications or 30 or more days for injections during a 12-month period (Baser et al., 2025).
[9] In this study, the authors used persistence as a measure of how long a patient stayed on their medication without taking a significant break. The longer the duration of continuous use before a patient stopped their therapy for an extended period, the higher their persistence (Baser et al., 2025).

The second study looked at a single accumulator program for a health plan in the self-insured market. The authors examined the utilization of specialty drugs used to treat autoimmune diseases for patients enrolled in a no-deductible preferred provider organization (PPO) plan compared to that of patients in high-deductible plans with a health savings account (HSA) or health reimbursement arrangement[10] design (Sherman et al., 2019). Those in the high-deductible plans have higher OOP costs for specialty drugs due to the requirement to meet a higher deductible. The pharmacy claims review found that adherence, as measured by the proportion of days covered, was significantly lower for HSA patients compared to PPO patients. In addition, monthly prescription fills for HSA patients decreased significantly more rapidly than for PPO patients (Sherman et al., 2019).

Based on the evidence from two studies, CHBRP concludes **there is *some evidence* that copay adjustment programs impact patient utilization of prescription drugs. However, impacts differ based on program design (i.e., maximizer vs. accumulator), plan design, prescription drug, and patient condition.**

Policy Context

Existing California Law and Regulations

Under existing law, pharmaceutical manufacturers are prohibited from offering discounts or other reductions to an enrollee's OOP expenses associated with their health insurance coverage, if a lower-cost, therapeutically equivalent generic drug is available.[11] This prohibition also applies to any prescription drugs for which the active ingredients are in Food and Drug Administration (FDA)–regulated products that are available without prescription at a lower cost, and not otherwise contraindicated for treatment of the condition for which the drug is approved.[12] There are limited exceptions to this law including, among other things, if the individual has completed any applicable step therapy or prior authorization for the prescription drug as mandated under their health coverage, or if a rebate is received by a state agency.[13]

California also has a cost-sharing cap on outpatient prescription drugs for nongrandfathered commercial market segments. Copays and coinsurance for prescription medications in these market segments is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's Affordable Care Act (ACA) marketplace.[14] Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible. The impacts of SB 1199 would therefore be dampened because enrollees in these plans and policies already pay no more than $250 per month at baseline.

California also requires pharmacists to inform customers about purchase options (e.g., whether the retail price of a drug is lower than the applicable cost-sharing amount for that drug) and ensures that outright purchasing of a drug applies to the patient's deductible and maximum OOP limit as applicable.[15]

Federal Regulations

In July 2021, the Centers for Medicare & Medicaid Services' (CMS) final rule on copayment adjustment programs deferred to states regarding their regulation for health plans sold on the ACA exchanges and in nongrandfathered individual and group health plans sold off exchange.[16] Health plans and insurers were authorized to count payments associated with drug manufacturer financial assistance towards an enrollee's cost-sharing limits but were not mandated to do so unless

[10] An health reimbursement arrangement is an employer-funded, tax-advantaged plan that reimburses employees for specific, qualified OOP medical expenses.
[11] Health and Safety Code (HSC) §132000.
[12] HSC §132002.
[13] HSC §132004.
[14] HSC 1342.73; INS 10123.1932.
[15] Business and Professions Code (BPC) §4079.
[16] Centers for Medicare & Medicaid Services (CMS), Department of Health & Human Services (HHS). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards. Federal Register.

the state regulates them otherwise. The 2021 federal rule encouraged, but did not require, health plans and policies to disclose the use of copayment accumulator programs on websites, brochures, plan documents, and other materials.

In September 2023, the U.S. District Court for the District of Columbia vacated, or set aside, this rule.[17] As of the date this analysis was published, an appeal from the federal government was withdrawn. The 2020 version of the federal rule is in effect as of the publication date of this report, which limits health plans/insurers to restricting only drug manufacturer financial assistance that have available generic equivalents from applying to OOP maximums; if there is no generic equivalent, drug manufacturer financial assistance must be applied towards the enrollee's OOP maximum.[18]

Essential Health Benefits, the Affordable Care Act, and SB 1199

When a state requires health plans/insurers to cover more than the federal essential health benefits (EHBs), it is considered 'exceeding EHBs.' In these cases, the state – rather than the federal government or the health plan/insurer – is responsible for paying the extra cost of that care. SB 1199 does not appear to exceed EHBs, as all health plans and insurers in California are already required to cover outpatient prescription drugs. Furthermore, the bill would not require health plans or insurers to set a deductible or OOP maximum higher than the federal limit.

As noted in the *What are Copayment Adjustment Programs?* section, federal rules requiring cost-sharing assistance to count toward OOP maximums only apply to EHBs. Drugs that are considered non-EHBs can still be placed in maximizer programs for copay assistance to continue to be collected once an enrollee hits their OOP maximum. In the final Health and Human Services Notice of Benefit and Payment Parameters for 2025, CMS clarified that prescription drugs beyond those covered by a state's EHB benchmark plan are considered EHBs (Treasury and CMS, 2024). Additional federal guidance further explained that this policy only applies to issuers of nongrandfathered individual and small group market plans subject to the ACA requirement to provide EHBs (Treasury and HHS, 2024). The guidance does state the intent to propose rulemaking that would align the standards applicable to large group health plans and self-insured health plans with those applicable to the small-group and individual markets, with regard to coverage of prescription drugs and EHBs, however it was not included in the 2026 proposed rulemaking cycle (Treasury and HHS, 2024).

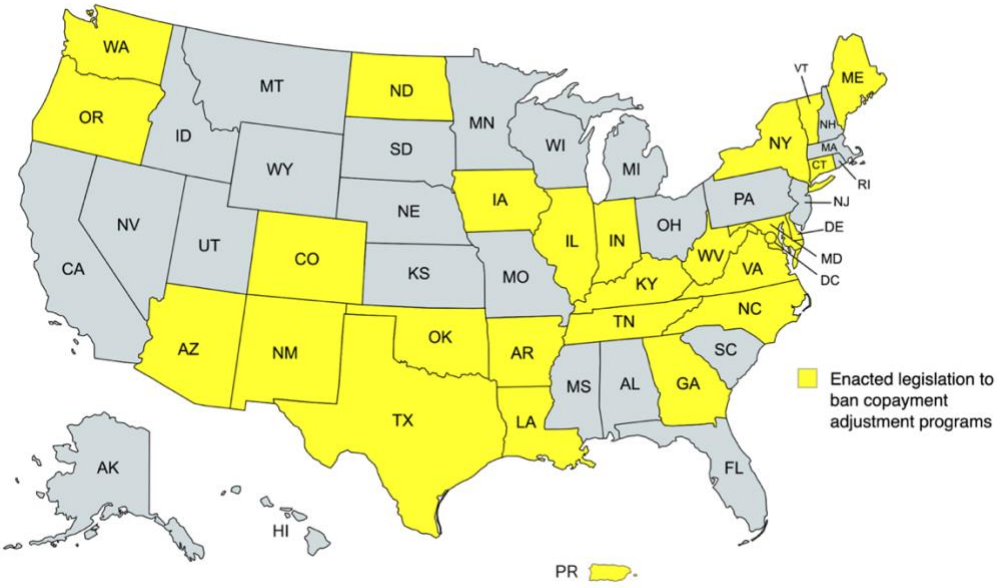
With regard to SB 1199, California law states that the cost-sharing limits for outpatient prescription drugs apply only to outpatient prescription drugs covered by a contract that constitute EHBs, as defined in statute.[19] Under that statute, health plans and policies in the individual and small-group markets must cover prescription drugs as an EHB; there is no explicit mention of the large-group market.[20] Thus, based on these provisions, SB 1199 would prohibit prescription drugs from being designated as non-EHBs and used in a maximizer program for enrollees with health plans or policies in only the individual and small-group markets. In the large-group market, health plans and policies that provide coverage for outpatient prescription drugs are still required to cover medically necessary drugs; this law applies to all commercial health plans and policies.[21] However, the designation of a prescription drug as a non-EHB does not preclude a health plan or policy from covering the drug, rather it shifts the cost sharing structure requirements. Therefore, if SB 1199 were enacted, health plans and policies in the large-group market may still designate drugs as a non-EHB and still comply with the existing California law to cover medically necessary drugs, but also continue to use third-party financial assistance through a non-EHB maximizer program.

Similar Legislation in Other States

Like California, Massachusetts has also banned the use of discounts or other reductions for prescription drugs when a generic equivalent is available.[22] As shown in Figure 5, to date, at least 25 states, the District of Columbia, and Puerto Rico have enacted legislation banning copayment adjustment programs (NCSL, 2025).

[17] HIV & Hepatitis Policy Institute et al., Plaintiffs, v. United States Department of Health and Human Services et al., Defendants. September 29, 2023.
[18] CMS Press Release, April 18, 2019. CMS Issues Final Rule for the 2020 Annual Notice of Benefit and Payment Parameters.
[19] HSC 1367.25(b); INS 10123.196.
[20] HSC 1367.005; INS 10112.27.
[21] HSC 1367.24; INS 10123.201.
[22] Massachusetts General Laws Chapter 175H § 3(b)(2).

Figure 5. States With Bans on Copay Adjustment Programs



Source: California Health Benefits Review Program, 2026; created with mapchart.net.

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Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current laws and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of SB 1199, unless otherwise specifically mentioned. CHBRP previously analyzed similar bill language in AB 874 (2023) and AB 2180 (2024), neither of which were enacted into law. Where applicable, this analysis builds off those previous analyses.

General

For the purposes of estimating the cost impact of SB 1199, CHBRP made the following assumptions, which are also summarized in Table 1:

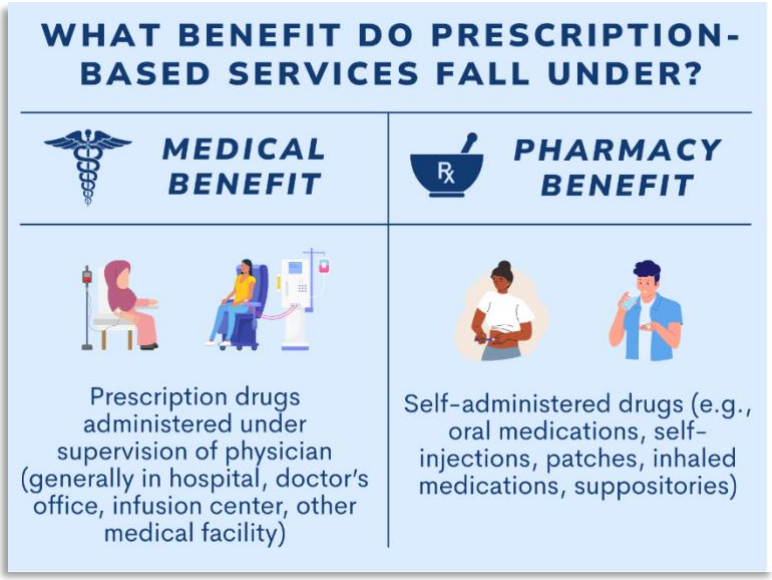
- **Copay accumulator or combined accumulator/maximizers:** For all noncompliant plans other than HSA-qualified high-deductible health plans (HDHPs), CHBRP assumed that copay maximizer programs are always implemented in conjunction with copay accumulator programs because copay maximizers allow health plans and insurers to take full advantage of the third-party financial assistance. As a result, CHBRP assumed that they would be implemented wherever possible. For noncompliant HDHPs with a qualified HSA, CHBRP assumed that copay accumulator programs are the primary program in place.
- **Specialty drugs only:** Health plans, insurers, and pharmacy benefit managers working on behalf of health plans and insurers typically only work with specialty pharmacies – which they either own or have exclusive contracts with – on implementation of copay adjustment programs. Accordingly, CHBRP assumed that SB 1199 would only impact specialty drugs, which are typically high-cost, brand-name drugs.
- **Financial assistance outside of insurance coverage does not apply:** CHBRP assumes the bill does not apply to prescription drug purchases that occur outside of insurance coverage, which include those for which claims are not, legally or by the enrollee's choice, submitted as a claim to their health insurance. Payments for prescription drugs made by patient assistance programs are also conducted outside of an enrollee's insurance coverage, and therefore, CHBRP assumed they would not be impacted by SB 1199.
- **Primary impact of SB 1199 from drug manufacturer coupons:** SB 1199 would require all third-party financial assistance that occurs under insurance coverage to count towards a patient's cost sharing. Currently the financial support from copay assistance programs sponsored by drug manufacturers is substantially larger than that of independent charities (Wreschnig, 2022). Therefore, CHBRP assumed that the impact of SB 1199 is driven by copay assistance programs from drug manufacturers in the form of drug manufacturer coupons. It should be noted that copay assistance programs from drug manufacturers are often more sophisticated than traditional coupons. For example, some drug manufacturer assistance programs operate more as an insurance or credit card to pay OOP costs until a patient meets their deductible (Pfizer, 2026). However, CHBRP uses the term "drug manufacturer coupons" because it is the industry standard despite being an oversimplification.

Table 1. Third Party Contributions Towards Cost Sharing: Assumptions for SB 1199

	Copay Accumulators	Copay Maximizers	No Accumulator / No Maximizer
Patient assistance programs (uninsured)	Does not exist	Does not exist	Out of scope
Copay assistance programs/ coupons (manufacturers)	Impacted by SB 1199	Impacted by SB 1199, except for non-EHB maximizers	No impact due to current compliance
Copay assistance programs (independent charities)	Impacted by SB 1199, yet relatively small compared to manufacturer contributions	Impacted by SB 1199, yet relatively small compared to manufacturer contributions	No impact due to current compliance
None	No impact	No impact	No impact

Source: California Health Benefits Review Program, 2026.
Key: EHB = essential health benefits.

Relevant Markets and Drugs



- For Medi-Cal beneficiaries, the pharmacy benefit is separate and administered by the Department of Health Care Services under the Medi-Cal Rx program and is not subject to DMHC regulation. Because SB 1199 would not require creation of a pharmacy benefit, baseline benefit coverage for enrollees is compliant if they are either without a pharmacy benefit or the pharmacy benefit is not regulated by DMHC or CDI. Being compliant with SB 1199 at baseline does not necessarily mean that these Medi-Cal plans have a pharmacy benefit that includes coverage for all specialty drugs, because CHBRP did not survey the administrator of the Medi-Cal pharmacy benefit.
- CHBRP assumed that no prescription drugs administered in a medical setting would be impacted by SB 1199. Although third-party financial assistance would be available to cover drugs administered in a medical setting, these drugs are generally not subject to copayment adjustment programs because these claims are not typically submitted to pharmacy benefit managers (PBMs) or to the specialty pharmacy associated with the PBM. Therefore, CHBRP assumed all third-party assistance provided for drugs administered in a medical setting already counts towards deductibles and OOP maximums.

Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of SB 1199 on benefit coverage, utilization, and cost for a single year.[23] Full-scale implementation typically requires a "ramp up" period that may include educating enrollees, providers, and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 1199. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The incremental impact estimates below assume there is

[23] For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP's estimates represent the full impact of the mandate in 1 year even if changes in coverage, utilization offsets, and costs may be realized in more than 1 year.

no "ramp up" period and represent ongoing annual costs at full-scale implementation of SB 1199, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.[24] For a discussion of long-term impacts of SB 1199, see the *Long-Term Impacts* section.

Approach and Assumptions on Baseline Coverage and Utilization

- CHBRP assumed all impacted enrollees fill 12 specialty prescriptions per year, each with a 30-day supply.
- At baseline, it is assumed that third-party financial assistance can help all enrollees with their cost-sharing requirements but that any dollars tracked by copay accumulator and/or copay maximizer programs are not counted towards an enrollee's deductible of OOP maximum.
- CHBRP used publicly available lists of drugs included in copay adjustment programs to identify drugs to include in this analysis. Claims data and underlying cost models were used to estimate the utilization and unit cost of drugs with eligible drug coupons. Drugs with a generic equivalent available were excluded from this list. CHBRP determined that roughly 9% of prescription drugs with coupons and a generic equivalent have a generic drug covered on a lower tier of the formulary, and would not be impacted by SB 1199, due to existing restrictions on drug coupons in California law.
- For the purposes of this analysis, CHBRP assumed that 41% of large group enrollees would not be impacted by SB 1199 based on the estimated market share of PBMs known to use non-EHB classifications for their maximizer programs.

Approach and Assumptions on Postmandate Coverage and Utilization

- CHBRP assumed that third-party financial assistance would be used to satisfy all enrollee cost-sharing requirements until exhausted. Once cost-sharing requirements were met, none of the remaining coupon value was assumed to reduce plan costs.
- CHBRP assumed that if SB 1199 were enacted, there would be an increase in other medical utilization and plan expenses due to a portion of enrollees who use these programs hitting their OOP maximum earlier in the year and receiving full coverage without cost sharing for subsequent services. CHBRP assumed that for every $1 of cost sharing "saved," there would be $0.05 in additional spending due to utilization of other services. For additional details, please see *Cost Impact Analysis: Data Sources, Caveats, and Assumptions* section of CHBRP's Technical Brief on SB 1199.
- Postmandate, to remain compliant with IRS minimums, it is assumed that HDHP enrollees would be responsible for $1,750 in OOP costs.[25]
- For enrollees in plans with copayment maximizer programs, CHBRP assumed that a PBM fee of 25% is applied to the coupon amount.
- CHBRP assumed that copay assistance would apply only until enrollee OOP maximum cost-sharing requirements were satisfied by the sum of copay assistance payments used to satisfy cost-sharing requirements plus enrollee cost-sharing contributions (described below).
- CHBRP assumed the average per enrollee per month (PMPM) allowed cost of total services would increase proportionally to the increase in utilization described above and did not assume a change in the average cost per service.

For further details on the underlying data sources, methods, and assumptions used in this analysis please see CHBRP's Technical Brief on SB 1199, available at www.chbrp.org.

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[24] CHBRP's Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.
[25] The projected minimum annual deductible to be considered an HDHP in 2027 is $1,750.

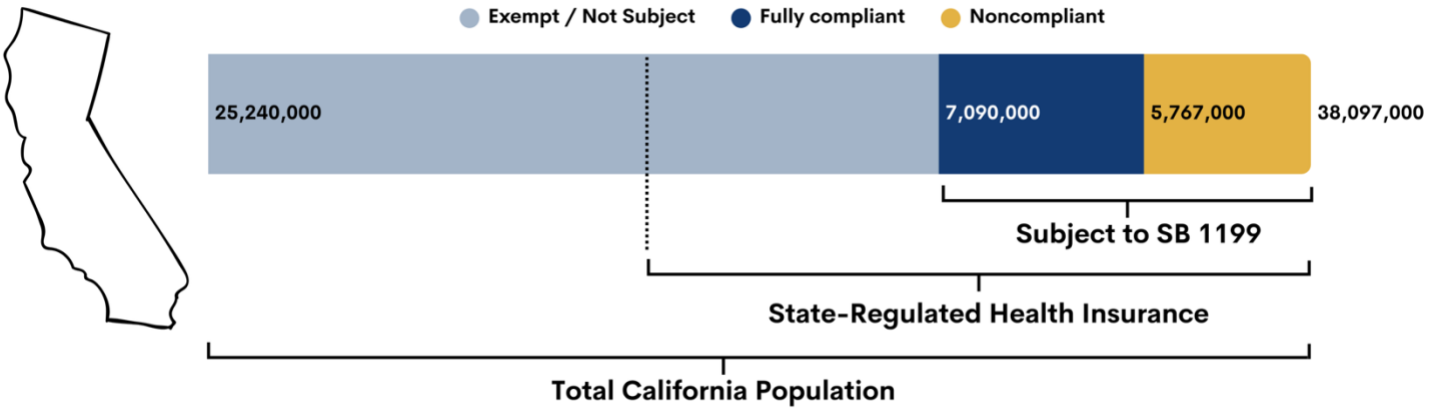
SB 1199 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that at baseline, 5,767,000 Californians (44.9%) with state-regulated insurance subject to the mandate are enrolled in plans or policies out of compliance with SB 1199, and 7,090,000 (55.1%) are enrolled in plans or policies that are compliant (Figure 6). Postmandate, CHBRP estimates 12,857,000 Californians would have coverage compliant with SB 1199. This includes enrollees in nongrandfathered commercial or CalPERS health insurance regulated by DMHC or CDI.

Please note that CHBRP's approach is to assume full compliance postmandate on the part of all health insurance subject to the proposed mandate. For additional details on impacts to benefit coverage, see Table 7 in Appendix.

Figure 6. California Health Insurance and Baseline Compliance With SB 1199



Source: California Health Benefits Review Program, 2026.

Utilization and Unit Cost

CHBRP identified prescription drugs relevant to SB 1199 using publicly available lists of drugs included in copay adjustment programs. Using this information and pharmacy claims data, CHBRP estimates that 44,300 enrollees would fill approximately 253,500 prescriptions impacted by SB 1199 (Table 2). CHBRP projects an increase of 300 specialty drug prescriptions filled postmandate. Because the elimination of copay adjustment programs would allow patients to reach their OOP maximum sooner, CHBRP assumed this would also lead to an increase in utilization of other medical services. Once an enrollee hits their annual OOP maximum, the health plan or insurer is responsible for all additional in-network services. In total, CHBRP estimates an additional $9.5 million would be spent on other health care services that patients would otherwise forego if they had not yet reached their annual OOP maximum.

Table 2. Impacts of SB 1199 on Utilization and Unit Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Number of impacted scripts filled (specialty scripts with manufacturer discount/coupons available where generic option is not covered on a lower tier for enrollees in noncompliant plans)	253,500	253,800	300	0.12%
Number of enrollees with impacted scripts filled	44,300	44,300	—	0.00%
Average cost of impacted 30-day scripts filled	$7,043	$7,043	$0	0.00%
Average manufacturer coupons used to offset member cost sharing requirements (total)	$725	$336	−$388	−53.60%
Average manufacturer coupons used to reduce member cost sharing requirement (but not tracked to deductible/OOP max) for impacted scripts filled	$725	$0	−$725	−100.00%
Average manufacturer coupons used to reduce member cost-sharing requirement (and tracked to deductible/OOP max) for impacted scripts filled	$0	$336	$336	0.00%
Average member contribution towards cost-sharing requirement for impacted scripts filled	$407	$219	−$189	−46.33%
Average coupon used to offset plan costs beyond member cost sharing for impacted scripts filled	$33	$0	−$33	−100.00%
Average net plan expense for impacted scripts filled	$5,879	$6,488	$610	10.37%
Additional expenditure from increased utilization due to lower cost sharing	$0	$9,528,000	$9,528,000	

Source: California Health Benefits Review Program, 2026.
Key: OOP max = out-of-pocket maximum; scripts = prescriptions.

Expenditures and Premium Impacts

Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[26] and (2) those who pay for the benefit but do not utilize it. Enrollees who use a benefit may be responsible for

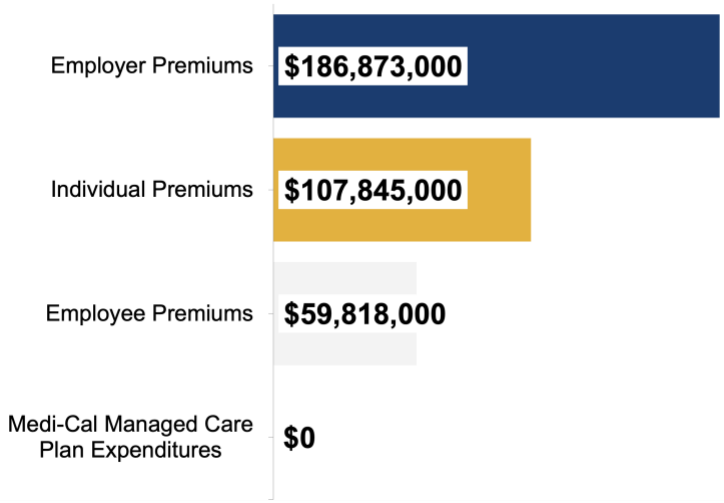
[26]Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

paying premiums and any out-of-pocket expenses related to the benefit (see Table 5). All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums (see Table 5 and Table 6).

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 7, for DMHC-regulated plans and CDI-regulated policies, SB 1199 would increase total premiums paid by employers and enrollees for newly covered benefits by approximately $354,536,000. For more details, see Table 4. Enrollee premiums calculated include premiums for those enrollees using the benefit in addition to those not using the benefit. No measurable offsets are projected. Changes in premiums as a result of SB 1199 would vary by market segment (Table 3; see also Table 8 and Table 9 in the Appendix). Note that there is no projected impact on Medi-Cal; this is due to the carve-out of prescription drug benefits for Medi-Cal Managed Care plans into Medi-Cal Rx.

Figure 7. Expenditure Impacts of SB 1199 on Employers and Enrollees



Source: California Health Benefits Review Program, 2026.

Table 3. Premium Impact Ranges of SB 1199 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$1.11 - $6.57
Covered California – individually purchased	$3.68
CalPERS	$1.74
Medi-Cal	$0.00

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System.

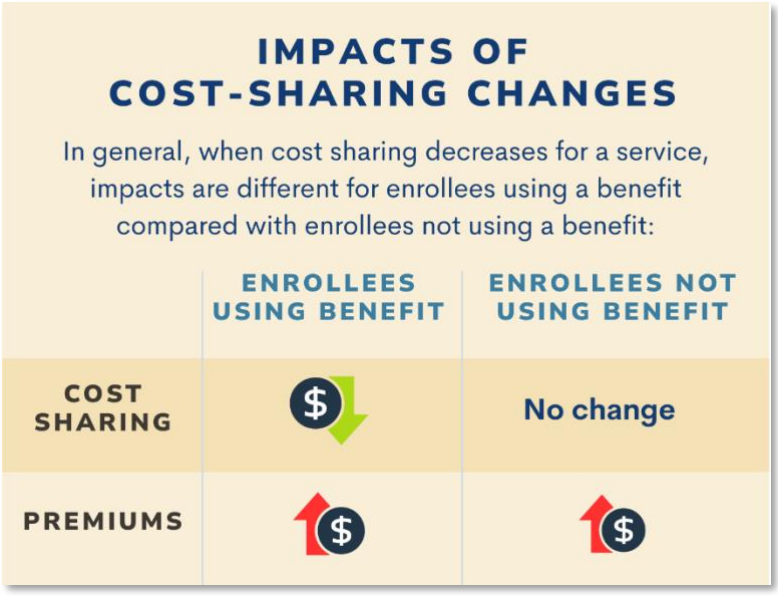
Below, Table 4 provides estimates of the aggregate impacts of SB 1199 on premiums.

Table 4. Impacts of SB 1199 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,901,432,000	$170,516,000	0.23%
CalPERS employer (b)	$8,611,855,000	$8,628,212,000	$16,357,000	0.19%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.00%

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,883,170,000	$107,845,000	0.42%
Outside Covered California	$9,551,761,000	$9,590,677,000	$38,916,000	0.41%
Through Covered California	$16,223,564,000	$16,292,493,000	$68,929,000	0.42%
Enrollees, group insurance (d)	$21,828,135,000	$21,887,953,000	$59,818,000	0.27%
Total premiums	**$174,928,615,000**	**$175,283,151,000**	**$354,536,000**	**0.20%**

Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC.[27] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.



Enrollee Expenses for Benefit Users

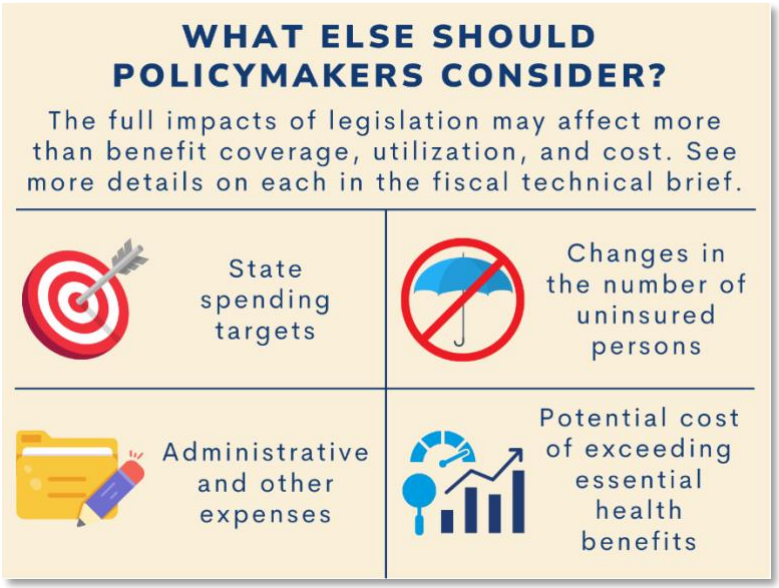
SB 1199 would impact expenses for those using the benefit by decreasing cost sharing by a total of $75,603,000 across all users. SB 1199 would not affect expenses for noncovered benefits (Table 9). Impacts on people in specific market segments would vary, ranging from an annual cost sharing savings of approximately $1,740 for enrollees in the large-group market and approximately $2,600 for those in the individual market (Table 5). It should be noted that CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to plans and insurers negotiating discounted rates that are unavailable to patients and their families.

The postmandate impact of SB 1199 on average enrollee premiums would increase for both users of third-party financial assistance for specialty drugs and those not using them, as shown in Table 5 and Table 6, ranging from an annual increase of $10.00 in the large-group market to $50.00 in the small-group market. SB 1199–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits are related to the number of enrollees with health insurance that would be subject to SB 1199 expected to use the relevant tests, treatments, or services during the year after enactment (see Table 4, Table 8, and Table 9). These changes would vary by market segment.

[27] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

The presence of a deductible not yet met for the year[28] could result in the enrollee paying the full unit cost but hitting the annual out-of-pocket maximum[29] would result in the enrollee having no further cost sharing.

See more information in CHBRP's Technical Brief on SB 1199, including what else policymakers should consider.



[28] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[29] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance for prescription medications is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

Table 5. Impact of SB 1199 on Average User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population with enrollee expenses impact due to SB 1199	0.70%	0.72%	0.73%	0.77%	0.00%
Average annual enrollee expenses and premium impact for users (a)	($1,740.00)	($2,420.00)	($2,600.00)	($530.00)	$0.00

Source: California Health Benefits Review Program, 2026.
Notes: Average annual enrollee expenses include cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

Table 6. Impact of SB 1199 on Average Non-User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population without enrollee expenses impact due to SB 1199	99.30%	99.28%	99.27%	99.23%	100.00%
Average annual enrollee expenses and premium impact for non-users (a)	$10.00	$50.00	$40.00	$20.00	$0.00

Source: California Health Benefits Review Program, 2026.
Average annual enrollee expenses include cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

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SB 1199 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of SB 1199, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[30] These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

The global biologics market is expected to grow significantly over the next few years. SB 1199 would not impose any requirements that would change the initial prices of biologics or other specialty drugs; these would still be set by drug manufacturers. Because biologics are typically classified as high-cost specialty drugs, more drug manufacturer coupons are likely to be introduced for new biologics as they become available to help offset the OOP costs to patients. If enacted, SB 1199 may compound this effect by removing a barrier to patient access to high-cost medications and creating an avenue for patients to reach their annual OOP maximum faster, thereby incentivizing additional coupons to be offered by drug manufacturers to encourage the utilization of more specialty drugs. Should this occur, premiums may continue to increase in the long term.

Health plans and insurers may respond in different ways. Some may decide to remove specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary; off-formulary drugs are not considered covered benefits, and therefore, SB 1199 would not apply to these drugs. Large-group plans that are not regulated by the Affordable Care Act may also decide to classify drugs with manufacturer coupons as non-essential health benefit (EHBs). Maximum OOP limits are not required to apply to non-EHBs, if the patient selects a prescription drug in circumstances in which a generic was available and medically appropriate (HHS, 2019). See the *Policy Context* section for more information.

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[30] Full-scale implementation typically requires a “ramp up” period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 1199. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no “ramp up” period and represent ongoing annual costs at full-scale implementation of SB 1199, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

Appendix. Impacts of SB 1199 on Benefit Coverage and Expenditures, 2027

Table 7. Impacts of SB 1199 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates*	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to SB 1199	12,857,000	12,857,000	0	0.00%
Total enrollees with health insurance and outpatient prescription drug benefits impacted by SB1199	12,302,000	12,302,000	0	0.00%
Total enrollees with health insurance but without outpatient prescription drug benefits impacted by SB1199 (deemed compliant with SB1199)	555,000	555,000	0	0.00%
Total enrollees with coverage fully compliant with SB1199 drug out-of-pocket mandate	7,090,000	12,857,000	5,767,000	81.34%

Source: California Health Benefits Review Program, 2026.
Note: * Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[31]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

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

Table 8. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 1199	7,245,000	1,966,000	2,372,000	931,000	0	0	301,000	42,000	0	12,857,000
Premiums										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$127,325,155,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$47,603,460,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$174,928,616,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,432,815,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$809.72**	**$986.63**	**$1,136.53**	**$986.84**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$194,361,431,000**

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[32] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[33]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

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[32] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[33] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 9. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 1199	7,245,000	1,966,000	2,372,000	931,000	0	0	301,000	42,000	0	12,857,000
Premiums										
Average portion of premium paid by employer (e)	$0.9100	$2.7886	$0.0000	$1.4641	$0.0000	$0.0000	$3.0239	$4.6167	$0.0000	$186,873,000
Average portion of premium paid by enrollee	$0.1969	$1.3632	$3.6772	$0.2762	$0.0000	$0.0000	$0.7164	$1.9501	$0.0000	$167,662,000
Total premium	$1.1069	$4.1518	$3.6772	$1.7403	$0.0000	$0.0000	$3.7403	$6.5668	$0.0000	**$354,536,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	−$0.1719	-$0.9849	-$1.0076	-$0.0945	$0.0000	$0.0000	-$0.7917	-$1.7117	$0.0000	-$75,603,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.9350	$3.1669	$2.6696	$1.6458	$0.0000	$0.0000	$2.9486	$4.8551	$0.0000	**$278,932,000**
Percent change										
Premiums	0.1469%	0.5173%	0.4252%	0.1899%	0.0000%	0.0000%	0.3875%	0.8053%	0.0000%	0.2027%
Total expenditures	0.1155%	0.3210%	0.2349%	0.1668%	0.0000%	0.0000%	0.2700%	0.4718%	0.0000%	0.1435%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[34] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS)..
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[35]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

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[34] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[35] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

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

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

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The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

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

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