Abbreviated Analysis

California Assembly Bill 2180: Cost Sharing

Report to the 2023–2024
California State Legislature

APRIL 16, 2024

CHBRP

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

www.chbrp.org

Summary

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of California Assembly Bill (AB) 2180, as introduced on February 7, 2024. AB 2180 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to apply any amounts paid by either an enrollee or a third-party manufacturer or other charitable program that provides financial assistance to the enrollee's cost-sharing requirement. In essence, the bill would prohibit the implementation of copayment adjustment programs on drug copay assistance programs administered by nonprofit organizations.

Background

In 2022, DMHC-regulated health plans in California, including those regulating plans for Medi-Cal beneficiaries, paid approximately $12.1 billion for prescription drugs — an increase of 12.3% from the previous year — which accounted for 14.2% of total DMHC-regulated health plan premiums. Specialty drugs (which typically include high-cost brand-name drugs delivered by specialty pharmacies) accounted for only 1.6% of all prescription drugs dispensed yet represented 64% of total annual spending on prescription drugs.

Nonprofit organizations, drug manufacturers and other for-profit entities, and state governments have established several initiatives to reduce some of the high out-of-pocket (OOP) costs patients face when purchasing prescriptions. AB 2180 addresses drug copay assistance programs, which are administered by nonprofit organizations to provide financial support for prescription drugs — particularly specialty drugs[2] — to underinsured populations. Patients eligible for these programs typically have insurance coverage but have trouble affording specialty medications due to deductibles and OOP maximums. Eligible applicants are awarded annual grants that must be used to pay for drugs specific to their condition or disease. The grants may be distributed through either a card that must be processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient).

To help control the cost of prescription drugs, existing California law prohibits pharmaceutical manufacturers 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.

To further counter the potential for financial assistance programs to drive up drug prices, many health plans/insurers and PBMs impose copayment adjustment programs in their pharmacy benefit designs. Copayment adjustment programs offset the impacts of certain pharmaceutical financial assistance; they operate by prohibiting the contributions made by a third party from counting towards the enrollee's OOP maximum. Copayment adjustment programs are intended to encourage the use of lower-cost prescription drugs, drive down drug prices, and reintroduce price sensitivity to enrollees who use financial assistance for OOP costs.

AB 2180 would prohibit the implementation of copayment adjustment programs on drug copay assistance programs; if enacted, any amounts paid for an enrollee's prescription drug using a drug copay assistance program would be required to be credited towards an enrollee's cost-sharing requirements and OOP maximums.

Relevant Populations

If enacted, AB 2180 would apply to the health insurance of approximately 22.3 million enrollees (58.6% of all Californians). This represents those who have commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC

[1] Refer to CHBRP's full report for full citations and references.
[2] Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs often cost $1,000 or more per month, and spending on them is growing 15 to 20 percent a year. Many prescription drug plans that cover specialty drugs have a separate "tier" that specifies how much an individual has to pay for specialty drugs.

and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

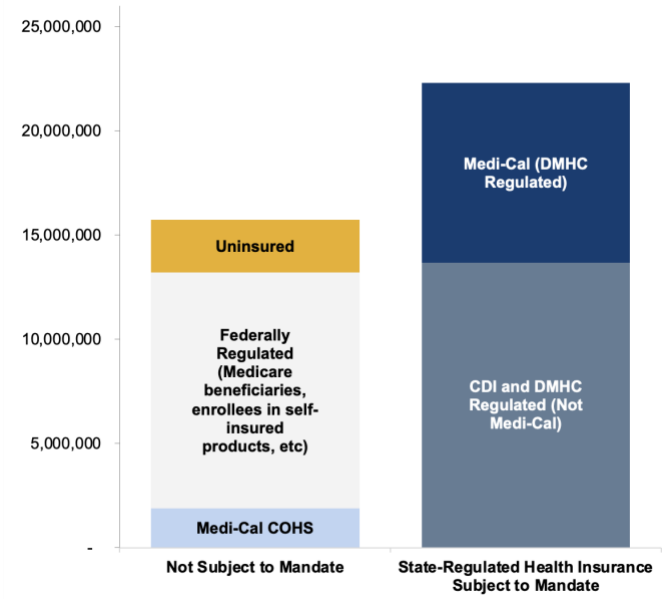
Assumptions

PBMs typically only work with specialty pharmacies — which they either own or have exclusive contracts with — on implementation of copayment adjustment programs. Accordingly, CHBRP has assumed that AB 2180 would only impact specialty drugs, which are typically high-cost brand-name drugs.

Specialty drugs come in various forms and may be billed under either the pharmacy benefit, medical benefit, or both. The timing of claims processing for specialty drugs varies significantly between those on the pharmacy versus medical benefit. Specialty drugs billed on the pharmacy benefit are processed in real time. In contrast, the billing system for medical benefit drugs is more complex, making it difficult to track claims and, therefore, track payments. In addition, claims for medical benefit drugs can take several weeks to process with third-party insurance. Because of this, it is difficult for PBMs to include medical benefit drugs in copayment adjustment programs. Thus, CHBRP assumes that specialty drugs administered in a medical setting are already compliant and AB 2180 would only impact specialty drugs on the pharmacy benefit.

Almost all (96.2%) commercial/CalPERS enrollees have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications. CHBRP has assumed that AB 2180 would not require creation of a pharmacy benefit and so baseline benefit coverage for enrollees would be compliant so long as they (1) are without a pharmacy benefit, or (2) their pharmacy benefit is not regulated by DMHC or CDI. The latter group includes all Medi-Cal beneficiaries enrolled in DMHC-regulated plans, as their pharmacy benefit is through the Medi-Cal program (not the DMHC-regulated plan). So, although all enrollees in plans and policies regulated by DMHC or CDI have health insurance that would be subject to AB 2180 (see Figure A), impacts would only be expected for those who currently have a pharmacy benefit regulated by DMHC or CDI.

Figure A. 2025 Health Insurance in CA and AB 2180



Source: California Health Benefits Review Program, 2024.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

At baseline, 13,162,000 enrollees have an outpatient pharmacy benefit regulated by DMHC or CDI and therefore have health insurance that would be impacted by AB 2180.

Postmandate, CHBRP estimates AB 2180 would result in approximately 5.6 million enrollees gaining coverage for drug copay assistance counting toward their deductibles and OOP maximum.

CHBRP also estimated impacts of AB 2180 in year 2 (2026). See Appendix B.

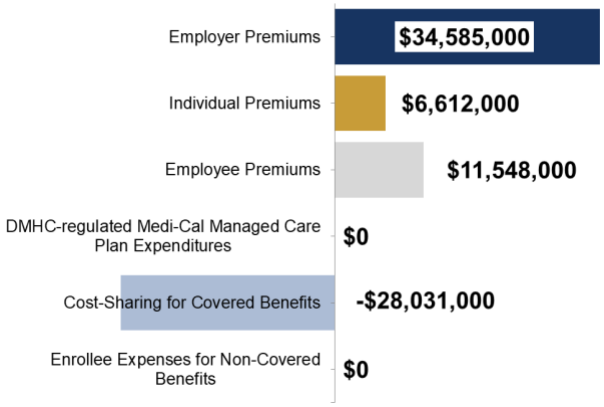
Utilization and Expenditures

CHBRP estimates the number of specialty prescriptions filled that have drug copay assistance (117,000) would not change due to AB 2180 in the first year. This represents approximately 11,000 enrollees who will be impacted by AB 2180. Similarly, the average unit cost (for a 30-day fill) for specialty medications of $7,964 would not change from baseline to postmandate.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers.

Overall, AB 2180 would increase total net annual expenditures by $24,714,000, or 0.02%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $52,745,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $28,031,000 decrease in enrollee expenses for covered and/or noncovered benefits.

Figure B. Expenditure Impacts of AB 2180.



Source: California Health Benefits Review Program, 2024
Key: DMHC = Department of Managed Health Care.

Premiums

Changes in premiums as a result of AB 2180 would vary by market segment. Among DMHC-regulated plans, large-group premiums would increase by 0.03%, individual market premiums would increase by 0.03%, and CalPERS would increase by 0.01%. However, DMHC-regulated small-group premiums would increase by 0.12%. In the CDI-regulated market, the large-group market would face the smallest increase (0.12%), while individual (0.16%) and small group (0.17%) would have the highest increase across all markets.

Enrollee Expenses

CHBRP estimates AB 2180 would result in enrollees in non-CalPERS commercial plans in all markets to pay less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a $0.10 reduction in enrollee expenses on the low end, with small-group DMHC-regulated enrollees experiencing a $0.48 decrease in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group ($0.92 decrease) and individual market ($0.68 decrease) policies would see the largest reduction in OOP expenses, while enrollees in large-group policies would experience $0.48 in reduced enrollee expenses on average. Overall, enrollee expenses would decrease by $28,031,000 across all markets.

Due to the decreases in cost sharing, measurable public health impacts at the population level may occur if it results in increased adherence to a prescription drug.

CalPERS

Postmandate, for enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% ($0.0066 per member per month, $429,000 total increase in expenditures).

Covered California – Individually purchased

Postmandate, premiums for enrollees in individual plans purchased through Covered California would increase by less than 0.01% (approximately $180,000 increase in total expenditures).

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2180.

Long-Term Impacts

Utilization Impacts

In the longer term, CHBRP anticipates that AB 2180, if enacted, would incentivize manufacturers to increase funding to drug copay assistance through nonprofit organizations. Manufacturers would stand to benefit from increased drug copay assistance because by removing barriers to patient access to high-cost medications, manufacturers may increase the overall demand for specialty medications. Health plans and insurers may respond by removing specific high-cost specialty drugs that have therapeutic equivalent drugs from their

formulary; off-formulary drugs are not considered covered benefits, and therefore AB 2180 would not apply to these drugs.

Cost Impacts

One key aspect of AB 2180 is the degree to which patients may be willing to switch to alternative therapies when presented with an opportunity to reduce OOP expenditures. Drug copay assistance may influence patient behavior, as patients with drug copay assistance may be less likely to search for lower-cost, alternative treatment options. Furthermore, these programs may even minimize or eliminate cost sharing for all other medical services throughout the year if the OOP maximum is reached. The presence of these programs may have the long-term potential to encourage patients to continue a specific therapy even as less costly, equivalent therapies become available. Therefore, these programs may have the potential to increase overall costs for drugs over time.

Another key consideration of AB 2180 is the degree to which the mandate impacts patients with chronic disease versus terminal diseases. Due to the ongoing nature of treatments for chronic disease, the potential for higher utilization is greater for medications for chronic conditions than those for terminal diseases.

CHBRP also notes that AB 2180 may address inequalities because of the current consequences of cost sharing on low-income patients. At baseline, some patients may face financial hardships in order to receive needed treatments or even postpone treatment if nonprofit organizations have insufficient drug copay assistance to meet patient demand. Assuming AB 2180 leads to an influx of additional financial contributions from pharmaceutical manufacturers and other organizations to copay assistance programs, the mandate may benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower income populations with commercial insurance.

In addition, postmandate, some patients may no longer be compelled to pay up front for their prescriptions, as AB 2180 eliminates the requirement to cover the deductible and OOP maximum for these patients, through drug copay assistance and a card processed by the PBM at the point of sale. This would benefit those who would otherwise suffer financial hardship, and may reduce health care disparities amongst lower-income populations with commercial insurance. In Year 2 (2026), CHBRP assumes that this factor would lead to increased utilization (see Appendix B of the main report for more details, including estimates of Year 2 expenditures). It stands to reason that in the long run, AB 2180 may improve the health status of patients who would not have otherwise received treatment.

Table of Contents

Lists of Tables and Figures

Background on Prescription Drug Costs and Cost Control Methods

Prescription Drug Costs in California

In 2022, DMHC-regulated health plans in California, including DMHC-regulated Medi-Cal managed care plans, paid approximately $12.1 billion for prescription drugs, accounting for 14.2% of total DMHC-regulated health plan premiums. During the same year, prescription drug costs increased by 12.3%, as medical expenses increased by 7.9%. Specialty drugs (which typically include high-cost brand-name drugs delivered by specialty pharmacies) accounted for only 1.6% of all prescription drugs dispensed yet represented 64% of total annual spending on prescription drugs (DMHC, 2023).

Types of Financial Assistance for Prescription Drugs

Nonprofit organizations, drug manufacturers and other for-profit entities, and state governments have established several strategies to reduce some of the high out-of-pocket (OOP) costs patients face when purchasing prescriptions. AB 2180 addresses financial assistance from nonprofit organizations, which are operated as pharmaceutical manufacturer foundations or independent charities. These are defined as follows:

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

These nonprofit organizations operate two types of financial assistance programs — drug copay assistance programs and patient assistance programs — and are described in the following bullets. AB 2180 is concerned only with drug copay assistance programs. Other programs are included to provide context and clarification on other financial assistance excluded from CHBRP's analysis.

- **Drug copay assistance programs:** programs administered by nonprofit organizations to provide financial support for prescription drugs — particularly specialty drugs[4] — to underinsured[5] populations. Patients eligible for these programs typically have insurance coverage but have trouble affording specialty medications due to deductibles and OOP maximums. For the purposes of AB 2180, CHBRP's analysis is concerned only with financial assistance provided through these programs. Eligibility for drug copay assistance programs is often based on poverty guidelines, which take family size into account, to help assess financial need. Eligible applicants are awarded annual grants that must be used to pay for drugs specific to their condition or disease. The grants may be distributed through either a card that must be processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient).

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

- **Patient assistance programs:** similar to drug copay assistance programs, however their financial assistance is targeted towards the uninsured population. Patient assistance programs are not applicable to AB 2180, as the bill addresses only state-regulated insurance.
- **State pharmaceutical assistance programs:** some states administer programs to provide financial assistance to certain populations. Depending on the program, they may be subsidized with state or federal funds, or both. California has one state patient assistance program, the AIDS Drug Assistance Program (ADAP), to assist uninsured and underinsured persons living with HIV and AIDS access medications (CDPH, 2024). Individuals enrolled in ADAP may be eligible for other programs administered by California's Office of AIDS that assist with premium and medical OOP benefits. The latter covers OOP costs that count towards the health insurance policy's annual OOP maximum (CDPH, 2024); therefore, ADAP would not be impacted by AB 2180, if enacted, due to compliance at baseline.
    - **State discount programs:** a subcategory of state pharmaceutical assistance programs, sometimes referred to as "prescription buying clubs" or "discount cards" (NCSL, 2022). The primary difference between these programs and state pharmaceutical assistance programs is that they do not rely on state or federal funds to pay for the prescription drugs. Instead, states use their purchasing power to buy medications in bulk. The patient then pays the discounted price at the pharmacy (NCSL, 2022). California currently administers one such program, called the Prescription Drug Discount Program for Medicare Recipients.
- **Drug manufacturer coupons:** prescription discounts offered to patients by a drug manufacturer to reduce enrollee cost at point of sale and entice use of certain products. Enrollees pay a reduced amount for their prescription and the drug manufacturer pays the difference between the original retail price and the discount; thus, the pharmacies receive payment for the original retail price of the drug. AB 2180 does not apply to drug manufacturer coupons.
- **Cash card programs:** prescription discounts administered typically by online prescription discount programs. Enrollees pay a discounted amount for their prescription because of the card, then pharmacies pay a transaction fee to the prescription discount card program for processing the claim; thus, pharmacies do not receive the original retail price for these drugs. Cash cards are not used in conjunction with health insurance and would not be impacted by AB 2180.

Copayment Adjustment Programs

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

- **Copay accumulator programs:** prohibit any amounts collected at the point of sale when using financial assistance from a third party for a prescription drug from counting towards their deductible or annual OOP maximum.
- **Copay maximizer programs:** amounts collected at the point of sale when using financial assistance from a third party for a prescription drug do not count towards their deductible or annual OOP maximum; however, the cost share is adjusted to an amount that maximizes the value of the financial assistance from a third party and applied throughout the benefit year.

See CHBRP's analysis of AB 874 (2023) for additional background information on copayment adjustment programs (CHBRP, 2023).

If enacted, AB 2180 would prohibit health plans and policies from imposing copayment adjustment programs on payments through copay assistance programs.

Programs Subject to AB 2180

Table 1 shows how AB 2180 relates to patient financial assistance programs and copayment adjustment programs.

Table 1. Relation of AB 2180 to Patient Financial Assistance Programs and Copayment Adjustment Programs

	Pharmacy Benefit Design (Relative to Copayment Adjustment Programs)		
	Accumulators	**Accumulators + Maximizers**	**No Accumulator**
Third-party contributions toward cost sharing			
Patient assistance programs (uninsured)	Does not exist	Does not exist	Out of scope
Drug copay assistance programs (manufacturers or independent charities)	Impacted by AB 2180	Impacted by AB 2180	No impact due to current compliance
Drug manufacturer coupons and discounts	N/A. Excluded from AB 2180	N/A. Excluded from AB 2180	N/A. Excluded from AB 2180
None	No impact	No impact	No impact

Source: California Health Benefits Program, 2024.

Policy Context

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[6] conduct an evidence-based assessment of the financial impacts of Assembly Bill (AB) 2180, Cost Sharing, as introduced on February 7, 2024.

Bill-Specific Analysis of AB 2180, Cost Sharing

Bill Language

AB 2180 would, to the extent permitted by state and federal law, require health plans regulated by DMHC and policies regulated by CDI to apply any amounts paid by either an enrollee or a third-party manufacturer or other charitable program that provides financial assistance, to the enrollee's cost-sharing requirement.

The bill limits the requirement to only those enrollees who have a chronic disease or terminal illness.

California Regulating Agencies

DMHC: California Department of Managed Health Care

CDI: California Department of Insurance

DHCS: Department of Health Care Services, which administers Medi-Cal

AB 2180 includes the following definitions:

- **Cost-sharing requirement:** any copayment, coinsurance, deductible, or annual limitation on cost-sharing, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan or policy.
  - AB 2180 further specifies that when calculating an enrollee's overall contribution to the annual out-of-pocket maximum, a health plan/insurer must "include expenditures for any item or service covered by the health plan or policy, and include within a category of essential health benefits [as described in the Affordable Care Act], which expenditures shall be considered expenditures for essential health coverage benefits covered" under the health plan or policy.
- **Third-party patient assistance program:** manufacturer or other charitable programs that provide financial assistance intended to augment existing prescription drug coverage. AB 2180 excludes discounts, drug vouchers, or general manufacturer coupons from the definition.
- **Chronic disease:** conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.
- **Terminal illness:** a medical condition that is life-limiting and expected to result in death.

The full text of AB 2180 can be found in Appendix A. Descriptions of cost sharing can be found in Appendix C.

Relevant Populations

If enacted, AB 2180 would apply to the health insurance of approximately 22.3 million enrollees (58.6% of all Californians). This represents those who have commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

The pharmacy benefit for Medi-Cal beneficiaries is carved out and administered through the Medi-Cal Rx program; therefore, CHBRP estimates Medi-Cal beneficiaries would not be impacted by the bill.

[6] CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

Analytic Approach and Key Assumptions

CHBRP previously analyzed similar bill language, AB 874 in 2023. Where applicable, this analysis builds off that previous analysis. The provisions of AB 874 (2023) were broader than those of AB 2180. They would have required DMHC-regulated plans and CDI-regulated policies, other health insurers, and pharmacy benefit managers (PBMs) that administer pharmacy benefits to take any amounts paid for an enrollee's out-of-pocket (OOP) expenses using a discount, repayment, product voucher, or other reduction and count them towards their health plan or policy's cost-sharing requirement (CHBRP, 2023). The provisions of AB 874 did not identify any specific patient population. CHBRP's full analysis of AB 874 (2023) can be accessed at www.chbrp.org.

Relevant Programs

AB 2180 is concerned only with charitable organizations that provide financial assistance to underinsured patients for prescription drugs. Therefore, CHBRP assumes that only financial assistance from nonprofit organizations, including pharmaceutical manufacturer foundations and independent charities, would be subject to AB 2180, if enacted. Accordingly, CHBRP assumes drug manufacturer coupons and cash card programs, which provide financial assistance from for-profit organizations, are not relevant to the bill. In addition, financial assistance from governmental programs, including AIDS Drug Assistance Program (ADAP), are excluded from CHBRP's analysis of AB 2180, as this program already includes methods to assist patient prescription costs in a manner that is applied to their OOP maximum.

As discussed in the *Background* section, financial assistance from nonprofit organizations typically comes in the form of drug copay assistance, via an annual grant distributed to the patient. CHBRP therefore considers drug copay assistance from nonprofit organizations as the financial assistance relevant to its analysis of AB 2180.

Pharmaceutical manufacturer foundations and independent charities provide financial assistance to both underinsured and uninsured. CHBRP does not include any financial assistance provided to the uninsured in this analysis.

Terminology

CHBRP uses the following terminology throughout this analysis:

- **Copayment adjustment program:** a pharmacy benefit design that prohibits certain contributions — such as drug copay assistance — made by the enrollee or a third party from counting towards the enrollee's OOP maximum.
- **Copay accumulator:** a type of copayment adjustment program that prohibits any amounts collected at the point of sale when using financial assistance from third parties for a prescription drug from counting towards their deductible or annual OOP maximum.
- **Copay maximizer:** a type of copayment adjustment program under which amounts collected at the point of sale when using financial assistance from third parties for a prescription drug do not count towards their deductible or annual OOP maximum; however, the cost share is adjusted to maximize the value of the financial assistance and applied throughout the benefit year. Copay maximizers only operate in conjunction with a copay accumulator.
- **Drug copay assistance:** financial assistance provided to patients by nonprofit organizations (i.e., pharmaceutical manufacturer foundations and independent charities) to aid in the cost of prescription drugs. Drug copay assistance is distributed to patients via annual grants for certain drugs based on eligibility criteria — including diagnosis of an explicit disease and condition — specified by the nonprofit.
- **Pharmacy benefit managers (PBMs):** entities that manage prescription drug benefits for health plans and insurers.

Drug Type and Benefit

Pharmacy benefit managers (PBMs) typically only work with specialty pharmacies — which they either own or have exclusive contracts with — on implementation of copayment adjustment programs; accordingly, CHBRP has assumed that AB 2180 would only impact specialty drugs, which are typically high-cost brand-name drugs.

Specialty drugs come in various forms and may be billed under either the pharmacy benefit, medical benefit, or both. Drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or specialty pharmacy. The timing of claims processing for specialty drugs varies significantly between those on the pharmacy versus medical benefit. Specialty drugs billed on the pharmacy benefit are processed in real time. In contrast, the billing system for medical benefit drugs is more complex, making it difficult to track claims and, therefore, track billing. In addition, claims for medical benefit drugs can take several weeks to process with third-party insurance. Because of this, it is difficult for PBMs to include medical benefit drugs in copayment adjustment programs. Thus, CHBRP assumes that specialty drugs administered in a medical setting are already compliant and AB 2180 would only impact specialty drugs on the pharmacy benefit.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

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.[7] This prohibition also applies to any prescription drugs for which the active ingredients are in Food and Drug Administration–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.[8] 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.[9]

California also requires pharmacists to inform customers about purchase options (i.e., 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.[10]

The state also has laws intended to increase prescription drug cost transparency. For example, existing law requires health plans and insurers that were already required under state law to report rate information to DMHC and CDI to also report prescription drug–specific information to the departments, including the most frequently prescribed drugs, the costliest drugs by total annual spending, and the drugs with the highest year-over-year increase in total annual plan spending.[11]

[7] Health and Safety Code (HSC) §132000.
[8] HSC §132002.
[9] HSC §132004.
[10] Business and Professions Code (BPC) §4079.
[11] HSC §1367.243.

Similar requirements in other states

Massachusetts has also banned the use of discounts or other reductions for prescription drugs when a generic equivalent is available.[12]

Twenty states, including Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia, and the District of Columbia and Puerto Rico have enacted legislation banning copayment adjustment programs (NCSL, 2024).

Federal Policy Landscape

Federal guidance on patient financial assistance programs

The Office of Inspector General (OIG) is a federal agency with a mission to provide objective oversight to promote efficiency, effectiveness, economy, and integrity of U.S. Health and Human Services (HHS) programs, and reduce waste, fraud, and abuse. The OIG has published guidance on the operation of nonprofit organizations offering financial assistance for prescription drugs in an effort to allow for the provision of medically necessary drugs to financially needy patients, and ensure the assistance is provided in a manner that does not conflict with the federal anti-kickback statute or other laws.[13,14] As part of this effort, pharmaceutical manufacturers are prohibited from influencing enrollees' drug choices through independent charity organizations; to help prevent this from happening, pharmaceutical manufacturers may not control which drugs an independent charities may offer to patients.

The OIG is also concerned about the influence of nonprofit organizations providing financial assistance for prescription drugs on overall drug prices. OIG guidance states that although the agency recognizes that a patient prescribed an expensive drug may have a greater need for financial assistance than a patient prescribed a less expensive alternative, the agency is concerned that limiting cost-sharing support from these organizations to expensive products may steer patients in a manner that is costly to federal health care programs and may even facilitate increases in drug prices. OIG guidance also specifies that the cost of the particular drug for which the patient is applying for assistance is not an appropriate stand-alone factor in determining individual financial need.[15]

Federal regulations on copayment adjustment programs

Commercial Insurance

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 exchanges and in nongrandfathered individual and group health plans sold off exchanges.[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 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

[12] Massachusetts General Laws Chapter 175H § 3(b)(2).
[13] Office of Inspector General (OIG). (2014) Supplemental Special Advisory Bulletin: Independent Charity Patient Assistance Programs. Federal Register. 79(104):31120-31123.
[14] The federal anti-kickback statute (42 U.S.C. § 1320a-7b) prohibits the knowing and willful exchange of anything of value in an effort to induce or reward the referral of business reimbursable by federal health care programs.
[15] Office of Inspector General (OIG). (2014) Supplemental Special Advisory Bulletin: Independent Charity Patient Assistance Programs. Federal Register. 79(104):31120-31123.
[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.
[17] **HIV & Hepatitis Policy Institute et al., Plaintiffs, v. United States Department of Health and Human Services et al., Defendants.** September 29, 2023.

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]

Medicare

The Centers for Medicare & Medicaid Services (CMS) allow for pharmaceutical patient assistance programs to provide assistance to Medicare Part D (prescription drug) enrollees; however, they must operate "outside the Part D benefit." In other words, the payments made by a pharmaceutical patient assistance program do not count towards a Part D beneficiary's true OOP cost. CMS uses the true OOP calculation to determine whether a beneficiary has reached the threshold for catastrophic coverage under the Part D benefit, after which Medicare covers all Part D drugs for the remainder of the calendar year.[19]

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 2180 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[20,21]

Essential Health Benefits

In California, nongrandfathered[22] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[23] In 2025, approximately 11.5% of all Californians will be enrolled in a plan or policy that must cover EHBs. [24]

States may require state-regulated health insurance to offer benefits that exceed EHBs.[25,26,27] Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.[28,29]

AB 2180 does not appear to exceed the definition of essential health benefits, as all health plans and insurers in California are already required to cover outpatient prescription drugs, and the reforms to counting OOP spending do not represent a new benefit.

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[18] CMS Press Release, April 18, 2019. **CMS Issues Final Rule for the 2020 Annual Notice of Benefit and Payment Parameters**.
[19] CMS webpage, last modified September 6, 2023. **Pharmaceutical Manufacturer Patient Assistance Program Information**.
[20] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: **www.chbrp.org/other-publications/issue-briefs**.
[21] 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.
[22] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Available at: **www.healthcare.gov/glossary/grandfathered-health-plan**.
[23] For more detail, see CHBRP's issue brief *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*, available at **www.chbrp.org/other-publications/issue-briefs**.
[24] See CHBRP's resource, *Sources of Health Insurance in California,* available at **hwww.chbrp.org/other-publications/resources**.
[25] ACA Section 1311(d)(3).
[26] State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: **www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf**.
[27] However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.
[28] Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: **www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf**.
[29] Both Massachusetts and Utah currently pay defrayment costs for exceeding EHBs. For more information about defrayal, refer to CHBRP's issue brief *Essential Health Benefits: Exceeding EHBs and they Defrayal Requirement*, available at: **www.chbrp.org/other-publications/issue-briefs**

Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, AB 2180 would require health plans and health policies regulated by DMHC or CDI to count drug copay assistance towards enrollees' cost-sharing requirements.

In addition to commercial enrollees, 74% of enrollees associated with CalPERS and 80% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[30] As noted in the *Policy Context* section, AB 2180 would not impact Medi-Cal beneficiaries' benefit coverage.

This section reports the potential incremental impacts of AB 2180 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

General Assumptions

- As discussed in the *Policy Context* section, there are a range of programs that reduce the costs of drugs from the perspective of patients. AB 2180 would impact drug copay assistance provided through nonprofit organizations, including pharmaceutical manufacturer foundations and independent charities.
- Drug copay assistance provided through nonprofit organizations can take different forms. These programs may provide financial assistance through either a card that must be processed by a pharmacy benefit manager (PBM) or through reimbursement after submission of a request by a grantee (a patient) (ACCC, 2022; PAN, 2024). At baseline, CHBRP has assumed that the mechanism of financial assistance will influence the extent to which it counts towards enrollee's cost sharing.
    - When a card is used and processed by the PBM to provide drug copay assistance, the PBM may have a copayment adjustment program in place. These programs are typically used for specialty drugs that can only be filled by specialty pharmacies with a relationship with the PBM. These specialty pharmacies may be owned by the PBM or have an exclusive contractual relationship with the PBM.
    - Reimbursement to enrollees after the point of sale is not tracked by health plans or insurers and therefore is not part of any copayment adjustment program. For example, if a patient goes to a pharmacy to fill a prescription and their copayment amount is $1,500 for any prescription drug through their health plan or insurer, the pharmacy will enter that amount in the patient's out-of-pocket (OOP) share and the patient will pay that amount directly to the pharmacy. That amount will later be reimbursed by the drug copay assistance program. This will result in patients getting "credit" for $1,500 of spending toward their deductible or OOP maximum regardless of AB 2180.
- AB 2180 would impact all copayment adjustment programs, including copay accumulator programs and copay maximizer programs. CHBRP also assumes that copay maximizer programs are always implemented in conjunction with copay accumulator programs. AB 2180 would only impact how copayment adjustment programs count drug copay assistance towards enrollees' deductibles and OOP maximum. See *Background* and *Policy Context* sections for more information.
- CHBRP assumed that some patient assistance programs (i.e., state- or charity-funded payments for drugs) would not be subject to AB 2180. Payments through these programs typically help offset the cost of noncovered services and take place outside of an enrollee's insurance coverage.

[30] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

- Prescription drug impacts would only be expected to apply to the portion of the population with outpatient prescription drug coverage who are currently covered by a policy that is not compliant with AB 2180 and that are using a combined copay maximizer and accumulator program (NCSL, 2024) or copay accumulator program (Galloway, 2022).
- Almost all (96.2%) commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications.[31] Of the remaining commercial/CalPERS enrollees, 1.2% do not have a pharmacy benefit and 2.6% have a pharmacy benefit that is not regulated by DMHC or CDI. For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and administered by DHCS under the Medi-Cal Rx program; therefore, it is not subject to DMHC regulation. Because AB 2180 would not require the creation of a pharmacy benefit — only compliant benefit coverage when a pharmacy benefit is present — baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is compliant.

Baseline Assumptions on Utilization and Cost

- The total cost-sharing requirements for specialty drugs with drug copay assistance were assumed to be the same as the average cost sharing for all services covered by the plan or policy. For enrollees in non–high deductible health plans (HDHPs) or enrollees in HDHPs after the deductible has been satisfied, cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost per service. For enrollees in HDHPs within the deductible phase of coverage, cost sharing is equal to 100% of drug expenses. For more information on HDHPs, see the *Policy Context* section.
- At baseline, it is assumed that copay assistance programs 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.
- At baseline, copay maximizer programs are assumed to have a potential benefit to plans that exceeds the value of enrollee cost sharing (i.e., plans may use these programs to realize the full value of drug copay assistance, beyond the plan benefit cost-sharing requirements). This additional value to the plan is treated like a drug manufacturer rebate for these medications and has a benefit to the plan premiums that is not evident to the enrollee filling medications. For example, suppose that an enrollee fills a specialty prescription drug on a monthly basis that costs $8,000 per fill with a cost-sharing requirement of a $250 copay. Suppose that this member is receiving drug copay assistance through a charity that is provided in the form of funding on a payment card (i.e., that may be tracked by a PBM) and that the drug copay assistance program provides annual assistance of up to $5,000. At baseline, CHBRP assumes that the PBM will process this transaction such that, for each fill, $250 of funding will be used to satisfy the member's copay and the remaining $167 ($5,000/12 - $250) of available drug copay assistance (less a cut taken by the PBM to administer the maximizer program) will benefit the plan alone. None of these dollar amounts will accumulate towards the enrollee's OOP maximum if they are provided through a funding source that can be tracked by the plan's PBM. It is not currently clear how this bill would be interpreted related to these payment amounts. For the purposes of AB 2180, CHBRP assumed all drug copay assistance amounts would be tracked toward the enrollee deductible and OOP maximum (including those that exceed plan benefit–required cost sharing).

Postmandate Assumptions on Utilization and Cost

- CHBRP assumed that if AB 2180 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 $0.28 in additional spending due to utilization of other services.
    - The rate of increase was determined by market segment using induced utilization[32] (IU) adjustment factors. For enrollees filling specialty drugs in plans where monthly cost-sharing requirements for the

[31] For more on outpatient prescription drug coverage among Californians with state-regulated health insurance, see CHBRP's resource, *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.
[32] Induced utilization can be described as the additional demand for prescriptions created by an increased level of coverage in the plan/policy (AAA, 2008).

specialty drugs alone are high enough to satisfy the OOP maximum in the year, the postmandate IU factor was a blend of the baseline IU factor and the IU factor reflecting a plan with zero cost-sharing requirements. IU factors were blended based on the month in the year when enrollee OOP maximums would be satisfied using copay assistance–eligible specialty drug fills alone.

  - For postmandate estimates, utilization was not adjusted for plans where specialty drug cost-sharing requirements were not high enough to meet the OOP maximum. The baseline utilization was multiplied by a ratio of the postmandate IU factor divided by the baseline IU factor. For the full methodology, see Appendix B.

  - CHBRP assumes that some drug copay assistance is currently being used to help patients with cost-sharing requirements for drugs administered in a medical setting. CHBRP assumes that this financial assistance is provided through reimbursements and therefore currently counts towards enrollees' cost-sharing requirements. For reference, Appendix B provides a comparison of utilization, costs, and average cost sharing for drugs administered in a medical setting. See the *Policy Context* section for additional information about claims for drugs under the medical benefit.

- CHBRP assumed that the total available funding for drug copay assistance available would increase if AB 2180 were to be enacted. CHBRP considered that the following factors would influence drug copay assistance programs:

  - Pharmaceutical manufacturers would be encouraged to make charitable contributions to foundations that provide drug copay assistance. Pharmaceutical manufacturers would potentially benefit from these programs because they increase the market demand for drugs by addressing cost sharing.

  - Because drug copay assistance is provided by charitable organizations and the grants provided are typically tied to a disease state, these funds may be used for drugs from multiple pharmaceutical manufacturers. These funds may also be used in a medical setting. Therefore, while any single manufacturer may benefit from a charitable contribution, there is an indirect relationship between the total funding available for these programs and the benefit accrued to a specific manufacturer.

- For enrollees in plans with only copay accumulator programs in the plan design, CHBRP assumed that drug copay assistance would apply only until enrollee OOP maximum cost-sharing requirements were satisfied through the combination of drug copay assistance and enrollee contributions, described above.

- Postmandate, it is assumed that copay assistance programs would not assist HDHP enrollees with cost sharing until they have covered the first $1,600 of deductible expenses out of pocket. However, any amounts paid by drug copay assistance programs to non-HDHP enrollees or HDHP enrollees after the first $1,600 paid out of pocket would track toward the enrollee's deductible and OOP maximum.

- For enrollees enrolled in plans with copayment maximizer programs in the plan design, CHBRP assumed that drug copay assistance would first be used to satisfy enrollee cost-sharing requirements. Any drug copay assistance remaining after enrollee cost-sharing requirements had been satisfied would be used to reduce plan expenses, net of an assumed 25% PBM fee charged to administer these programs.

  - CHBRP assumed that drug copay assistance would apply only until enrollee OOP maximum cost-sharing requirements were satisfied by the sum of drug copay assistance payments used to satisfy cost-sharing requirements, enrollee cost-sharing contributions (described below), plus any drug copay assistance payments used to offset plan expenses.

- CHBRP assumed the average per enrollee per month (PMPM) allowed cost of total services would increase proportional 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 and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

Below, Table 2 provides estimates of how many Californians have health insurance that would have to comply with AB 2180 in terms of benefit coverage.

Table 2. Impacts of AB 2180 on Benefit Coverage, 2025

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,297,000	22,297,000	0	0.00%
Total enrollees with health insurance impacted by AB 2180	13,688,000	13,688,000	0	0.00%
Total enrollees with health insurance and outpatient prescription drug benefits impacted by AB 2180	13,162,000	13,162,000	0	0.00%
Number of enrollees with health insurance fully compliant with AB 2180	8,084,000	13,688,000	5,604,000	69.32%

Source: California Health Benefits Review Program, 2024.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[33]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

At baseline, 13,162,000 enrollees have an outpatient pharmacy benefit regulated by DMHC or CDI and therefore have health insurance that would be impacted by AB 2180.

Postmandate, AB 2180 would result in approximately 5.6 million enrollees gaining coverage for drug copay assistance counting toward their deductibles and OOP maximum out of 13.16 million enrollees with outpatient prescription drug benefits in commercial plans. This represents a 69.32% percent increase from baseline. Although AB 2180 does apply to coverage for Medi-Cal beneficiaries in DMHC-regulated plans, it would not have an impact due to the carve out of pharmacy benefits through the Medi-Cal Rx program.

Baseline and Postmandate Utilization and Unit Cost

Table 3 provides estimates of the impacts of AB 2180 on utilization and unit cost of specialty prescriptions and other pharmacy and medical expenses.

[33] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

Table 3. Impacts of AB 2180 on Utilization and Unit Cost, 2025

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Number of impacted prescriptions filled (specialty prescriptions with third-party assistance available in noncompliant plans)	117,000	117,000	-	0.00%
Number of impacted enrollees filling specialty prescriptions	11,000	11,000	-	0.00%
Average unit cost of impacted prescriptions filled	$7,964	$7,964	$0	0.00%
Average third-party assistance used to reduce enrollee cost-sharing requirements (total)	$774	$532	-$242	-31.23%
Average third-party assistance used to reduce enrollee cost-sharing requirement (but not tracked to deductible/OOP max) for impacted prescriptions filled	$774	$0	-$774	-100.00%
Average third-party assistance used to reduce enrollee cost-sharing requirement (and tracked to deductible/OOP max) for impacted prescriptions filled	$0	$532	$532	0.00%
Average enrollee contribution towards cost-sharing requirement for impacted prescriptions filled	$307	$110	-$198	-64.32%
Average third-party assistance used to offset plan costs beyond enrollee cost sharing for impacted prescriptions filled	$12	$0	-$12	-100.00%
Average net plan expense for impacted prescriptions filled	$6,870	$7,322	$451	6.57%
Additional expenditures paid by plan/policy from increased utilization due to lower cost sharing (a)	-	$7,763,000	$7,763,000	

Source: California Health Benefits Review Program, 2024.
Notes: (a) Includes costs for nonspecialty drugs and other medical or pharmacy expenses once the enrollee meets their OOP maximum.
Key: OOP max = annual out-of-pocket maximum.

CHBRP estimates the number of specialty prescriptions filled that have drug copay assistance (117,000) would not change due to AB 2180 in the first year. Similarly, the average unit cost of $7,964 would not change from baseline to postmandate. However, CHBRP estimates the amount of drug copay assistance would decrease from $774 at baseline to $532 postmandate due to the increased likelihood that individual enrollees would hit their OOP maximum earlier and would not use drug copay assistance. Postmandate, nonprofit organizations would contribute, on average, $532 to cost sharing that would be used to calculate total enrollee deductible spending and OOP maximum (Table 3). Overall, CHBRP anticipates net expenses for specialty drugs would increase for health plans and policies.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers.

The amount of spending related to that additional utilization is discussed below.

Baseline and Postmandate Expenditures

Below, Table 4 provides estimates of the impacts of AB 2180 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

Table 4. Impacts of AB 2180 on Expenditures, 2025

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$64,203,365,000	$64,237,521,000	$34,156,000	0.05%
CalPERS employer (b)	$6,974,311,000	$6,974,740,000	$429,000	0.01%
Medi-Cal (excludes COHS) (c)	$30,043,243,000	$30,043,243,000	$0	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$20,751,015,000	$20,757,627,000	$6,612,000	0.03%
Outside Covered California	$5,089,510,000	$5,095,942,000	$6,432,000	0.13%
Through Covered California	$15,661,505,000	$15,661,685,000	$180,000	0.00%
Enrollees, group insurance (d)	$20,397,418,000	$20,408,966,000	$11,548,000	0.06%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copays, etc.)	$15,689,351,000	$15,661,320,000	-$28,031,000	-0.18%
Expenses for noncovered benefits (e) (f)	$464,000	$464,000	$0	0.00%
Total expenditures	$158,059,167,000	$158,083,881,000	$24,714,000	0.02%

Source: California Health Benefits Review Program, 2024.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. 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.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[34] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

For DMHC-regulated plans and CDI-regulated policies, AB 2180 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee OOP expenses for covered benefits would decrease. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

Premiums

At the end of this section, Table 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of AB 2180 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 2, Table 5, and Table 6) with health insurance that would be subject to AB 2180.

Premium increases due to AB 2180 would be relatively lower in the DMHC-regulated commercial market than the CDI-regulated commercial market. Among DMHC-regulated plans, large-group premiums would increase by 0.03%, individual market premiums would increase by 0.03%, and CalPERS would increase by 0.01%. However, DMHC-regulated small-group premiums would increase by 0.12%. In the CDI-regulated market the large-group market would face the smallest increase (0.12%), while individual (0.16%) and small group (0.17%) would have the highest increase across all markets.

Enrollee Expenses

AB 2180–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and OOP expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 2, Table 5, and Table 6) with health insurance that would be subject to AB 2180 expected to use the relevant outpatient prescription drugs during the year after enactment.

AB 2180 would cause enrollees in CalPERS/commercial plans in all markets to pay less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a $0.10 reduction in enrollee expenses on the low end, with small-group DMHC-regulated enrollees experiencing a $0.48 decrease in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group ($0.92 decrease) and individual market ($0.68 decrease) plans would experience the greatest reduction, while large-group enrollees would experience $0.48 in reduced enrollee expenses on average. Enrollees with health insurance associated with CalPERS would have a reduction in enrollee expenses of less than one cent PMPM ($0.0066). Overall, enrollee expenses would decrease by $28,031,000 across all markets (Table 4).

Average enrollee out-of-pocket expenses per user

The impact on enrollee OOP expenses would vary depending on the enrollee's plan design as well as the funding availability from the nonprofit organizations, i.e. pharmaceutical manufacturer foundations and independent charities, that administer copay assistance programs (which may range from $2,000 to $10,000). In general, enrollees in leaner plans receiving large grants would see the largest reductions in OOP expenses.

Due to the decreases in cost sharing, measurable impacts at the population level may occur if it results in increased adherence to a prescription drug.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies would remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums. In this case, the infrastructure for tracking cost sharing already exists in the PBMs and specialty pharmacies.

Other Considerations for Policymakers

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

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 4), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2180.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 2180.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,864,000	2,161,000	2,378,000	894,000	7,791,000	818,000	293,000	62,000	36,000	22,297,000
Total enrollees in plans/policies subject to AB 2180	7,864,000	2,161,000	2,378,000	894,000	0	0	293,000	62,000	36,000	13,688,000
Premiums										
Average portion of premium paid by employer (e)	$527.59	$461.25	$0.00	$650.10	$263.09	$554.83	$585.36	$533.03	$0.00	$101,220,919,000
Average portion of premium paid by enrollee	$138.26	$193.80	$716.04	$133.99	$0.00	$0.00	$215.50	$174.12	$736.61	$41,148,433,000
Total premium	$665.85	$655.05	$716.04	$784.09	$263.09	$554.83	$800.87	$707.15	$736.61	$142,369,352,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$48.82	$146.52	$209.79	$56.41	$0.00	$0.00	$119.25	$246.95	$203.25	$15,689,351,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.01	$0.01	$464,000
Total expenditures	$714.67	$801.57	$925.83	$840.51	$263.09	$554.83	$920.13	$954.10	$939.86	$158,059,167,000

Source: California Health Benefits Review Program, 2024.
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.[35] 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.[36]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

[35] For more detail, see CHBRP's resource *Estimates of Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at https://www.chbrp.org/other-publications/resources.
[36] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,864,000	2,161,000	2,378,000	894,000	7,791,000	818,000	293,000	62,000	36,000	22,297,000
Total enrollees in plans/policies subject to AB 2180	7,864,000	2,161,000	2,378,000	894,000	0	0	293,000	62,000	36,000	13,688,000
Premiums										
Average portion of premium paid by employer (e)	$0.1812	$0.5389	$0.0000	$0.0400	$0.0000	$0.0000	$0.6883	$0.8865	$0.0000	$34,585,000
Average portion of premium paid by enrollee	$0.0475	$0.2264	$0.2137	$0.0082	$0.0000	$0.0000	$0.2534	$0.2896	$1.1915	$18,160,000
Total premium	$0.2287	$0.7653	$0.2137	$0.0482	$0.0000	$0.0000	$0.9418	$1.1760	$1.1915	**$52,746,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$0.0951	-$0.4801	-$0.1359	-$0.0066	$0.0000	$0.0000	-$0.4778	-$0.9203	-$0.6762	-$28,031,000
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	$0.1336	$0.2853	$0.0777	$0.0416	$0.0000	$0.0000	$0.4640	$0.2558	$0.5153	**$24,715,000**
Percent change										
Premiums	0.0344%	0.1168%	0.0298%	0.0061%	0.0000%	0.0000%	0.1176%	0.1663%	0.1618%	0.0370%
Total expenditures	0.0187%	0.0356%	0.0084%	0.0049%	0.0000%	0.0000%	0.0504%	0.0268%	0.0548%	0.0156%

Source: California Health Benefits Review Program, 2024.
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.[37] 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.

[37] For more detail, see CHBRP's resource, *Pharmacy Benefit Coverage in State-Regulated Health Insurance,* available at www.chbrp.org/other-publications/resources.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[38]
(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.

[38] For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

Long-Term Impacts

In this section, CHBRP estimates the long-term impacts of AB 2180, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

In the longer term, CHBRP anticipates that AB 2180, if enacted, would incentivize manufacturers to increase funding to drug copay assistance programs through nonprofit organizations. Manufacturers would stand to benefit from increased drug copay assistance because by removing barriers to patient access to high-cost medications, manufacturers may increase the overall demand for specialty medications. Therefore, the overall utilization of specialty medications may increase postmandate.

There is an existing process that could be applied more broadly to avoid implementation/enforcement of AB 2180. Currently, health plans and insurers remove specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary. They will still provide the drug through a specialty pharmacy based on medical necessity (which requires prior authorization). When a patient obtains the drug through that pharmacy, the accumulator- or maximizer-related discounts can be applied to make their copayment $0, but not be counted toward their deductible or OOP maximum because it is off-formulary and is not considered a covered benefit. If AB 2180 were enacted, the use of this approach could increase to avoid oversight for drugs that can be provided off-formulary (e.g., if they have a substitute in a class of medication). This approach is used frequently in the self-insured market, but there are circumstances where a DMHC-regulated plan or CDI-regulated policy could use the same approach and still comply with state law. CHBRP cannot predict the degree to which health plans and insurers may choose this approach.

Cost Impacts

One key aspect that affects the impact of AB 2180 is the degree to which patients may be willing to switch to alternative therapies when presented with an opportunity to reduce OOP expenditures. Drug copay assistance may influence patient behavior, as patients with drug copay assistance may be less likely to search for lower-cost, alternative treatment options. Furthermore, these programs may even minimize or eliminate cost sharing for all other medical services throughout the year if the OOP maximum is reached. The presence of these programs may have the long-term potential to encourage patients to continue a specific therapy even as less costly, equivalent therapies become available. Therefore, these programs may have the potential to increase overall unit costs for drugs over time.

Another key consideration of AB 2180 is the degree to which the mandate impacts chronic disease versus terminal diseases. Due to the ongoing nature of treatments for chronic disease, the potential for higher utilization is greater for medications for chronic conditions than those for terminal diseases.

CHBRP also notes that AB 2180 may address inequalities because of the current consequences of cost sharing on low-income patients. At baseline, some patients may face financial hardships in order to receive needed treatments or even postpone treatment if nonprofit organizations have insufficient drug copay assistance to meet patient demand. Assuming AB 2180 leads to an influx of additional financial contributions from pharmaceutical manufacturers and other organizations to drug copay assistance programs, the mandate may benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower-income populations with commercial insurance.

In addition, postmandate, some patients may no longer be compelled to pay up front for their prescriptions, as AB 2180 eliminates the requirement to cover the deductible and OOP maximum for these patients, through drug copay assistance and a card processed by the PBM at the point of sale. This would benefit those who would otherwise suffer financial hardship, and may reduce health care disparities amongst lower-income populations with commercial insurance. In Year 2 (2026), CHBRP assumes that this factor would lead to increased utilization (see Appendix B for more details, including estimates of Year 2 expenditures). It stands to reason that in the long run, AB 2180 may improve the health status of patients who would not have otherwise received treatment.

Appendix A. Text of Bill Analyzed

On February 20, 2024 the California Assembly Committee on Health requested that CHBRP analyze AB 2180 as introduced on February 7, 2024

ASSEMBLY BILL **NO. 2180**

Introduced by Assembly Member Weber

February 07, 2024

An act to add Section 1367.0062 to the Health and Safety Code, and to add Section 10192.292 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2180, as introduced, Weber. Health care coverage: cost sharing.

Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved.

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.

This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan contract or health insurance policy. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. Because a willful violation of these requirements by a health care service plan would be a crime, this 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

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

SECTION 1. Section 1367.0062 is added to the Health and Safety Code, to read:

1367.0062. (a) (1) To the extent permitted by federal law, and consistent with Sections 132000 and 132002, a health care service plan or a pharmacy benefit manager that administers pharmacy benefits for a health care service plan shall apply any amounts paid by either the enrollee or third-party patient assistance program to the enrollee's cost-sharing requirement. This requirement shall be limited to only those enrollees who have a chronic disease or terminal illness.

(2) This section shall only apply with respect to health care service plan contracts issued, amended, delivered, or renewed on or after January 1, 2025.

(b) If under federal law, application of subdivision (a) would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of a policy after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this subdivision shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(c) This section does not apply with respect to self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

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

(1) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health care service plan contract. When calculating an enrollee's overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health care service plan shall include expenditures for any item or service covered by the health care service plan, and include within a category of essential health benefits as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health care service plan contract.

(2) "Pharmacy Benefit Manager" means a person or business that administers the prescription drug or device program of one or more health care service plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

(3) "Third-party patient assistance program" shall include, but is not limited to, manufacturer or other charitable programs that provide financial assistance intended to augment existing prescription drug coverage. "Third-party patient assistance program" does not include discounts, drug vouchers, or general manufacturer coupons.

(4) "Chronic disease" is defined as conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.

(5) "Terminal illness" is defined as a medical condition that is life-limiting and expected to result in death.

SEC. 2. Section 10192.292 is added to the Insurance Code, to read:

10192.292. (a) (1) To the extent permitted by federal law, and consistent with Sections 132000 and 132002 of the Health and Safety Code, a health insurer or a pharmacy benefit manager that administers pharmacy benefits for a health insurer shall apply any amounts paid by either the insured, or third-party patient assistance program to the insured's cost-sharing requirement. This requirement shall be limited to only those insureds who have a chronic disease or terminal illness.

(2) This section shall only apply with respect to health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025.

(b) If under federal law, application of subdivision (a) would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of a policy after the insured has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this subdivision shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(c) This section does not apply with respect to self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

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

(1) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, required by, or on behalf of, an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health insurance policy. When calculating an insured's overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health insurer shall include expenditures for any item or service covered by the health insurer, and include within a category of essential health benefits as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the health insurance policy.

(2) "Pharmacy Benefit Manager" means a person or business that administers the prescription drug or device program of one or more health insurance policies on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

(3) "Third-party patient assistance program" shall include, but is not limited to, manufacturer or other charitable programs that provide financial assistance intended to augment existing prescription drug coverage. "Third party patient assistance program" does not include discounts, drug vouchers or general manufacturer coupons.

(4) "Chronic disease" is defined as conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both.

(5) "Terminal illness" is defined as a medical condition that is life-limiting and expected to result in death.

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. Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[39] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available on CHBRP's website.[40]

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

Analysis-Specific Data Sources

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act that include coverage of outpatient prescription drugs.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage that is already compliant with AB 2180. For carriers who did not respond to the survey, results from the 2023 survey of AB 874 were used as this mandate had a similar impact on copay adjustment programs (CHBRP, 2023).

Current coverage of specialty prescription drugs that is compliant with AB 2180 for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 87% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS plans were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies.

For this analysis, CHBRP relied on Current Procedural Terminology (CPT®) codes to identify relevant services: CPT copyright 2022 American Medical Association (AMA). All rights reserved. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the AMA.

Health Cost Guidelines

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

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.

[39] CHBRP's authorizing statute, available at www.chbrp.org/about/faqs, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[40] See method documents posted at www.chbrp.org/about/analysis-methodology/cost-impact-analysis; in particular, see *Cost Analyses: Data Sources, Caveats, and Assumptions*.

- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small-group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures; inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Methodology and Assumptions for Baseline Utilization

Prescription drugs

- CHBRP assumed that drug copay assistance programs are for medications with an average monthly cost of at least $3,000.
- CHBRP determined the number of specialty prescriptions filled per 1,000 commercially insured enrollees based on Milliman's proprietary 2022 Consolidated Health Cost Guidelines™ Sources Database. The definition of specialty used for the analysis of AB 2180 is described in the *Benefit Coverage, Utilization, and Cost Impacts* section.
- Table 7 shows the proportion of specialty drugs that CHBRP assumed would have drug copay assistance available in each time period.

Table 7. Specialty Drugs With Copay Assistance, 2025 and 2026

Time Period	Baseline	Postmandate
Year 1 (2025)	20%	20%
Year 2 (2026)	24%	25%

Source: California Health Benefits Review Program, 2024.

- The rate of prescriptions filled per 1,000 commercially insured enrollees was trended from 2022 to 2025 or 2026 (year 1 and year 2 impacts, respectively; see Table 8) using the annual utilization trends for specialty drugs (Table 9), which are based on the 2022-2024 Commercial HCG trend assumptions.

Table 8. Annual Prescription Utilization Rate Trends, 2022-2026.

Time Period	Prescriptions/1,000 Commercially Insured Enrollees Trend
2022 to 2023	7.0%
2023 to 2024	6.5%
2024 to 2025	6.5%
2025 to 2026	6.5%

Source: California Health Benefits Review Program, 2024; Commercial HCGs, 2022-2024.

Table 9 includes the specialty drug classes on which the annual utilization trends were based for Table 8.

Table 9. Top Therapeutic Classes with Specialty Prescription Drug Fills in California

Therapeutic Class
1. Analgesics - Anti-Inflammatory
2. Dermatologicals
3. Antineoplastics and Adjunctive Therapies
4. Antivirals
5. Psychotherapeutic and Neurological Agents
6. Endocrine and Metabolic Agents
7. Hematological Agents
8. Respiratory Agents
9. Cardiovascular Agents
10. Gastrointestinal Agents

Source: California Health Benefits Review Program, 2024; Commercial HCGs, 2022-2024.

Prescription drugs in a medical setting

- CHBRP assumed that no prescription drugs administered in a medical setting would be impacted by AB 2180. While the grants available from nonprofits would be available to cover drugs administered in a medical setting, it is generally not possible for these drugs to be 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, currently, all such grants and other charitable assistance provided for drugs administered in a medical setting already count towards deductibles and out-of-pocket (OOP) maximums.
- Although drugs administered in a medical setting would not be impacted by AB 2180, CHBRP has compiled information about the utilization and unit cost of these drugs. Table 10 provides information on the number of enrollees using specialty drugs in a medical setting through an outpatient drug benefit, or through both. It also estimates the number of individuals impacted by AB 2180. The definition of specialty drugs in the table below is consistent with the definition for outpatient prescription drugs used throughout this analysis (more than $3,000 cost).

Table 10. Settings for Specialty Prescription Drug Utilization in California (Commercial Population)

Setting	% of Enrollees (a)	Number of Enrollees (a)	Number of Enrollees Impacted by AB 2180
Outpatient Rx Only	0.9%	119,000	10,000
Outpatient Rx and Medically Administered Drugs	0.1%	10,000	1,000
Medically Administered Drugs Only	0.4%	58,000	
No Utilization of Specialty Drugs	98.6%	12,975,000	
Total	**100.0%**	**13,162,000**	**11,000**

Source: California Health Benefits Review Program, 2024.
Note: These figures are for informational purposes and are not used in the analysis of AB 2180.
(a) The number of enrollees includes all enrollees subject to AB 2180 with outpatient prescription drug coverage.

- Table 11 provides information on the top 10 drugs administered in a medical setting ranked in terms of per member per month costs.

Table 11. Top Drugs Administered in a Medical Setting in California

Drug
1. Injectable pembrolizumab
2. Injection, vedolizumab
3. Injection, ocrelizumab, 1 mg
4. Injectable pegfilgrast ex bio 0.5mg
5. Daratumumab, hyaluronidase
6. Injection, nivolumab
7. Injection, pertuzumab, 1 mg
8. Infliximab not biosimil 10mg
9. Denosumab injection
10. Adalimumab injection

Source: California Health Benefits Review Program, 2024.

- As described in the *Long-Term Impacts* section, CHBRP anticipates that drug copay assistance would increase over time. Therefore, drugs administered in a medical setting would have increased available funding for drug copay assistance, thereby reducing enrollee cost sharing indirectly. CHBRP has not estimated this indirect impact of AB 2180.

Methodology and Assumptions for Baseline Cost

Prescription drugs

- CHBRP estimated the average cost per prescription based on Milliman's proprietary 2022 Consolidated Health Cost Guidelines™ Sources Database. The definition of specialty used for the analysis of AB 2180 is described in the *Benefit Coverage, Utilization, and Cost Impacts* section.
- The average costs per prescription were trended from 2022 to 2025 or 2026 (year 1 and year 2 impacts, respectively) using the annual cost trends summarized below, which are based on the 2022-2024 Commercial HCG trend assumptions.

Table 12. Annual Cost Trends, 2022-2024

Time Period	Cost/Prescription Trend
2022 to 2023	1.5%
2023 to 2024	2.5%
2024 to 2025	3.5%
2025 to 2026	3.5%

Source: California Health Benefits Review Program, 2024; Commercial HCGs 2022-2024.

Total services – PMPM total allowed cost

- Baseline per member per month (PMPM) medical expenses were measured using the results of Commercial and CalPERS surveys. The premium amounts provided by carriers were reduced by the reported administrative and profit loads to determine the expected annual plan covered expenses. The plan covered expenses were increased by the reported average enrollee cost sharing amounts to determine the average allowed total expenses on a PMPM basis.
- Total expenses PMPM were trended from 2022 to 2025 using historical market-specific trends and projected assumptions based on historical patterns.

Methodology and Assumptions for Baseline Cost Sharing

CHBRP assumed that cost-sharing requirements for both prescription drug and medical services were the same as the average cost sharing for all services covered under major medical policies. Cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost of the service. For medical services, it is assumed that the enrollee is responsible for the total cost-sharing requirement. For enrollees in high deductible health plans (HDHPs), cost sharing is assumed to be 100% of expenses until the deductible is satisfied and the average cost-sharing rate for expenses incurred after the deductible is satisfied.

For enrollees in noncompliant policies offering outpatient prescription drug benefits, CHBRP assumed that 50% were enrolled in copay accumulator programs only and 50% were enrolled in combination copay accumulator and copay maximizer programs at baseline. The enrollee cost-sharing requirements for these two programs were not assumed to differ.

Methodology and Assumptions for Postmandate Utilization

CHBRP assumes that in the first year of enactment, there would be increased overall funding available through nonprofits for drug copay assistance as charitable foundations and manufacturer-sponsored foundations recognize that their programs would be more effective at reducing patient out-of-pocket costs. The number of prescriptions filled that would be impacted by AB 2180 was determined by CHBRP based upon a review and consideration of the following sources of information:

- Publicly available financial statements from nonprofit organizations;
- The sources of insurance coverage for patients receive such grants;
- The requirements to receive drug copay assistance;
- The process by which patients submit and receive drug copay assistance; and
- Reforms under the Inflation Reduction Act that would reduce patient cost sharing for Medicare beneficiaries, thereby increasing the available funding for commercial enrollees.

Although CHBRP assumed that while the overall funding level would increase in the first year, it would not lead to an increase in the total number of specialty prescriptions in the first year. This is because CHBRP assumed there would be no change in patient behavior in the first year of enactment. Patients may not recognize that they have been impacted by a copay adjustment program until later in the year when their grant for drug copay assistance is exhausted and they are subject to cost sharing. Also, because there are a variety of funding sources other than drug copay assistance (such as drug manufacturer coupons) subject to copay adjustment programs, CHBRP anticipates that in the first year stakeholders may be slow to change behavior. The baseline presented in Table 2, Table 3, and Table 4 presents the number of impacted scripts with the overall estimated increase in funding because there is no change in the estimated number of scripts. While the analysis shows a reduction in drug copay assistance for each impacted script filled (Table 3) this is more than offset by the overall estimated increase in funding for these programs and estimates of the number of impacted scripts.

Because AB 2180 would allow drug copay assistance programs to increase their effectiveness in terms of reducing patient cost sharing, these nonprofit organizations would potentially be able to serve a greater number of patients with the same level of funding.

Increases in the second year are discussed in the Second-Year Utilization and Unit Cost section below.

Methodology and Assumptions for Postmandate Cost

Prescription drugs

- CHBRP assumed the average cost per prescription would not change as a result of AB 2180.
- CHBRP considered how trends in biosimilars might impact assumptions for AB 2180. The interaction of biosimilar availability and adoption on AB 2180 is potentially mixed. Considerations include the extent to which biosimilars are available from multiple manufacturers, the extent to which biosimilars impact drug prices (including rebates) as well as total member cost-sharing requirements, and the extent to which biosimilars are available and even preferred on formularies developed by PBMs.
    - For a medical condition where a multitude of manufacturers may have developed biosimilar products, this might on one hand decrease the impetus for any one manufacturer to contribute to nonprofits for drug copay assistance while on the other hand increase the number of different manufacturers that might consider a manufacturer contribution.
    - The potential impact of biosimilars on drug prices and enrollee cost-sharing requirements may also play a role. Currently, the costs for many biosimilars still create affordability challenges for patients. This suggests that the need for drug copay assistance programs may be sustained in the future. On the other hand, if biosimilar availability results in marked decreases in drug prices, then drug copay assistance programs may no longer be necessary to address affordability issues amongst the insured and underinsured populations.

Total services – PMPM total allowed cost

- CHBRP assumed the average PMPM allowed cost of total services would increase proportional to the increase in utilization described above and did not assume a change in the average cost per service.

Methodology and Assumptions for Postmandate Cost Sharing

The approach for cost sharing is discussed in the Analytic Approach and Key Assumptions section above.

CHBRP assumed that $0.5M was paid through drug copay assistance programs funded by the State of California or charities to help enrollees cover the cost of noncovered drugs. These payments are understood to occur outside of the insurance market to pay for benefits without existing coverage and are not subject to this mandate. This amount is shown in Table 4 under “Expenses for noncovered benefits.” Because these payments occur outside of insurance, there would be no change to these amounts.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

In order to develop Tables 13 through 15, CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 2180 would have a substantial impact on utilization of either specialty drugs for which coverage was directly addressed, the utilization of any indirectly affected drug, or both. To generate these tables, CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and applied what was learned to a projection of a second year of implementation.

Some differences in expenditures and utilization are due to population changes between 2025 and 2026. Other differences are due to increased funding for drug copay assistance and the tendency for patients to utilize more specialty prescription drugs. As discussed above, because drug copay assistance would always count toward deductibles and OOP maximums postmandate, there may be more overall patients obtaining treatments from high-cost specialty drugs. Also there may be fewer patients discontinuing treatment. Overall, CHBRP anticipates there would be an increase in the number of specialty prescriptions filled.

Second-Year Benefit Coverage

Below, Table 13 provides estimates of how many Californians have health insurance that would have to comply with AB 2180 in terms of benefit coverage during 2026.

Table 13. Impacts of AB 2180 on Benefit Coverage, 2026

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,310,000	22,310,000	0	0.00%
Total enrollees with health insurance impacted by AB 2180	13,703,000	13,703,000	0	0.00%
Total enrollees with health insurance and outpatient prescription drug benefits impacted by AB 2180	13,177,000	13,177,000	0	0.00%
Number of enrollees with health insurance fully compliant with AB 2180	8,094,000	13,703,000	5,609,000	69.30%

Source: California Health Benefits Review Program, 2024.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[41]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[41] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

Postmandate, AB 2180 would result in 5.61 million enrollees gaining coverage for drug copay assistance counting toward their deductibles and OOP maximum out of 13.18 million enrollees with outpatient prescription drug benefits in commercial plans.

Second-Year Utilization and Unit Cost

Below, Table 14 provides second-year estimates of the impacts of AB 2180 on utilization and unit cost of specialty prescriptions and other pharmacy and medical expenses.

Table 14. Impacts of AB 2180 on Utilization and Unit Cost, 2026

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Number of impacted prescriptions filled (specialty prescriptions with third-party assistance available in noncompliant plans)	149,000	155,000	6,000	4.03%
Average unit cost of impacted prescriptions filled	$8,242	$8,242	$0	0.00%
Average third-party assistance used to offset enrollee cost-sharing requirements (total)	$773	$538	-$235	-30.37%
Average third-party assistance used to reduce enrollee cost-sharing requirement (but not tracked to deductible/OOP max) for impacted prescriptions filled	$773	$0	-$773	-100.00%
Average third-party assistance used to reduce enrollee cost-sharing requirement (and tracked to deductible/OOP max) for impacted prescriptions filled	$0	$538	$538	0.00%
Average enrollee contribution towards cost-sharing requirement for impacted prescriptions filled	$327	$113	-$214	-65.44%
Average third-party assistance used to offset plan costs beyond enrollee cost sharing for impacted prescriptions filled	$14	$0	-$14	-100.00%
Average net plan expense for impacted prescriptions filled	$7,128	$7,591	$463	6.50%
Additional expenditure from increased utilization due to lower cost sharing (a)	-	$10,202,000	$10,202,000	

Source: California Health Benefits Review Program, 2024.
Notes: (a) Includes costs for nonspecialty drugs and other medical or pharmacy expenses once the enrollee meets their OOP maximum.
Key: OOP max = annual out-of-pocket maximum.

As discussed above, the number of specialty prescriptions filled that have drug copay assistance (155,000) would be anticipated to increase due to AB 2180 in the second year.

The average unit cost of $8,242 would not change from baseline to postmandate although it would be anticipated to increase from the first year to the second year. The relationship between funding for specialty drugs for drug copay assistance, enrollee cost sharing, and plan expenses would be similar to the first year. Overall, patient cost sharing and drug copay assistance would be expected to decrease while plan expenses increase as a result of AB 2180. Drug copay assistance would decrease as less funding is required to cover patient cost sharing postmandate because these funds will count towards deductible and OOP maximums. Overall, net expenses for specialty drugs would increase for health plans and policies.

Postmandate, some enrollees would reach their OOP maximum earlier in the year as a result of AB 2180 and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers. The amount of spending related to that additional utilization is discussed below.

Second-Year Expenditures

Below, Table 15 provides second-year estimates of the impacts of AB 2180 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits. Overall, second-year expenditures would be anticipated to be much higher than first-year expenditures.

Table 15. Impacts of AB 2180 on Expenditures, 2026

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$67,494,395,000	$67,572,562,000	$78,167,000	0.12%
CalPERS employer (b)	$7,435,629,000	$7,437,875,000	$2,246,000	0.03%
Medi-Cal (excludes COHS) (c)	$31,005,921,000	$31,005,921,000	$0	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$22,437,582,000	$22,462,618,000	$25,036,000	0.11%
Outside Covered California	$5,421,372,000	$5,433,947,000	$12,575,000	0.23%
Through Covered California	$17,016,210,000	$17,028,671,000	$12,461,000	0.07%
Enrollees, group insurance (d)	$21,469,949,000	$21,496,140,000	$26,191,000	0.12%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copays, etc.)	$16,690,545,000	$16,653,858,000	-$36,687,000	-0.22%
Expenses for noncovered benefits (e) (f)	$593,000	$593,000	$0	0.00%
Total expenditures	$166,534,614,000	$166,629,567,000	$94,953,000	0.06%

Source: California Health Benefits Review Program, 2024.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[42] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its enrollees (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

For DMHC-regulated plans and CDI-regulated policies, AB 2180 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered and/or noncovered benefits would decrease. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

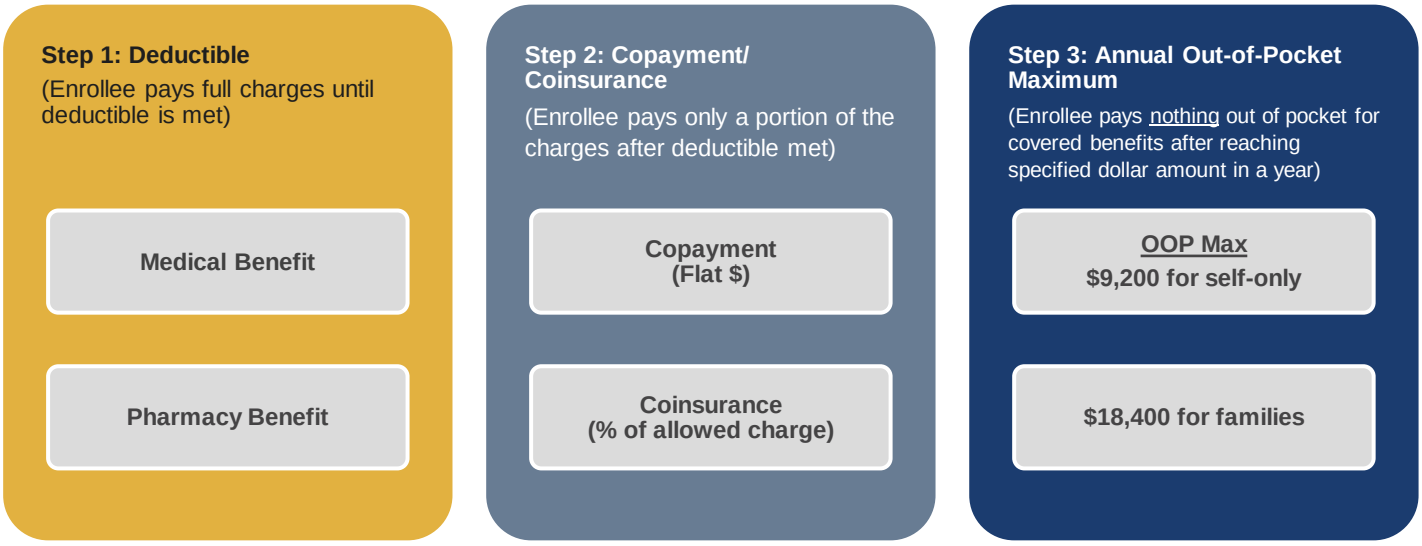
[42] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

Appendix C. Cost Sharing

Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[43]). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (**Error! Reference source not found.**). Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.[44]

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

Figure 1. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2024; CMS, 2023b.
Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also, copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2). The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2023b).
Key: OOP Max = annual out-of-pocket maximum.

High deductible health plans

Both DMHC-regulated plans and CDI-regulated policies may be designated as high deductible health plans (HDHPs).[45] HDHPs are a type of health plan with requirements set by federal regulation (CMS, n.d.). As the name implies, these plans include a deductible, but they are not allowed to have separate medical and pharmacy deductibles. For the 2024 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,600 for an

[43] Premiums are paid by most enrollees, regardless of their use any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through the Covered California, or they receive benefits through Medi-Cal.
[44] Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percent of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost-sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.
[45] For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*, available at www.chbrp.org/other-publications/resources.

individual and $3,200 for a family.[46] Annual OOP expenses for coverage of in-network tests, treatments, and services — which would result from cost sharing[47] applicable after the deductible is met — are not allowed to be more than $8,050 for an individual and $16,100 for a family.[48]

Health Savings Account–qualified HDHPs

To be eligible to establish a Health Savings Account (HSA) for taxable years beginning after December 31, 2003[49] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA-qualified HDHP.

In order for an HDHP to be HSA qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied, but federal law provides a safe harbor for the absence of a deductible applicable to preventive care.[50] Therefore, an HDHP may cover preventive care benefits without any deductible or with a deductible below the minimum annual deductible but is not required to do so for a specified list of preventive services. The list of preventive services for which application of a deductible is not required includes treatments for chronic conditions.[51]

Allowed Cost Amounts for Medical Services

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

[46] IRS Revenue Procedure 2023-23, available at www.irs.gov/pub/irs-drop/rp-23-23.pdf.
[47] Such as copays and coinsurance applicable to the covered test, treatment, or service.
[48] There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.
[49] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.
[50] For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725, available at https://www.irs.gov/irb/2004-15_IRB. For additional guidance on preventive care, see Notice 2004-50, 2004-2 C.B. 196, Q&A 26 and 27, available at www.IRS.gov/irb/2004-33_IRB#NOT-2004-50; and Notice 2013-57, 2013-40 I.R.B. 293, available at IRS.gov/pub/irs-drop/n-13-57.pdf.
[51] For information on preventive care for chronic conditions, see Notice 2019-45, 2019-32 I.R.B. 593, available at www.IRS.gov/pub/irs-drop/n-19-45.pdf.

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

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