



**CALIFORNIA**  
HEALTH BENEFITS REVIEW PROGRAM

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**Executive Summary**  
Analysis of Assembly Bill 310:  
Prescription Drugs

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A Report to the 2011-2012 California Legislature  
April 14, 2011

# **A Report to the 2011-2012 California State Legislature**

## **Analysis of Assembly Bill 310 Prescription Drugs**

**April 14, 2011**

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## EXECUTIVE SUMMARY

### California Health Benefits Review Program Analysis of Assembly Bill 310

The California Assembly Committee on Health requested on February 10, 2011, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 310, a bill that would impose a health benefit mandate. Specifically, AB 310 would prohibit coinsurance as a basis for cost sharing for outpatient prescription drugs; limit copayments to \$150 per one-month supply; and require that a health plan's or policy's out-of-pocket maximum include the outpatient prescription drug benefit. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.<sup>1</sup>

Approximately 21.9 million Californians (59%) have health insurance that may be subject to a health benefit mandate law passed at the state level.<sup>2</sup> Of the rest of the state's population, a portion is uninsured (and so has no health insurance subject to any benefit mandate) and another portion has health insurance subject to other state law or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state-level benefit mandates. The California Department of Managed Health Care (DMHC)<sup>3</sup> regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers<sup>4</sup>, which offer benefit coverage to their enrollees through health insurance policies.

Enrollees in health insurance products not subject to state-level benefit mandates would not be affected by AB 310. Examples would include those enrolled in Medicare (including Medicare Advantage plans) or those who have coverage through self-insured employer plans. In addition, only DMHC-regulated plans and CDI-regulated policies that cover outpatient prescription drugs would be subject to AB 310. Therefore, the mandate would not affect about 968,000 enrollees who do not have an outpatient prescription drug benefit through their health plan or policy. Thus, the mandate would affect the health insurance of approximately 20.9 million Californians (56%).

### Bill Language and Key Definitions

The full text of AB 310 can be found in Appendix A.

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<sup>1</sup> CHBRP's authorizing statute is available at: [http://www.chbrp.org/documents/authorizing\\_statute.pdf](http://www.chbrp.org/documents/authorizing_statute.pdf)

<sup>2</sup> CHBRP's estimates are available at: [http://www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>3</sup> The DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code, Section 1340.

<sup>4</sup> The CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code, Section 106(b) or subdivision (a) of Section 10198.6.

AB 310 would:

- Prohibit coinsurance (i.e., percentage cost of the prescription) as the basis for cost sharing for outpatient prescription drug benefits;
- Limit copayments for outpatient prescription drugs to \$150 per one-month supply or its equivalent for prescriptions for longer periods, adjusted for inflation; and,
- If a plan or policy has an annual out-of-pocket maximum, require outpatient prescription drug benefit cost sharing to be included under that annual out-of-pocket maximum.

AB 310 would not:

- require plans or policies without an outpatient prescription drug benefit to begin to cover prescription drugs.
- require coverage of specific drugs or require plans or policies to make changes to their formularies.

The definitions of “inflation” and “one-month supply” are not further specified by AB 310.

A *copayment* is a fixed, flat-dollar amount that an enrollee pays when filling a prescription. *Coinsurance* is where the enrollee pays a percentage cost of the prescription, rather than a fixed amount. An *out-of-pocket maximum* is an annual limit on the total out-of-pocket costs (excluding premium payments) that an enrollee is responsible for during plan year.<sup>5</sup>

## **Analytic Approach and Key Assumptions**

AB 310 is not a typical benefit mandate, in that it does not mandate coverage of specific treatments or services. Therefore, CHBRP’s analysis regarding medical effectiveness, cost, and public health impacts has been adjusted to address the questions relevant to this bill. Because AB 310 would not require coverage of any specific prescription drugs or classes of drugs nor require changes to a plan or policy’s formulary, the *Medical Effectiveness* section reviews and analyzes the literature related to the effects of cost sharing on utilization of prescription drugs.

The *Benefit Coverage, Utilization, and Cost Impacts* section addresses the effects of AB 310’s three key provisions on overall utilization of the prescription drug benefit, premiums, and health care expenditures. The impacts modeled in the *Benefit Coverage, Utilization, and Cost Impacts* section rely on some key assumptions. The analysis assumes there are no changes in benefit design (such as changes to deductibles, out-of-pocket maximums, or annual limits) other than that copayments exceeding \$150 per one-month supply would be lowered to that number, coinsurance exceeding \$150 per one-month supply would become a copayment at that number, and prescription drug cost sharing would be included under the plan or policy’s out-of-pocket maximum, if it already includes one.

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<sup>5</sup> Out-of-pocket maximums may alternately or additionally apply in other ways, such as per service, per month, per quarter, or per family.

The *Public Health Impacts* section provides analysis of specific drugs or classes of drugs for which cost sharing for some enrollees is currently high (defined as above \$150), and therefore, would be reduced by this bill. The section also discusses how changes in cost sharing would affect certain subpopulations of enrollees who use specific drugs, when there is available evidence and data.

#### *Existing California requirements*

Current regulations governing DMHC-regulated health plans include provisions regarding outpatient prescription drug benefits. Rules related to cost sharing (copayments, coinsurance, and deductibles) state that copayment may not be more than the retail price of the drug; that a copayment or percentage coinsurance may not exceed 50% of the “cost to the plan.” It also specifies that if a plan uses coinsurance it must either: have a maximum dollar amount cap on the percentage coinsurance that would be charged for an individual prescription; apply towards an annual out-of-pocket maximum for the plan; or, apply towards an annual out-of-pocket maximum for the prescription drug benefit. CDI-regulated policies have no analogous requirements except that they provide that health insurers must cover benefits mandated under the Insurance Code.

CHBRP is aware of one other state with a similar law. In 2010, New York prohibited the implementation of “specialty tiers” for prescription drug benefits. Similar legislation has also been recently introduced in other states but has not passed into law.

## **Medical Effectiveness**

Prescription drugs can be divided into two major categories: traditional agents and specialty drugs.

- Specialty drugs are new, high-cost drugs, primarily biologics.
  - Specialty drugs are primarily used to treat complex chronic conditions, such as anemia, cancer, growth hormone deficiency, hemophilia, hepatitis, multiple sclerosis, and rheumatoid arthritis.
  - Specialty drugs are administered by injection, intravenously, or orally.
  - Specialty drugs are more expensive than traditional oral agents because they are more expensive to produce and because no generic or “biosimilar” (biologics with properties similar to existing biologics) versions of them are available.
- Traditional agents consist of generic and brand-name drugs that are produced using traditional pharmaceutical manufacturing processes.
  - Traditional agents are used to treat a wide range of chronic and acute conditions. They play major roles in the prevention and treatment of common conditions such as heart disease, diabetes, asthma, and depression.

- Most traditional agents are administered orally as tablets or capsules, although some are inhaled (e.g., aerosol and dry powder medications for asthma and chronic obstructive pulmonary disease), injected (e.g., cortisone injections for inflammation associated with arthritis or other conditions), or administered transdermally (e.g., transdermal patches for contraception and pain relief).

CHBRP's medical effectiveness analysis for AB 310 focuses on the impact of cost sharing (i.e., the portion of expenditures paid by enrollees) on use of prescription drugs. CHBRP chose this analytic approach because AB 310 would not increase the number of Californians who have coverage for prescription drugs, but would instead affect the terms and conditions of prescription drug coverage for enrollees who have such coverage.

### Methodological Considerations

- No randomized controlled trials (RCTs) of the impact of variation in prescription drug cost sharing on the use of prescription drugs or other health care services have been conducted since the RAND Health Insurance Experiment was conducted in the late 1970s and early 1980s.
- Newer studies of the impact of cost sharing for prescription drugs have not randomized participants, which limits confidence that differences in use of prescription drugs or other services between persons facing higher and lower cost sharing for prescription drugs are due to cost sharing versus other factors.

The best nonrandomized studies of cost sharing for prescription drugs have used rigorous methods to control for other factors that may affect use of prescription drugs, such as health behaviors, health status, income, and expenses for other types of health care services.

### Study Findings

#### *Specialty drugs*

- Only a small number of studies of the impact of cost sharing on use of specialty drugs have been published.
- The *preponderance of evidence* from these studies suggests that demand for specialty drugs is sensitive to price but that the size of the effect is small. Estimates of the price elasticity of demand<sup>6</sup> for specialty drugs suggest that each 10% increase in cost sharing for specialty drugs would reduce spending for these drugs by 0.1% to 2.1% depending on the disease a specialty drug is used to treat.
  - Demand for specialty drugs to treat multiple sclerosis and rheumatoid arthritis appears to be more sensitive to cost sharing than demand for specialty drugs for cancer and kidney disease.
- Findings from a single study suggest that the impact of cost sharing on use of specialty drugs for multiple sclerosis varies depending on whether a person's coverage is subject to

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<sup>6</sup> Price elasticity of demand shows how the quantity demanded or supplied will change when the price changes.

coinsurance or a copayment. Reductions in use associated with higher cost sharing were greater for persons who were required to pay coinsurance instead of a copayment.

- CHBRP identified no studies of the effects of cost sharing for specialty drugs on use of other types of health care services. No evidence of effect is not evidence of no effect. It is possible that some persons who face higher cost sharing for specialty drugs have more hospitalizations, emergency department visits, and outpatient visits than persons who face lower cost sharing.

#### *Traditional agents*

- A large number of studies on the effects of cost sharing on use of traditional agents have been published.
- The *preponderance of evidence* from these studies suggests that demand for traditional agents is more sensitive to price than demand for specialty drugs.
  - A systematic review of 65 studies of the impact of cost sharing on use of traditional agents found that increases in cost sharing are consistently associated with decreases in use of traditional oral agents. Each 10% increase in cost sharing for traditional agents is associated with a 2% to 6% reduction in their use. Subsequent studies reported similar findings.
  - Findings from studies that compared the impact of cost sharing on use of different types of traditional agents are *ambiguous*. Some studies have found large differences across classes of traditional agents, whereas others have found no differences across drug classes.
- Two studies examined whether responses to cost sharing differ between persons whose pharmacy benefits require coinsurance versus copayments for traditional agents.
  - One study reported that higher cost sharing is associated with poorer adherence to prescription drug regimens for diabetes and that the effect was more pronounced for persons with coinsurance than persons with copayments.
  - One study found that changing cost sharing for prescription drugs from a tiered copayment to tiered coinsurance is associated with small and clinically insignificant reductions in use of prescription drugs when combined with maximums on out-of-pocket costs for each tier of coinsurance.
- Findings from studies that have assessed the effects of differences in cost sharing for prescription drugs on use of other types of health care services are *ambiguous*.
  - Some studies have found no differences in hospitalizations, emergency department visits, or outpatient visits.
  - Others have found that higher cost sharing is associated with higher rates of hospitalization, emergency department visits, and/or outpatient visits among persons with acute coronary syndrome, congestive heart failure, lipid disorders, and diabetes.

## **Benefit Coverage, Utilization, and Cost Impacts**

AB 310 applies to all plans and policies that have an outpatient prescription drug benefit (96% of the plans and policies that may be subject to state level mandates). Therefore, the mandate would directly affect the health insurance of 20.9 million people (56% of Californians). Table 1 summarizes the expected benefit coverage, cost, and utilization impacts for AB 310.

### Analytic Approach and Assumptions

- If AB 310 were enacted, use of coinsurance as a cost-sharing mechanism for the outpatient prescription drug benefit would be prohibited. Therefore, outpatient prescription drug designs would be altered to eliminate the use of coinsurance and would use copayments as the cost-sharing mechanism.
- For those plans or policies that have an annual out-of-pocket maximum (OOP maximum), out-of-pocket costs (copayments, deductibles) for prescription drugs would be applied toward the annual OOP maximum. For the purposes of this analysis, CHBRP assumes that the total annual OOP maximum amount would not increase.

### Benefit Coverage Impacts

- Among the enrollees with an outpatient prescription drug benefit, CHBRP estimates that:
  - 12% of enrollees (2,520,000) with health insurance subject to the mandate have coinsurance requirements for outpatient prescription drug benefits;
  - No enrollees have copayments for outpatient prescription drugs over \$150 for a one-month supply; and
  - 66.9% of enrollees (14,015,000) have an annual out-of-pocket maximum for their plan or policy but their outpatient prescription drug benefit is excluded from that annual out-of-pocket maximum.
- Medi-Cal Managed Care plans and MRMIB plans provide coverage for outpatient prescription drugs at no charge or with minimal copayment requirements. Therefore, CHBRP estimates no impact on these publicly funded plans.
- CalPERS HMOs' OOP maximum (set at \$1,500 per enrollee and \$3,000 per family) excludes the outpatient prescription drug benefit. Therefore CalPERS HMOs would have to make adjustments to the outpatient prescription drug benefits to become compliant with AB 310.
- CHBRP estimates no measurable impact of the mandate on the number of uninsured due to premium increases.

## Utilization Impacts

- Premandate, CHBRP estimates that 0.018% of enrollees with outpatient prescription drug benefit have filled prescriptions where the cost share exceeded \$150 for a one-month supply. The utilization rate among such persons was approximately 8.8 prescriptions per 1,000 enrollees with the coinsurance provision per year. These enrollees' out-of-pocket costs were on average \$271 per prescription.
- Postmandate, overall utilization rates and resulting out-of-pocket expenses are expected to change as a result of the mandate. Prescriptions for which coinsurance cost sharing would have exceeded \$150 per one-month supply would be limited to that amount. The average cost share for those prescriptions would therefore fall from \$271 premandate to \$150 per one-month supply postmandate. As a result of this decrease in cost share, CHBRP estimates an 4% increase in utilization for these prescriptions.

## Cost Impacts

- Increases in per member per month (PMPM) premiums vary by market segment. Increases as measured by percentage changes in PMPM premiums are estimated to range from 0.00% (for Medi-Cal Managed Care plans) to an average 0.74% (for CDI-regulated large group policies) in the affected market segments. Increases as measured by PMPM premiums are estimated to range from an average of \$0.00 to \$3.69.
- In the privately funded large-group market, the increase in premiums is estimated to range from an average \$1.12 PMPM among DMHC-regulated plans and \$3.69 PMPM among CDI-regulated policies.
- In the privately funded small-group market, health insurance premiums are estimated to increase by an average of \$0.74 PMPM for DMHC-regulated plans and \$1.16 PMPM for CDI-regulated policies.
- In the privately funded individual market, health insurance premiums are estimated to increase by an average of \$0.36 PMPM and \$0.53 PMPM in the DMHC- and CDI-regulated markets, respectively.
- The premiums for CalPERS HMOs are estimated to increase by \$1.38 PMPM. This impact is attributable to the OOP maximum provision of AB 310.
- Total net health expenditures are projected to increase by \$31.7 million (0.033%) (Table 1). This is due to a \$220.3 million increase in health insurance premiums partially offset by reductions in enrollee cost sharing (\$188.6 million).
- There are likely to be long-term cost impacts but the magnitude is unknown at this time. Advances in drug development are likely to yield new, higher-cost drugs. CHBRP recognizes that a decrease in out-of-pocket expenditures may interact with these trends and thereby further increase the demands for these medications as a result of AB 310. While demand and availability of high-cost drugs increases, insurers and employers could respond in a variety of ways, including increasing the total out of pocket maximum for plans and policies, varying

the cost-sharing structure so additional prescription drugs are associated with higher copayments (capped at \$150 per one-month supply), or engaging in additional utilization management strategies. Over time, the combined effects of demand for higher cost prescription drugs with lower out-of-pocket expenditures may lead to increased utilization for these prescription drugs and overall premium increases.

## Public Health Impacts

- CHBRP estimates no public health impact of the provision capping copayments at \$150 per prescription per one-month supply since CHBRP estimates that no enrollees are currently in plans and policies with outpatient prescription drug copayments exceeding \$150.
- AB 310's provision requiring those plans or policies that have an annual OOP maximum to include out-of-pocket cost for the prescription drug benefit may have a public health impact; however, given lack of evidence and data, the potential public health impact is unknown. CHBRP estimates that approximately 0.07% of enrollees have prescription drug cost sharing that currently exceeds the total annual OOP maximum, and approximately 2.77% of enrollees have medical cost sharing that exceeds the cap.
- The public health impact of AB 310's provision prohibiting the use of coinsurance as a cost-sharing mechanism for the prescription drug benefit is limited to those drugs for which coinsurance is currently used and with cost sharing exceeding \$150. CHBRP further limited discussion of potential impacts to those drugs and conditions for which there is existing evidence from the literature of the association between cost sharing and prescription drug utilization. The public health impact analysis is therefore limited to the following drugs and conditions:
  - Etanercept and adalimumab for rheumatoid arthritis (RA): An estimated 460 enrollees would be subject to a 21% reduction in cost sharing for RA drugs postmandate. This represents approximately 60% of all enrollees who have drug claims for the RA drugs etanercept and adalimumab subject to coinsurance. Based on existing evidence, these enrollees may increase utilization depending on various factors, including whether cost was a barrier to use.
  - Interferon beta-1a for multiple sclerosis (MS): An estimated 78 enrollees would be subject to a 41% reduction in cost sharing for MS drugs postmandate. This represents approximately 62% of all enrollees who have drug claims for interferon beta-1a subject to any coinsurance. Based on existing evidence, these enrollees may increase utilization depending on various factors, including whether cost was a barrier to use.
  - Imatinib mesylate for chromosome-positive chronic myeloid leukemia: CHBRP estimates no public health impacts from the mandate, given existing evidence that cost sharing does not affect utilization for this subpopulation.

- To the extent that more people have access to these drugs, there is the potential for beneficial long term health impacts for people who have chronic conditions such as multiple sclerosis and rheumatoid arthritis. However, the long-term public health impacts due to AB 310 are unknown given the uncertainty of how the market may respond to the lower cost-sharing requirements of AB 310.

## **Potential Effects of the Federal Affordable Care Act**

The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and the “Health Care and Education Reconciliation Act” (H.R.4872) were enacted in March 2010. These laws (together referred to as the “Affordable Care Act [ACA]”) are expected to dramatically affect the California health insurance market and its regulatory environment, with most changes becoming effective in 2014. How these provisions are implemented in California will largely depend on pending legal actions, funding decisions, regulations to be promulgated by federal agencies, and statutory and regulatory actions to be taken by California state government. The provisions that go into effect during these transitional years would affect the baseline, or current enrollment, expenditures, and premiums. It is important to note that CHBRP’s analysis of specific mandate bills typically address the marginal effects of the mandate bill—specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP’s estimates of these marginal effects are presented in this report.

### Essential Health Benefits Offered by Qualified Health Plans in the Exchange and Potential Interactions with AB 310

The ACA requires beginning 2014 that states “make payments...to defray the cost of any additional benefits” beyond the essential health benefits (EHBs) required to be covered by qualified health plans (QHPs) sold in the Exchange.<sup>7</sup> AB 310 does not require coverage of additional benefits as it specifically states, that “Nothing in this section shall be construed to require a [health care service plan/health insurance policy] to provide coverage not otherwise required by law for any prescription drug.”

In addition, AB 310 would make the requirements of the bill inoperative if the Director of the DMHC or the Insurance Commissioner determines that the requirements would result in the “assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104(e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.”

EHBs explicitly include “prescription drugs.”<sup>8</sup> In order for the Director or the Commissioner to determine whether any additional state fiscal liability as it relates to the Exchange would be incurred under AB 310, the following factors would need to be examined:

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<sup>7</sup> Affordable Care Act, 1311(d)(3)(B).

<sup>8</sup> Affordable Care Act, Section 1302(b)(1)(F).

- a determination of whether AB 310 actually constitutes a requirement of “additional benefits,” given provision (e) stating that the bill does not mandate coverage of prescription drugs;
- the scope of “prescription drug” benefits in the final EHB package;
- a determination of whether the cost-sharing requirement under AB 310 is consistent with the cost-sharing structures of the QHPs to be offered in the California Exchange;
- the number of enrollees in QHPs; and
- the methods used to define and calculate the cost of additional benefits.

If AB 310 were determined by the Director or Commissioner to incur state fiscal liability under the ACA provisions governing QHPs, the section would become inoperative, meaning the requirements would be nullified for all plans and policies.

#### ACA’s Provisions Related to Annual Out-of-Pocket Maximums

Additionally, beginning in 2014, all plans and policies in the small-group and individual markets (including QHPs sold in the Exchange) will be required to have an annual limit on cost sharing not exceeding the levels for high-deductible health plans (HDHPs) qualifying as Health Savings Accounts (HSAs).<sup>9,10</sup> This would increase the number of enrollees in plans with an annual out-of-pocket maximum, and, concomitantly, increase the number of enrollees whose out-of-pocket expenses for prescription drugs would be required to be included under the out-of-pocket maximum per AB 310.

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<sup>9</sup> Affordable Care Act, Section 1302(c)(1).

<sup>10</sup> CMS estimates these limits would be \$6,645 for an individual and \$13,290 for a family in 2014, as the limits are adjusted annually. See: [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf).

**Table 1. AB 310 Impacts on Benefit Coverage, Utilization, and Cost, 2011**

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
<b>Benefit Coverage</b>				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,902,000	21,902,000	0	0.0%
Total enrollees with health insurance subject to AB 310	20,934,000	20,934,000	0	0.0%
Percentage of enrollees with coverage for the mandated benefit				
Outpatient prescription drug benefit requiring coinsurance for any tier	12.0%	0.0%	-12.0%	-100%
Outpatient prescription drug benefit with copayment exceeds \$150	0.0%	0.0%	0.0%	0.0%
Outpatient prescription drug benefit cost share not included in OOPM	66.9%	0.0%	-66.9%	-100%
Outpatient prescription drug benefit compliant with AB 310	30.0%	100.0%	70.0	234%
Number of enrollees with coverage for the mandated benefits				
Outpatient prescription drug benefit requiring coinsurance for any tier	2,520,000	0	-2,520,000	-100%
Outpatient prescription drug benefit with copayment exceeds \$150	0	0	0	0.0%
Outpatient prescription drug benefit Rx cost share not included in OOPM	14,015,000	0	-14,015,000	-100%
Outpatient prescription drug benefit compliant with AB 310	6,270,000	20,934,000	12,664,000	234%
<b>Utilization and cost for those enrollees affected by the coinsurance provision (2,520,000 enrollees)</b>				
Claims without coinsurance:				
Prescriptions per 1,000 enrollees per year	9,840	9,840	0	0.0%
Average cost per prescription	\$97	\$97	\$0	0.0%
Average cost share per prescription	\$13	\$13	\$0	0.0%
Claims with coinsurance and cost share amount ≤ \$150				
Prescriptions per 1,000 enrollees per year	2,941	2,941	0	0.0%
Average cost per prescription	\$105	\$105	\$0	0.0%
Average cost share per prescription	\$20	\$20	\$0	0.0%
Claims with coinsurance and cost share > \$150				
Prescriptions per 1,000 enrollees per year	8.8	9.1	0	4.0%
Average cost per prescription	\$1,638	\$1,638	\$0	0.0%
Average cost share per prescription	\$271	\$150	-\$121	-44.7%
Combined				
Prescriptions per 1,000 enrollees per year	12,789.9	12,790.2	0	0.0%
Average cost per prescription	\$100	\$100	\$0.04	0.0%
Average cost share per prescription	\$14.99	\$14.91	-\$0.08	-0.5%

**Table 1. AB 310 Impacts on Benefit Coverage, Utilization, and Cost, 2011 (Cont'd)**

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
<b>Expenditures</b>				
Premium expenditures by private employers for group insurance	\$52,713,266,000	\$52,866,488,000	\$153,222,000	0.2907%
Premium expenditures for individually purchased insurance	\$6,724,851,000	\$6,736,556,000	\$11,708,000	0.1741%
Premium expenditures by persons with group insurance, CalPERS HMOs, Healthy Families Program, AIM or MRMIP(b)	\$15,173,472,000	\$15,217,892,000	\$44,420,000	0.2927%
CalPERS HMO employer expenditures (c)	\$3,465,785,000	\$3,476,762,000	\$10,977,000	0.3167%
Medi-Cal Managed Care Plan expenditures	\$8,657,688,000	\$8,657,688,000	\$0	0.0000%
MRMIB Plan expenditures (d)	\$1,050,631,000	\$1,050,631,000	\$0	0.0000%
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$7,548,415,000	\$7,359,776,000	-\$188,639,000	-2.4991%
<b>Total Expenditures</b>	<b>\$95,334,108,000</b>	<b>\$95,365,796,000</b>	<b>\$31,688,000</b>	<b>0.0332%</b>

Source: California Health Benefits Review Program, 2011.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans, Healthy Families Program, AIM, MRMIP) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 58% or \$6,367,000 would be expenditures for CalPERS members who are state employees or their dependents.

(d) MRMIB Plan expenditures include expenditures for 874,000 enrollees of the Healthy Families Program, 8,000 enrollees of MRMIP, and 7,000 enrollees of the AIM program.

Key: AIM=Access for Infants and Mothers; CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health; MRMIB=Managed Risk Medical Insurance Board; MRMIP=Major Risk Medical Insurance Program.

## ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 310. In response to a request from the California Assembly Committee on Health on February 10, 2011, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Janet Coffman, MPP, PhD, and Mi-Kyung (Miki) Hong, MPH, of the University of California, San Francisco, prepared the medical effectiveness analysis. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Yali Bair, PhD, Consultant, and Dominique Ritley, MPH, of the University of California, Davis prepared the public health impact analysis. Ying-Ying Meng, DrPH, of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, of Milliman, provided actuarial analysis. Geoff Joyce, PhD, of the University of Southern California, and Debi Reissman, PharmD, of Rxperts, Inc., provided technical assistance with the literature review and expert input on the analytic approach. David Guarino, and Susan Philip, MPP, of CHBRP staff prepared the introduction and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Kathleen Johnson, PharmD, MPH, PhD, of the University of Southern California, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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Director

## California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact. 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. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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