KEY FINDINGS

Analysis of California Assembly Bill 298: Cost Sharing

Summary to the 2025-2026 California State Legislature, March 30, 2025

CHBRP

Summary

The version of AB 298 analyzed by California Health Benefits Review Program (CHBRP) would prohibit California Department of Managed Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies from imposing a deductible, coinsurance, copayment, or other cost sharing for covered, in-network health care services provided to enrollees younger than 21 years.

In 2026, 100% of the 22.2 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 298.

Benefit Coverage

At baseline, there are 7.47 million enrollees younger than 21 in DMHC-regulated plans and CDI-regulated policies. Of these, 51% are in DMHC-regulated Medi-Cal plans and already have coverage for in-network medical services without cost sharing. The remaining 49% of the 7.47 million enrollees at baseline are in commercial/ California Public Employees' Retirement System (CalPERS) plans and policies that impose some cost sharing on in-network medical services.

Cost and Health Impacts

Overall, in 2026, AB 298 would increase total expenditures by $711,201,000 or 0.42%.

In 2026, AB 298 would reduce enrollee cost sharing by a total of $694,204,000. The average reduction in cost sharing per enrollee would vary based on market segment.

Total premiums would increase by $1,405,405,000.

Increases in premiums vary by market segment.

Because these premium increases are over 1% in the commercial market, CHBRP estimates that 6,430 Californians could become uninsured.

Overall, the reduction in cost sharing would increase utilization across most types of care. To the extent utilization results in improved health outcomes, there would be a public health impact.

Context[1]

In 2022, 7.4% of Californians younger than 21 delayed or did not get health care, and over one-third (37%) of them listed cost, lack of insurance, or other insurance-related issues as the cause.

Even among people with health insurance coverage, cost can be a barrier. In addition to monthly premiums, enrollees of commercial and CalPERS plans have some level of out-of-pocket cost obligations for care due to the cost sharing tied to their plan or policy. Cost sharing includes deductibles — which is the amount enrollees must meet before the insurer begins to cover the cost of services — as well as coinsurance and/or copayments. After an enrollee meets the deductible, they usually still have copayments and coinsurance obligations for covered services until the maximum out-of-pocket cap is met. High deductible health plans (HDHPs) pair a deductible — of at least $1,650 for an individual and $3,300 for a family in 2025 — with a lower monthly premium. These plans can be used with health savings accounts (HSAs) if they meet certain federal requirements.

State law requires certain recommended preventive services to be covered without cost sharing in state-regulated plans and policies, including in HSA-qualified HDHPs. Federal law further allows HSA-qualified HDHPs to cover certain additional preventive services

[1] Refer to CHBRP's full report for full citations and references.

prior to the application of a deductible, but other cost sharing may apply. For other services, plan design would determine the level and amount of cost sharing for enrollees.

The impact of cost on utilization can depend on the type of care. For instance, inpatient care has a minimal response to changes in cost sharing, whereas patients may delay or forgo behavioral health care due to cost. While care for persons younger than 21 years is often centered around regular, preventive care, they also have acute and chronic health care needs for which utilization can be influenced by cost.

Bill Summary

AB 298 would prohibit DMHC-regulated plans and CDI-regulated policies from imposing:

- A deductible, coinsurance, copayment, or other cost sharing for covered in-network services provided to enrollees younger than 21 years.

For HSA-qualified HDHPs, AB 298 would prohibit the application of:

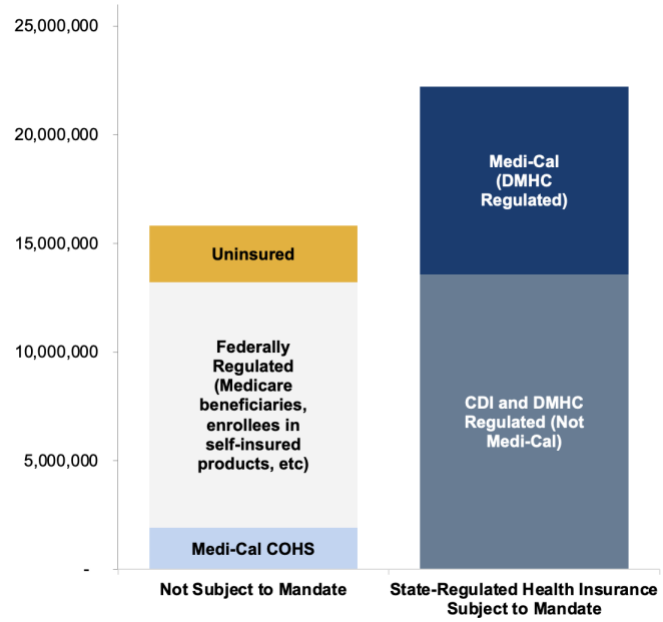
- A deductible, coinsurance, copayment, or other cost sharing for preventive care services, as defined at Section 223(c)(2) of Title 26 of the United States Code, provided to enrollees younger than 21 years; and
- Coinsurance, copayment, or other cost sharing for services provided to enrollees younger than 21 years once the deductible has been met.

The elimination of cost sharing under AB 298 would apply to health care services under a plan or policy's medical benefit. The bill would not apply to services under the pharmacy benefit or durable medical equipment benefit.

AB 298 defines in-network health care services to include covered services for which the plan or policy design applies in-network cost sharing to enrollees receiving covered services from out-of-network providers and/or facilities, as applicable under federal and state law.

Figure A notes how many Californians have health insurance that would be subject to AB 298.

Figure A. Health Insurance in CA and AB 298



Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

At baseline, 51% of enrollees younger than 21 years with health insurance that would be subject to AB 298 already have fully compliant coverage for in-network health care services without cost sharing through coverage in DMHC-regulated Medi-Cal. The remainder of enrollees are in commercial or CalPERS plans or policies that impose some cost sharing for in-network health care services; 45% of enrollees younger than 21 years are in state-regulated plans and policies that are not HSA-qualified, and 4% are in state-regulated HSA-qualified HDHPs.

Postmandate, 100% of DMHC-regulated plans and CDI-regulated policies would have coverage in compliance with AB 298.

Utilization

Since AB 298 would apply broadly across all services in a plan or policy's medical benefit, CHBRP estimates changes in utilization through changes in per member per month (PMPM) costs. DMHC-regulated Medi-Cal

plans are already in compliance and therefore would see no change in utilization postmandate.

Postmandate, eliminating cost sharing for enrollees younger than 21 years would increase utilization of some medical services for enrollees in commercial/CalPERS plans or policies. In plans or policies that are not HSA-qualified, the estimated increase in average PMPM charges for all ages due to the increases in utilization across all medical services would be 0.57% ($3.90) postmandate. For enrollees in HSA-qualified HDHPs, average PMPM charges for all ages due to utilization would increase by 0.28% ($1.73).

Expenditures

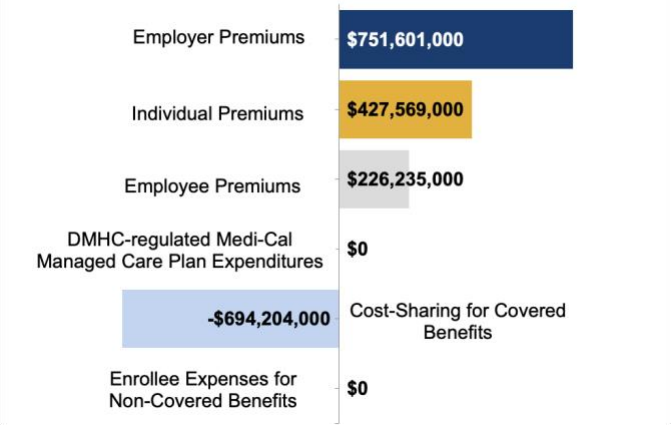
Overall, in 2026, AB 298 would increase total expenditures (premiums plus enrollee expenses) by $711,201,000 or 0.42% postmandate. This is in part due to a $1,405,405,000 increase in premiums.

Premium increases postmandate stem from three factors: increase in utilization (accounting for 44% of the premium increase), shift in cost sharing from point-of-service to premiums (49%), and administrative costs (7%).

AB 298 would result in a reduction in enrollee cost sharing by $694,204,000 postmandate.

Overall, premiums would increase as a result of AB 298, with variation by market segment. The increase would impact both employers and employees (Figure B).

Figure B. Expenditure Impacts of AB 298



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Commercial

PMPM premium increases in DMHC-regulated commercial plans range from 0.85% ($5.98 PMPM) for large-group plans to 1.95% ($15.96 PMPM) for individual plans. Among CDI-regulated policies, PMPM increases range from 1.29% ($10.79 PMPM) for large-group policies to 2.92% ($22.74 PMPM) for individual policies. These increases are due in part to new utilization, as well as a shift in costs to insurers, with reductions in enrollee expenses for covered benefits.

Reductions in enrollee cost sharing range from reductions of $2.69 PMPM for DMHC-regulated large-group plans to $11.84 PMPM for CDI-regulated individual policies.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, total expenditures are expected to increase by 0.61% and premiums are expected to increase by 0.82% ($7.04 PMPM) postmandate. Enrollee cost sharing, meanwhile, would be reduced by $1.32 PMPM postmandate.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there would be no impact as coverage at baseline is already compliant with AB 298.

Sample Small-Group Gold Plan

CHBRP also estimated the impact of AB 298 on a sample small-group gold plan in order to model the impact on specific types of care. In this sample plan, utilization would increase across nearly all types of care and stay the same for inpatient care and ancillary services as a result of AB 298. Behavioral health services, emergency room care, and office visits would experience the highest increases in PMPM costs postmandate (3.5%, 2.6%, and 2.2%, respectively). Enrollee cost sharing would decrease in each category of care except outpatient pharmacy; while AB 298 does not apply to pharmacy benefits, the increased utilization of health care (e.g., office visits) would result in an increase in prescription medication use.

Overall, enrollee cost sharing would decrease by $5.90 PMPM postmandate.

Number of Uninsured in California

Because the change in premiums would exceed 1% in the small-group and individual DMHC-regulated markets and the large-group, small-group, and individual CDI-regulated markets, CHBRP would expect a measurable change in the number of uninsured persons due to the enactment of AB 298. The premium increase in the DMHC-regulated CalPERS and large-group market segments are not above 1%, so CHBRP does not anticipate coverage losses in those markets.

Due to an estimated premium increase of greater than 1% due to AB 298 in several market segments, CHBRP estimates that the increases in premiums would cause more than 6,430 enrollees to lose or drop health insurance.

Public Health

In the first year postmandate, 3,632,000 enrollees younger than 21 years with health insurance subject to AB 298 would experience a change in cost-sharing requirements and overall would increase utilization of health care services. The increase in utilization would be across most types of care, including behavioral health, office visits, emergency room care, and more.

To the extent that the increase in utilization results in improved health outcomes, AB 298 would have a public health impact.

Essential Health Benefits and the Affordable Care Act

AB 298 would not require coverage for a new state benefit mandate and instead would modify cost-sharing terms and conditions of already covered services. Therefore, AB 298 would not exceed the definition of EHBs in California.