Date of Hearing: January 13, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 298 (Bonta) – As Amended January 5, 2026

SUBJECT: Health care coverage cost-sharing.

SUMMARY: Prohibits large group health care service plans (health plans) and health insurers from imposing deductible, coinsurance, copayment or other cost-sharing requirements for in-network health care services provided to enrollees or insureds under 21 years of age, as specified. Specifically, **this bill**:

1) Prohibits a health plan contract or health insurance policy issued, amended, or renewed after January 1, 2027 from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to enrollees or insureds under 21 years of age, except as provided in 2) below.

2) Specifies that high deductible large group health plan contracts and health insurance policies qualifying as eligible for use in combination with a health savings account (HSA) are prohibited from imposing either:

    a) A deductible, coinsurance, copayment, or other cost-sharing requirement for preventive care services provided to an enrollee or insured under 21 years of age; or,

    b) Coinsurance, copayment or other cost-sharing requirement for in-network health care services provided to an enrollee or insured under 21 years of age once their deductible has been satisfied for the plan year.

EXISTING LAW:

1) Establishes the Department Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Requires health plans and insurers, at a minimum, to provide coverage for and prohibits any cost-sharing requirements for the following:

    a) Evidence-based items or services that had in effect on January 1, 2025 a rating of "A" or "B in the recommendations of the United States Preventive Services Taskforce (USPSTF);

    b) Immunizations that had a recommendation in effect on January 1, 2025 from the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control; and,

    c) With respect to infants, children, adolescents, and women, additional preventive care and screenings provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA) as of January 1, 2025. [HSC § 1367.002 and INS § 10112.2]

3) Permits the State Department of Public Health (DPH) to modify or supplement baseline recommendations by the USPSTF, ACIP and HRSA that were in effect on January 1, 2025. Allows DPH to take into consideration guidance and recommendations from additional medical and scientific organizations, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. [HSC § 120164]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California families are struggling with the high cost of living and unexpected medical expenses can quickly strain household budgets. Preventive care and timely treatment are essential for ensuring children stay healthy and thrive, yet out-of-pocket costs often deter families from seeking necessary care. The author states that this bill addresses financial barriers for children's health care by prohibiting cost-sharing for children's health care services in large group commercial health plans, the source of health insurance for millions of California's children. The author concludes that by facilitating access to timely screenings, early interventions, and ongoing treatments, this bill promotes better health outcomes for children and helps avoid costly medical needs later in life.

2) **BACKGROUND.** Cost can be a barrier to accessing care, even among people with health insurance coverage. Studies have repeatedly shown out-of-pocket costs reduce access to care, especially for those with income restraints or those with chronic illnesses. The California Health Care Foundation (CHCF) reports that 53% of all Californians skipped or delayed care in 2023 because it cost too much. For low-income families that delay in care jumped to 74%. The California Health Interview Survey found that 7.4% of Californians younger than 21 years of age delayed or did not get medical care in 2022, and over 37% of them listed cost, lack of insurance, or other insurance-related issues as the reason. Of those who skipped care across the state, 54% reported that their health worsened. Thirty eight percent of all Californians and 52% of low-income Californians report carrying some sort of medical debt.

   a) **Cost-sharing.** This bill prohibits cost-sharing for enrollees under 21 years of age in large group plans, which cover workers of an employer or association with 51 or more employees. Large group coverage typically requires a portion of costs to be paid out-of-pocket when health services are used. The following are types of cost-sharing explicitly prohibited in this bill:

      i) **Deductible:** Most health plans have an annual deductible that enrollees must meet before the plan pays for the majority of care (with exceptions for free preventive care). The enrollee is responsible for paying the full cost of covered benefits subject to the deductible until the full value of the deductible is paid by the enrollee. For example, if an enrollee has a $300 deductible and uses four $100 services that are subject to the deductible throughout the course of the year, the enrollee would pay for the first three services in full. At that point, the deductible would be met and a different form of cost-sharing such as a copayment or coinsurance may be applied to the fourth visit, depending on the plan. According to the 2025 California Health Benefits Survey (CHBS), 75% of California workers have plans with a deductible and the average deductible is $1,620 annually. One in ten Californians have a deductible

of more than $3,000. Enrollees must pay those dollars out-of-pocket before their plan pays for covered services.

ii) **Copayment:** A copayment is a flat dollar amount paid by the enrollee for services subject to a copayment. Copayments may be applied on their own or to services subject to a deductible after the deductible is met. According to the CHBS, 79% of Californians with insurance through their employer had copays for primary care visits and 73% had copays for specialist visits. The average cost of those copays were $28 and $42 respectively.

iii) **Coinsurance:** Coinsurance is the percentage of the total cost of a service that will be paid by the enrollee. For example, on a $250 service subject to a 10% coinsurance, the enrollee cost-sharing would be $25. Coinsurance may be applied on its own or to services subject to deductible after the deductible is met.

b) **California Health Benefits Review Program (CHBRP).** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:

i) **Premium increases.** Premiums paid by employers and enrollees would increase upon enaction of this bill. Employer premiums are estimated to increase $4.85-$8.30 per member per month (PMPM) depending on the market and regulator. Employee premiums are estimated to increase $1.24-$3.06 PMPM.

ii) **Out-of-pocket decreases.** Average cost-sharing for medical services for enrollees under 21 years of age are estimated to decrease. For enrollees younger than 21 years of age in DMHC- and CDI-regulated commercial large-group coverage, average cost-sharing PMPM is expected to decrease by $12.72 and for those in HSA-qualified high deductible health plans average cost-sharing is expected to decrease by $19.52 PMPM. For enrollees younger than 21 years of age in CalPERS plans, cost-sharing is expected to decrease by $4.97 PMPM.

iii) **Increased utilization of care.** Eliminating cost-sharing for enrollees younger than 21 years of age is anticipated to increase utilization of medical services overall for the 2,588,000 children subject to the benefits of this bill. To the extent that increased utilization results in improved health outcomes, there would be a positive public health impact from this bill.

c) **Office of Health Care Affordability (OHCA) cost targets.** OHCA was established in 2022 in response to widespread cost-related access challenges across California. According to CHCF, over half of Californians say they skip or delay health care due to costs. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA's spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA

approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity's costs exceed the target. Some entities have raised concerns that new legislative insurance mandates will make it difficult for them to meet the established cost growth target.

Current law does not explicitly require OHCA to adjust the cost growth targets based on changes to state policy, such as insurance mandates, that may increase spending. However, it does require OHCA to consider state benefit mandates in its development and enforcement of cost growth targets. Specifically, when establishing cost growth target methodology, OHCA is required to review relevant state policy changes impacting covered benefits, provider reimbursement, and costs, among other factors. In addition, in enforcing cost growth targets, OHCA is required to consider factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

3) **SUPPORT.** The National Center for Youth Law (NCYL) supports this bill, stating that Medi-Cal covers nearly half of California's children and does not charge any out-of-pocket costs for many health care services. Commercial health plans, however, impose cost-sharing on most health care services provided to children. NCYL states that peer-reviewed literature indicates higher cost-sharing at the point of service reduces low-income children's use of health care services. Currently, families with a deductible need to pay the entire cost of care, up to thousands of dollars, until their deductible is met. NCYL argues that even without a high deductible, no parent should be forced to choose between a co-pay for their son's doctor visit and groceries for the next week. NCYL continues that these costs hit all commercially insured families, but they are particularly acute for families of children with chronic conditions and those who incur a sudden illness or injury. Many families have to take off work to care for children who are sick or injured; they should not be doubly penalized by high copayments or paying the full cost for every health care service their child needs. NCYL concludes that this is a common-sense bill that will protect families from high costs and get kids the early intervention, diagnosis, and treatment they need.

4) **OPPOSITION.** The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC) and America's Health Insurance Plans (AHIP) oppose this bill. CAHP, ACLHIC, and AHIP state that cost-sharing is a critical tool in benefit design that helps keep premiums affordable for families and employers while encouraging clinically appropriate use of health care services. CAHP, ACLHIC, and AHIP argue that by eliminating cost-sharing this bill would undermine these goals, leading to higher premiums, increased wasteful utilization, and greater instability in the market. CAHP, ACLHIC, and AHIP continue that Californians are navigating growing uncertainty around health care affordability as shifting federal policies create instability for consumers, employers, and health plans alike. CAHP, ACLHIC, and AHIP argue that while this bill eliminates cost-sharing at the point of service for minors, it does not eliminate the underlying costs of care as higher premiums risk pushing coverage out of reach for families and employers, ultimately reducing access to care. CAHP, ACLHIC, and AHIP conclude that recent amendments limiting the application to large group employers could cause these businesses to flee the fully insured market altogether and reduce state consumer health protections for thousands of employees across the state.

REGISTERED SUPPORT / OPPOSITION:

Support

Biocom California
California Chapter of the American College of Emergency Physicians
California State PTA
California WIC Association
California Youth Empowerment Network
Community Clinic Association of Los Angeles County
Family Voices of California
Health Access California
Mental Health America of California
National Center for Youth Law
Peace and Freedom Party of California

Opposition

America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Kern County Superintendent of Schools Office

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097