PROVIDING OBJECTIVE LEGISLATIVE ANALYSIS

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

California
Health Benefits
Review Program

California Health Insurance

John Lewis, MPA
Associate Director

February 11, 2021

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

HEALTH INSURANCE…

- Covers medically necessary test, treatments, and services (excepting some exclusions)
- Protects against some or all financial loss due to health-related expenses
- Can be publicly or privately financed

HEALTH INSURANCE…

- Is regulated at the federal level or both the federal and state level
- May be (or may not be) subject to state laws, such as benefit mandates

STATE-REGULATED HEALTH INSURANCE…

Health care service plan contracts are:

- Subject to CA Health and Safety Code
- Regulated by DMHC

STATE-REGULATED HEALTH INSURANCE…

Health insurance policies are:

- Subject to CA Insurance Code
- Regulated by CDI

SOURCES OF HEALTH INSURANCE

Prepared by
California Health Benefits Review Program
University of California, Berkeley
MC 3116
Berkeley, CA 94720-3116

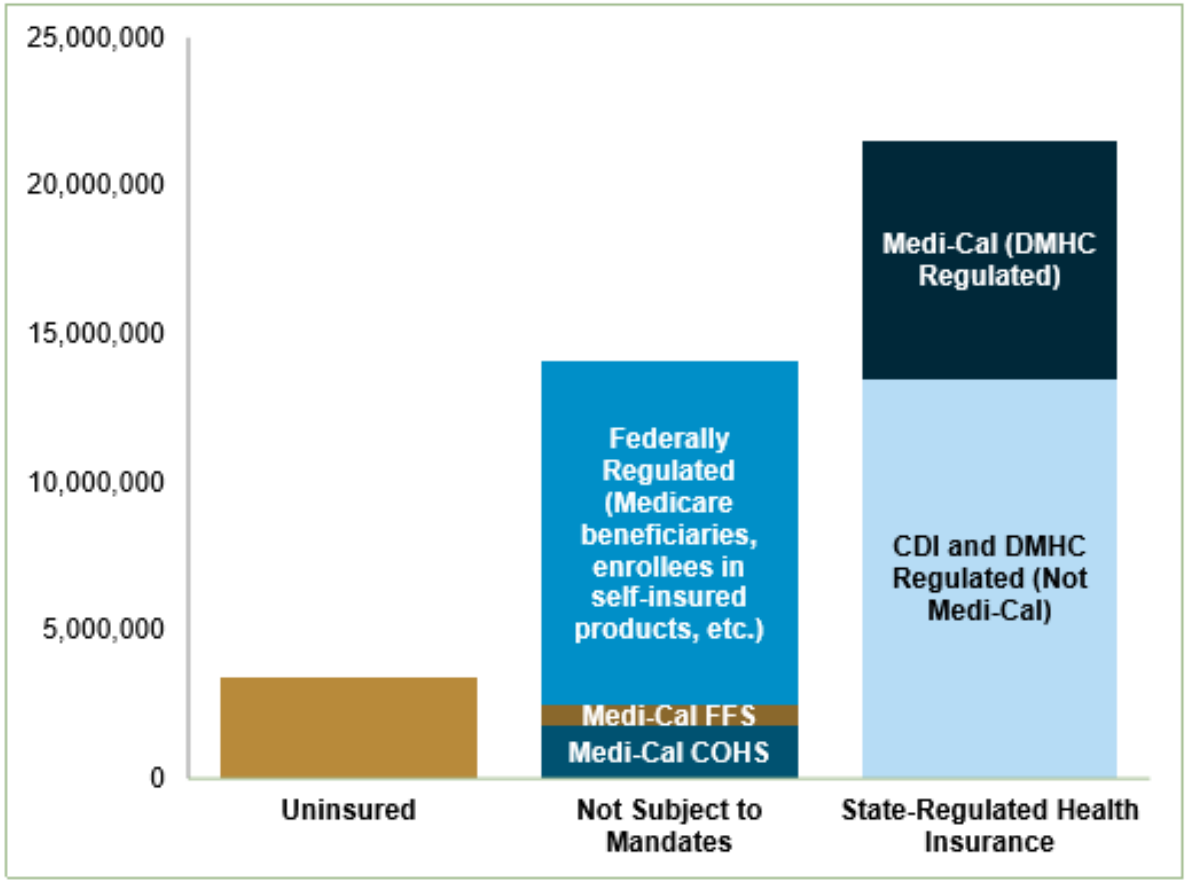
T: (510) 664-5306

www.chbrp.org

Additional copies of this and other CHBRP products may be obtained by visiting the CHBRP website at www.chbrp.org.

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: Estimates of Sources of Health Insurance in California for 2022. Berkeley, CA*

2022 ESTIMATES – SOURCES OF HEALTH INSURANCE



Source: California Health Benefits Review Program, 2021.
Key: FFS = Fee for Service; COHS = County-Organized Health System; CDI = California Department of Insurance; DMHC = California Department of Managed Health Care

HEALTH INSURANCE MARKETS IN CALIFORNIA

DMHC-Regulated Plans	CDI-Regulated Policies
Large Group (101+)	Large Group (101+)
Small Group (2-100)	Small Group (2-100)
Individual	Individual
Medi-Cal Managed Care*	----------

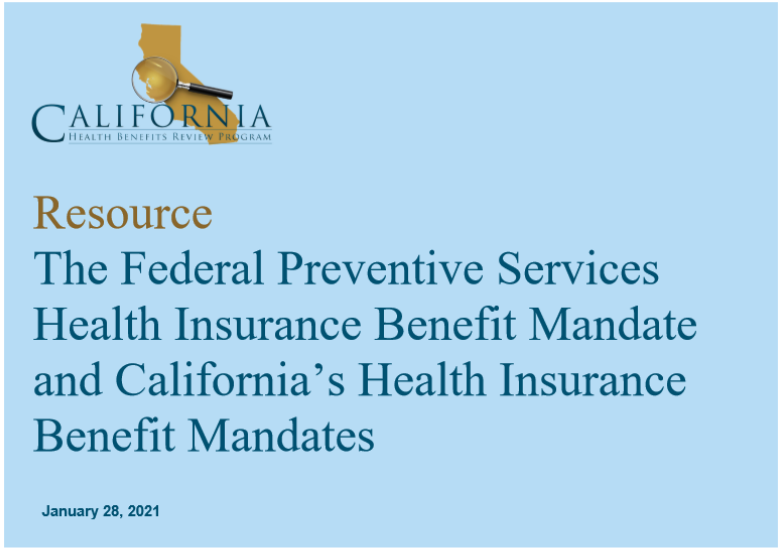
*except county organized health systems (COHS)

BENEFIT MANDATE LIST

BENEFIT MANDATES

- **State Laws** (Health & Safety/Insurance Codes)
  - 79 benefit mandates in California
- **Federal Laws**
  - Pregnancy Discrimination Act
  - Newborns' & Mothers' Health Protection Act
  - Women's Health and Cancer Rights Act
  - Mental Health Parity and Addiction Equity Act
  - Affordable Care Act (ACA)
    - Federal Preventive Services
    - Essential Health Benefits (EHBs)

FEDERAL PREVENTIVE SERVICES



Prepared by
California Health Benefits Review Program

www.chbrp.org

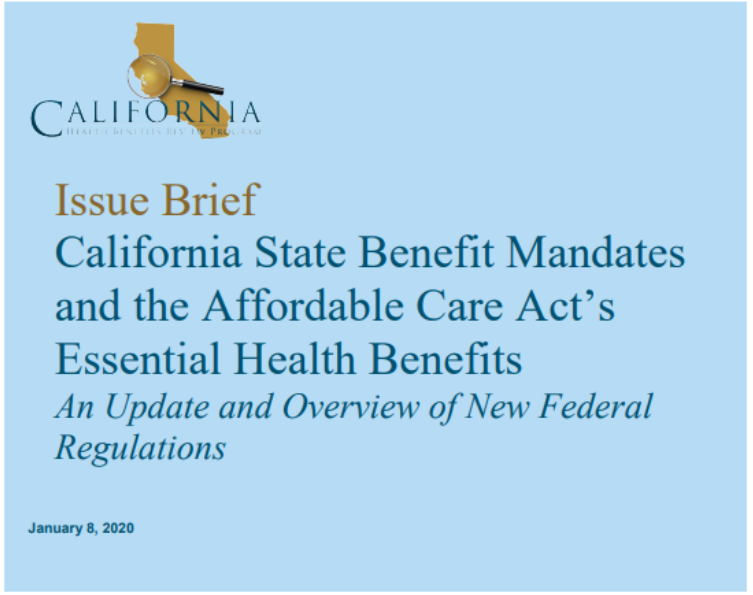
Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates. Berkeley, CA*

FEDERAL PREVENTIVE SERVICES

73 Benefit Mandates from these sources:

- **USPSTF** (United States Preventive Services Task Force) A and B recommendations
- **HRSA** (Health Resources and Services Administration)
  - Health plan coverage guidelines for women's preventive services
  - Comprehensive guidelines for infants, children, and adolescents
- **ACIP** (Advisory Committee on Immunization Practices) recommendations adopted by the CDC (Centers for Disease Control and Prevention)

ESSENTIAL HEALTH BENEFITS (EHBS)


CALIFORNIA

Issue Brief

California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits

An Update and Overview of New Federal Regulations

January 8, 2020

Prepared by
California Health Benefits Review Program

www.chbrp.org

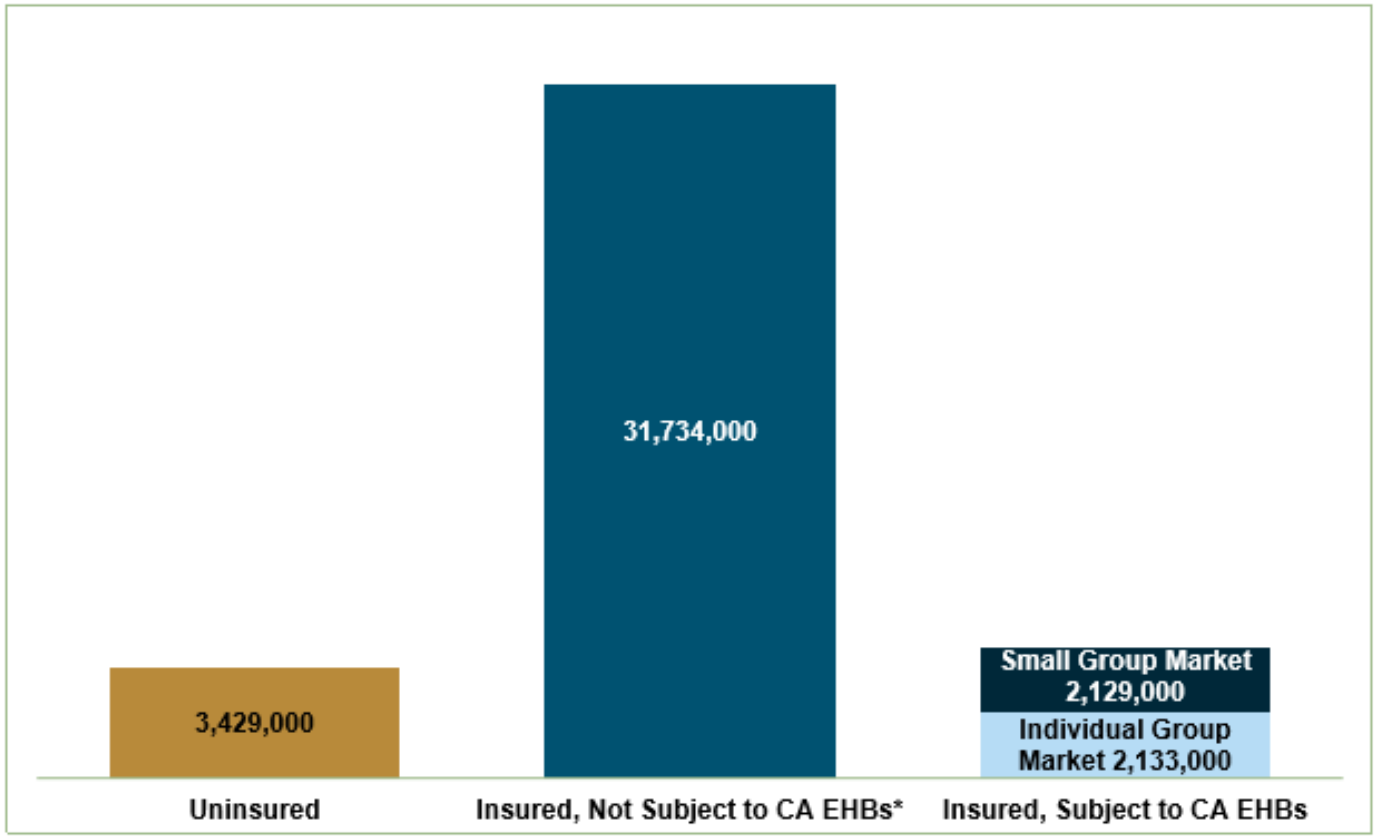
Suggested Citation: *California Health Benefits Review Program (CHBRP). (2020). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA*

ESSENTIAL HEALTH BENEFITS (EHBS)

Categories

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

ESSENTIAL HEALTH BENEFITS (EHBS)



Source: California Health Benefit Review Program, 2021.
Notes: "Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies,

California
Health Benefits
Review Program

California Health Insurance

John Lewis, MPA
Associate Director

February 11, 2021

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

California
Health Benefits
Review Program

Overview: CHBRP

Providing Evidence-Based Analysis to the California Legislature

Garen Corbett, MS
Director

February 11, 2021

CHBRP: BRIDGING ACADEMIA & THE LEGISLATURE

- What is CHBRP?
- Who is CHBRP?
- How does CHBRP work?
- What resources does CHBRP have available?

WHAT IS CHBRP?

- Independent analytic resource located in UC
- Multi-disciplinary
- Provides rapid, evidence-based information to the Legislature
- Neutral analysis of introduced bills at the **request** of the Legislature

WHO IS CHBRP?

- CHBRP Staff (based at UC Berkeley)
- Contract CHBRP Leads
- Task Force of faculty and researchers
- Actuarial firm: Milliman, Inc.
- Librarians
- National Advisory Council
- Content Experts
- Student Assistants
- Graduate Summer Interns

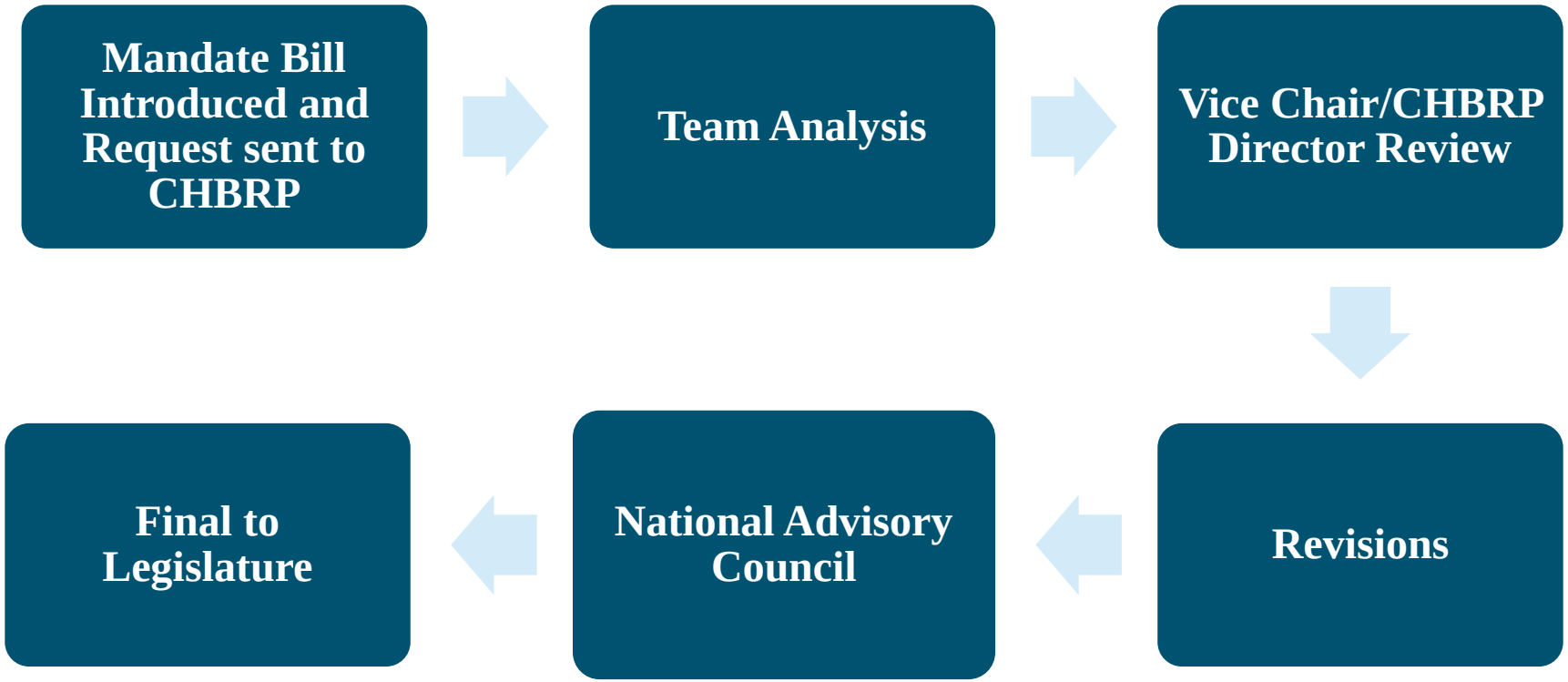




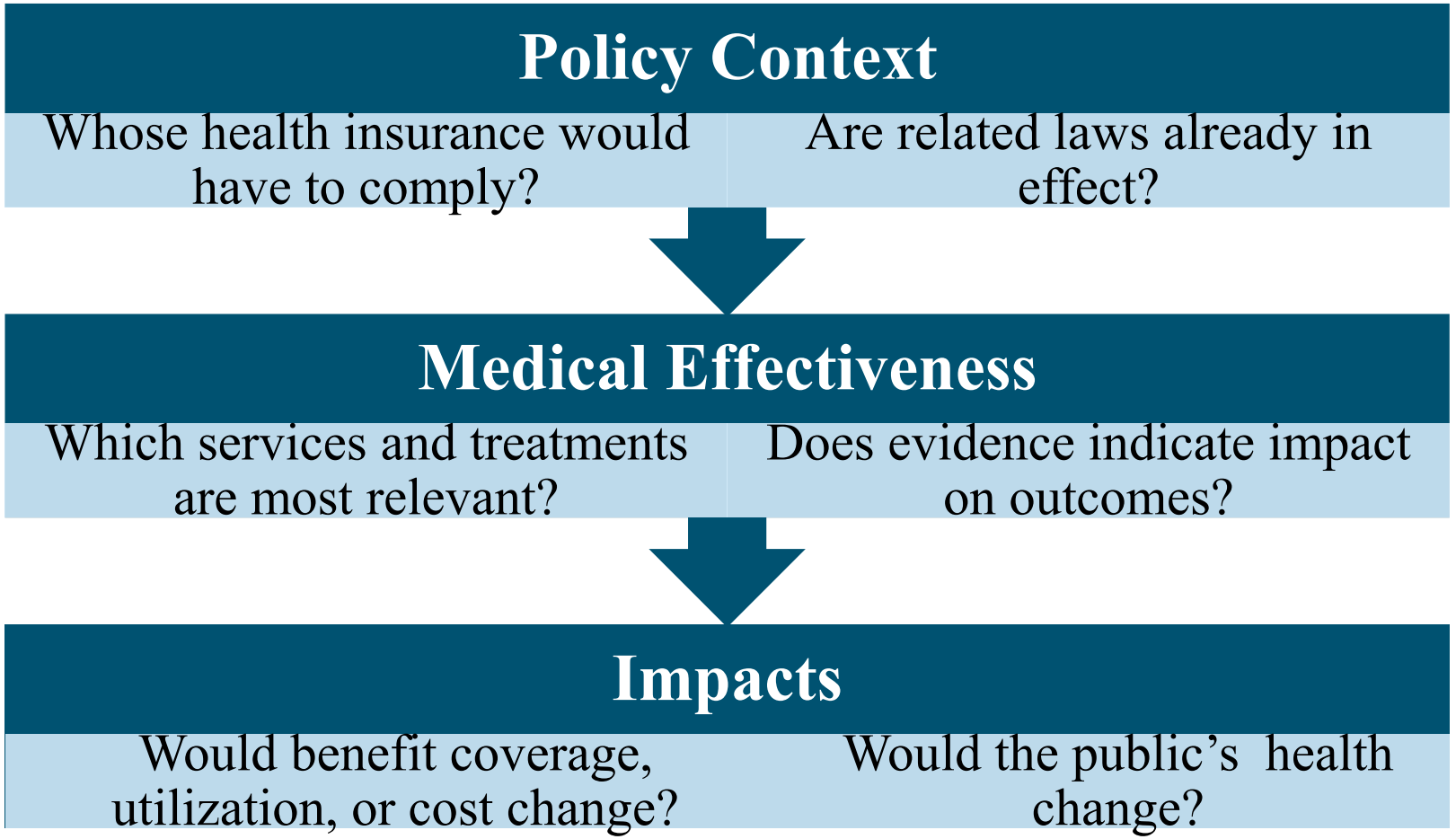

HOW CHBRP WORKS

- Upon receipt Legislature's request, CHBRP convenes multi-disciplinary, analytic teams to provide rigorous, objective analysis ***before*** policy committee hearing
- CHBRP typically analyzes health insurance benefit mandates or other health insurance-related legislation

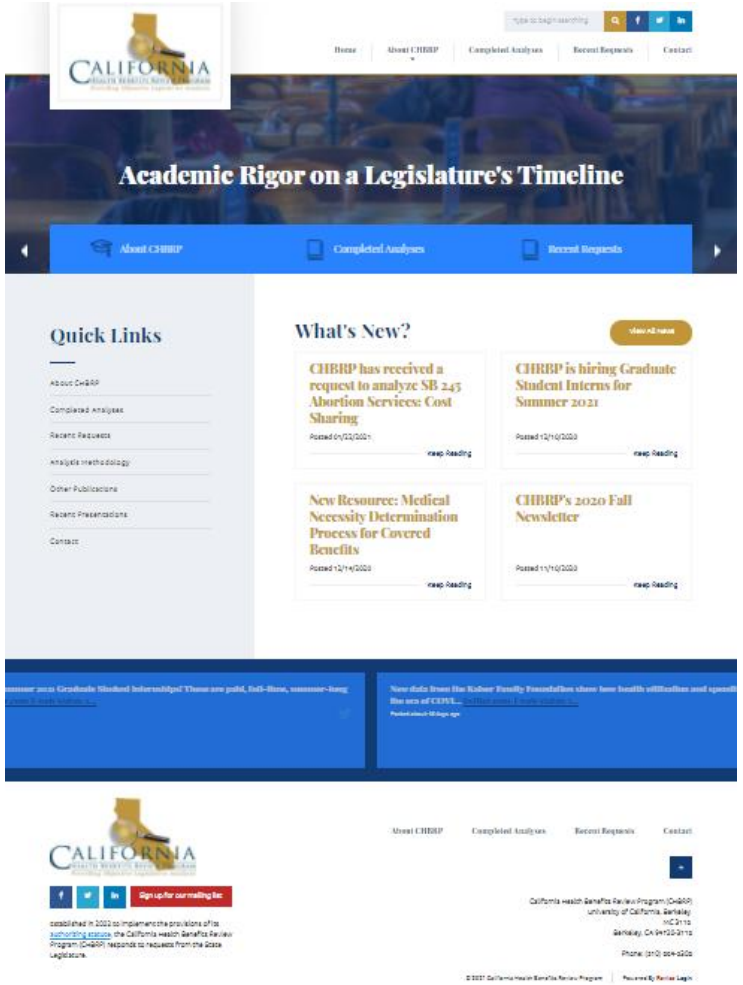
CHBRP'S 60 DAY OR LESS TIMELINE



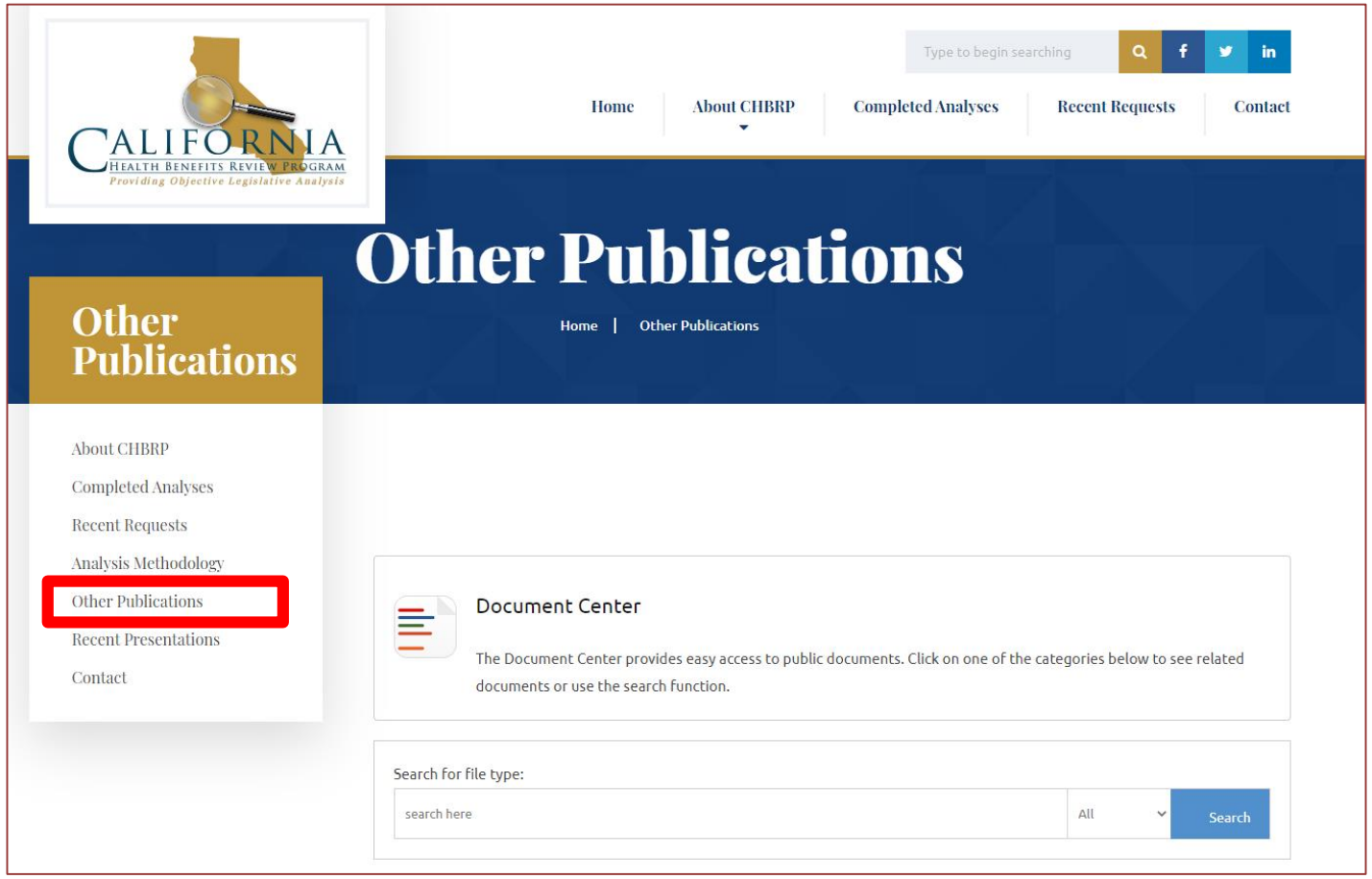
CHBRP ANALYSES PROVIDE:



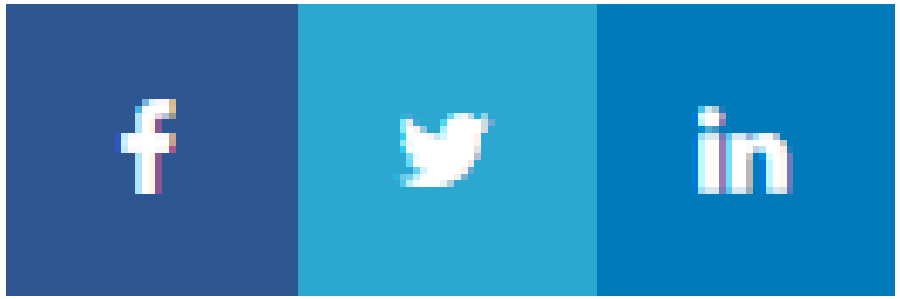
CHBRP'S WEBSITE: WWW.CHBRP.ORG



CHBRP'S WEBSITE: OTHER PUBLICATIONS



CHBRP IS ON SOCIAL MEDIA!



California
Health Benefits
Review Program

Showcasing CHBRP's Methods:

A review of AB 2203 Insulin Cost-Sharing Cap

Adara Citron, MPH
Principal Policy Analyst

February 11, 2021

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

2020 ANALYSIS: AB 2203 INSULIN COST SHARING CAP

As introduced, AB 2203 would limit cost sharing for insulin prescriptions to:

- $50 for a 30-day supply and no more than $100 per month
- regardless of the type or quantity prescribed
- applies to co-payments, co-insurance, and deductibles

Quick facts:

- About 10% of the CA population has been diagnosed with diabetes
- Insulin can be used to treat all three types of diabetes

KEY FINDINGS

Key Findings
Analysis of California Assembly Bill 2203
Insulin Cost-Sharing Cap

Summary to the 2019–2020 California State Legislature, April 13, 2020

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill (AB) 2203 analyzed by CHBRP would limit allowed copayments for insulin to $50 for a 30-day supply and no more than $100 per month total, regardless of the amount or type of insulin prescribed.

1. CHBRP estimates that, in 2020, of the 21.7 million Californians enrolled in state-regulated health insurance, 13.4 million of them will have insurance subject to AB 2203.
2. **Benefit coverage.** At baseline there are 121,442 enrollees who use insulin, where 75,059 enrollees using insulin have cost sharing that does not exceed the AB 2203 cost-sharing cap. Of enrollees using insulin, 46,383 have cost sharing that exceeds the AB 2203 cap. Postmandate, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap.
3. **Utilization.** Postmandate, 38% of enrollees who use insulin at baseline would experience changes in cost sharing, resulting in a 13% increase in utilization of insulin among these enrollees.
4. **Expenditures.** Total net annual expenditures would increase by $2,581,000 (0.002%). This is due to an increase of $20,310,000 in total health insurance premiums paid by employers and enrollees due to the cost-sharing caps, adjusted by a $17,729,000 decrease in enrollee expenses.
   a. Out-of-pocket cost-sharing reductions due to AB 2203 are the greatest for enrollees who have the highest out-of-pocket expenses for insulin at baseline, potentially due to benefit designs such as high deductibles and high coinsurance.
5. **Medical effectiveness.**
   a. There is *limited evidence* on cost-related insulin use/adherence that cost sharing affects insulin use and adherence in patients with diabetes.
   b. There is *insufficient evidence* on the effect of cost sharing for insulin on diabetes-related health outcomes and utilization.

AT A GLANCE (CONT'D)

6. **Public health.** AB 2203 may result in improved glycemic control, a reduction in healthcare utilization, a reduction in long-term complications attributable to diabetes mellitus, and improved quality of life for enrollees that experience a decrease in cost-sharing and improved insulin adherence, or begin using insulin due to reduced costs.

CONTEXT

Diabetes is one of the most common chronic conditions in California and the United States. According to the 2018 California Health Interview Survey (CHIS), about 10% of the population in California has been diagnosed with diabetes.

Diabetes mellitus (DM) is a chronic disease with short- and long-term health effects that prevent the proper production of and/or response to insulin, a hormone that facilitates the transfer of glucose into cells to provide energy.[1] Insulin can be used to treat all three types of diabetes: Type 1 diabetes mellitus (T1DM); Type 2 diabetes mellitus (T2DM); and gestational diabetes (GDM). The American Diabetes Association recommends different insulin regimens based on the type of diabetes a person has. Insulin is necessary for the treatment of T1DM and sometimes necessary for the treatment of T2DM and GDM.

In general, insulin has become expensive for individuals living with diabetes; therefore, cost may be a barrier to insulin use for some individuals. Other identified barriers to insulin use that are independent of cost include regimen complexity and treatment tolerability, as well as injection-related factors.

BILL SUMMARY

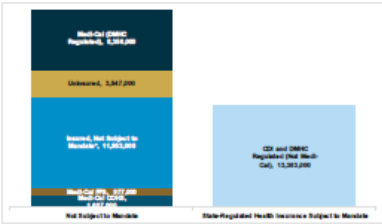
Assembly Bill (AB) 2203 would limit allowed copayments for insulin to $50 for a 30-day supply and no more than $100 per month total, regardless of the amount or type of insulin prescribed. AB 2203 also prohibits plans and

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

policies from applying a deductible, coinsurance, and other cost-sharing requirements on insulin prescriptions. The $100 per month cap may impact enrollees using multiple insulin prescriptions per month.

Figure A notes how many Californians have health insurance that would be subject to AB 2203.

Figure A. Health Insurance in CA and AB 2203



Source: California Health Benefits Review Program, 2020.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates at baseline there are 121,442 enrollees who use insulin in plans regulated by the California Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI), where 75,059 enrollees using insulin have cost sharing that does not exceed the AB 2203 cost-sharing cap. CHBRP estimates 46,383 enrollees using insulin have cost sharing that exceeds the AB 2203 cap. Postmandate, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap.

Utilization

Utilization (measured as number of 30-day supply insulin prescriptions per month per user) is 0.82 for enrollees whose claims did not exceed the cost-sharing cap at baseline and 0.86 for enrollees whose claims did exceed the cost-sharing cap. Postmandate, the group whose claims exceeded the cost-sharing cap at baseline would experience an increase in utilization because this group would experience a decrease in cost sharing due to the bill. Utilization among enrollees who exceeded the cap at baseline is higher than those under the cap, which reflects the greater need for insulin in this group of enrollees.

To estimate changes in utilization postmandate, CHBRP applied an estimate of price elasticity of demand to enrollees exceeding the cap at baseline. CHBRP assumes that for every 10% reduction in cost sharing, insulin utilization increases by 2.57%. Based on this assumption, CHBRP estimates a 51% reduction in cost sharing for those enrollees who have cost sharing exceeding the cost-sharing cap at baseline, and therefore estimates a 13% increase in utilization of insulin postmandate for those enrollees.

Expenditures

Based on Milliman's 2017 Consolidated Health Cost Guidelines Sources Database (CHSD) and Marketscan claims data, the average cost of insulin per prescription per month is $559. For enrollees whose claims do not exceed the cost-sharing cap at baseline, the average cost sharing for insulin is $18, and for those enrollees whose claims exceed the cost-sharing cap at baseline, the average cost sharing for insulin is $74. Postmandate, cost sharing for enrollees who had claims exceeding the cap would experience a 51% reduction in cost sharing, resulting in an average cost share of $36 per month.

AB 2203 would increase total net annual expenditures by $2,581,000 or total net annual 0.002% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase in $20,310,000 in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $17,729,000 decrease in enrollee expenses for covered benefits.

CHBRP estimates that total premiums for private employers purchasing group health insurance would increase by $10,936,000, or 0.0202%. Total premiums for purchasers of individual market health insurance would increase by $6,018,000, or 0.0384%. The greatest change in premiums as a result of AB 2203 is for the small-group plans in the DMHC-regulated market (0.045% increase) and for the individual plans in the CDI-regulated market (0.047% increase).

Based on the medical effectiveness review, which examined the literature on outcomes associated with better adherence to insulin, CHBRP assumed a 10% decrease in diabetes-related emergency department visits due to increased insulin utilization stemming from better adherence to insulin prescription regimens for those who underuse. Offsets stemming from this reduction in diabetes-related emergency department visits are estimated to result in $1.1 million lower allowed costs postmandate in 2021.

MEDICAL EFFECTIVENESS IMPACTS

Key Questions:

1. Effects of cost sharing on insulin use/adherence for enrollees with diabetes?

2. Associated effects of cost sharing for insulin on health outcomes and utilization?

MEDICAL EFFECTIVENESS IMPACTS, CONT.

Key Findings

1. Limited evidence that cost sharing affects insulin use and adherence in patients with diabetes
2. Insufficient evidence on the effect of cost sharing for insulin on diabetes-related health outcomes and utilization

Figure 2. Effect of Cost Sharing for Insulin Use & Adherence

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

- Cost sharing exceeding cap among enrollees using insulin:
  38% at baseline
- Utilization of insulin ⬆
- Total net annual expenditures ⬆ by $2,581,000 or 0.002%
  - Increase in total premiums of $20,310,000
  - Decrease in enrollee cost sharing of $17,729,000

PUBLIC HEALTH IMPACTS

- cost-sharing ⬇
- utilization ⬆
- ? glycemic control, healthcare utilization, long-term complications, quality of life

Questions? Want more info?
www.chbrp.org

Contacts:

Garen Corbett, MS, Director
garen.corbett@chbrp.org

John Lewis, MPA, Associate Director
john.lewis@chbrp.org

Adara Citron, MPH, Principal Policy Analyst
adara.citron@chbrp.org

Karen Shore, PhD, An-Chi Tsou, PhD
info@chbrp.org

Follow CHBRP:

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

PROVIDING OBJECTIVE LEGISLATIVE ANALYSIS

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM