PROVIDING OBJECTIVE LEGISLATIVE ANALYSIS

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM
California Health Benefits Review Program

California Health Insurance

John Lewis, MPA
Associate Director

February 11, 2021
• 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

Resource:
Estimates of Sources of Health Insurance in California for 2022

February 4, 2021

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

2022 ESTIMATES – SOURCES OF HEALTH INSURANCE

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

<table>
<thead>
<tr>
<th>DMHC-Regulated Plans</th>
<th>CDI-Regulated Policies</th>
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<tr>
<td>Large Group (101+)</td>
<td>Large Group (101+)</td>
</tr>
<tr>
<td>Small Group (2-100)</td>
<td>Small Group (2-100)</td>
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<tr>
<td>Individual</td>
<td>Individual</td>
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<tr>
<td>Medi-Cal Managed Care*</td>
<td>-------------------------------</td>
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*except county organized health systems (COHS)
BENEFIT MANDATE LIST

Resource:
Health Insurance Benefit Mandates in California State and Federal Law

Prepared by:
California Health Benefits Review Program
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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

Resource
The Federal Preventive Services Health Insurance Benefit Mandate and California’s Health Insurance Benefit Mandates

January 28, 2021

Prepared by
California Health Benefits Review Program

www.chbrp.org

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)
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)

Notes: “Insured, Not Subject to CA EHBS” includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies.
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

1. Mandate Bill Introduced and Request sent to CHBRP
2. Team Analysis
3. Vice Chair/CHBRP Director Review
4. National Advisory Council
5. Revisions
6. Final to Legislature
CHBRP ANALYSES PROVIDE:

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<th>Medical Effectiveness</th>
<th>Impacts</th>
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<td>Whose health insurance would have to comply?</td>
<td>Are related laws already in effect?</td>
<td>Would benefit coverage, utilization, or cost change?</td>
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<td></td>
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<td>Would the public’s health change?</td>
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<tr>
<td>Which services and treatments are most relevant?</td>
<td>Does evidence indicate impact on outcomes?</td>
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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM
CHBRP’S WEBSITE: WWW.CHBRP.ORG
CHBRP’S WEBSITE: OTHER PUBLICATIONS
CHBRP IS ON SOCIAL MEDIA!
Showcasing CHBRP’s Methods:
A review of AB 2203 Insulin Cost-Sharing Cap

Adara Citron, MPH
Principal Policy Analyst

February 11, 2021
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 of the 2019–2020 California State Legislature, April 15, 2020

AT A GLANCE

The version of California Assembly Bill (AB) 2203 accepted by CHIRP would limit allowable payments for insulin to $50 for a 30-day supply and no more than $150 per month total, regardless of the amount or type of insulin prescribed.

1. CHIRP estimated that, in 2020, at the 7.1 million Californians enrolled in state-regulated health insurance, 1.9 million people will have insulin costs subject to AB 2203.

2. Benefit coverage. At baseline there are 121,442 enrollees who use insulin, where 75,052 enrollees using insulin have cost sharing that does not exceed the AB 2203 cost-sharing cap. Of enrollees using insulin, 46,302 have cost sharing that exceeds the AB 2203 cap.

3. Postmarket, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap.

4. Utilization. Postmarket, 30% of enrollees who use insulin at baseline would experience changes in cost sharing, resulting in a 13% increase in utilization of insulin among those enrollees.

5. Expenditures. Total net annual expenditures would increase by $2,587,000 (0.06%). This is due to an increase of $2,510,000 in total health insurance payments, partly paid by enrollees and enrollees due to the cost-sharing cap, adjusted by a $77,200 decrease in insulin expenditures.


At baseline, the 121,442 enrollees are the greatest cost savings 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.

Medical effectiveness.

- There is limited evidence on cost-related insulin use/advantage that cost sharing affects insulin use and adherence in patients with diabetes.

- There is insufficient evidence on the effect of cost sharing for insulin on diabetes-related health outcomes and utilization.

At a Glance (cont’d)

- Public health. AB 2203 may result in increased glycemic control, a reduction in healthcare utilization, a reduction in long-term complications attributable to diabetes mellitus, and improved health 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 and/or absorption of insulin, a hormone that facilitates the transfer of glucose into cells to provide energy. Insulin can be used to treat all types of diabetes. Type 1 diabetes mellitus (T1DM) and Type 2 diabetes mellitus (T2DM) and professional diabetes (OMC). 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 for the treatment of T2DM and OMC.

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 allowable payments for insulin to $50 for a 30-day supply and no more than $150 per month total, regardless of the amount or type of insulin prescribed. AB 2203 also prohibits plans and

CHIRP estimates that total premiums for private employers purchasing group health insurance would increase by $0,810,000, or 0.02%. Total premiums for purchasers of individual health insurance would increase by $0,916,000, or 0.05%. The greatest change in premiums as a result of AB 2203 is for the small-group plans in the California-regulated market (0.04% increase) and for the individual plans in the CDI-regulated market (0.07% increase).

Based on the medical effectiveness review, which examined the literature on outcomes associated with better adherence to insulin, CHIRP estimated 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 are insulin users. Offsets stemming from this reduction in diabetes-related emergency department visits are estimated to result in $1.1 million lower allowed costs postmarket 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?
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
BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

• Cost sharing exceeding cap among enrollees using insulin: 38% at baseline
• Utilization of insulin $\uparrow$
• Total net annual expenditures $\uparrow$ 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

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