California
Health Benefits
Review Program

California Health Insurance

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January 20, 2022

HEALTH INSURANCE …

- Covers medically necessary tests, 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 at 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 & 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
California Health Benefits Review Program
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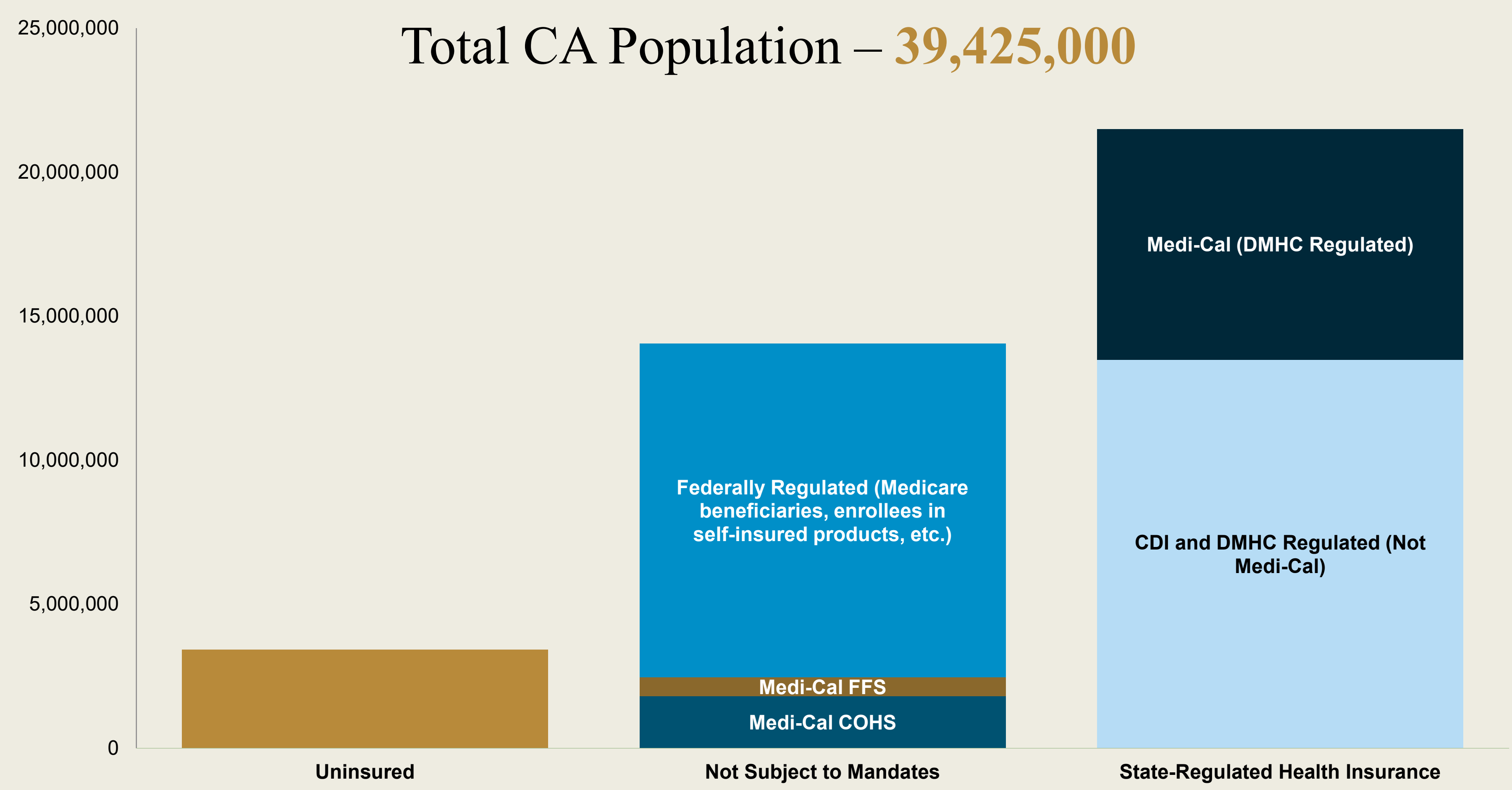
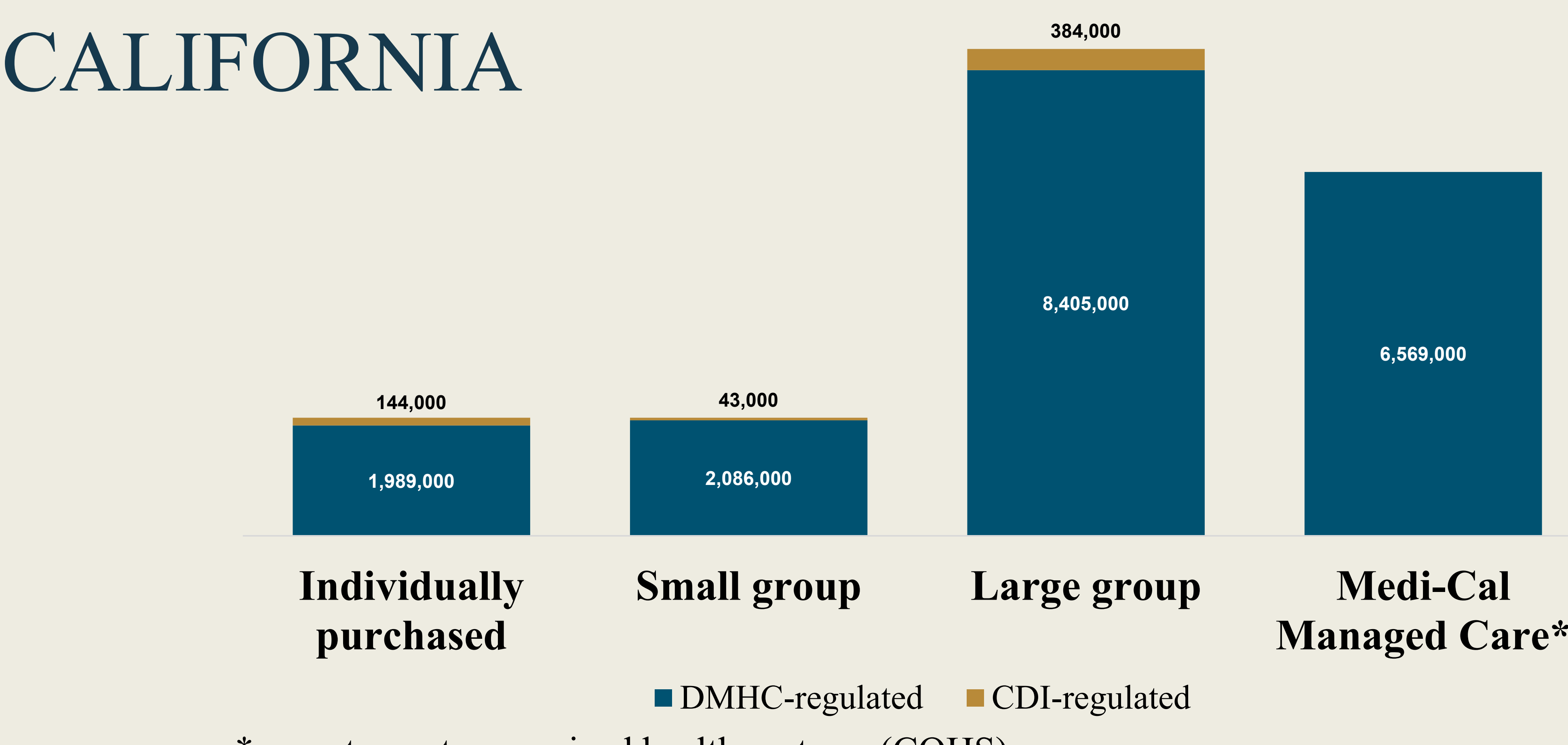
Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: Estimates of Sources of Health Insurance in California for 2022. Berkeley, CA*

2022 ESTIMATES – CA HEALTH INSURANCE



Source: California Health Benefits Review Program, 2022

HEALTH INSURANCE MARKETS IN CALIFORNIA



*except county organized health systems (COHS)

Source: California Health Benefits Review Program, 2022

BENEFIT MANDATES LIST

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

December 2021

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2021). Resource: Health Insurance Benefit Mandates in California State and Federal Law. Berkeley, CA*

BENEFIT MANDATES

State Laws (Health & Safety/Insurance Codes)

- 82 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

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)

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

January 2022

Prepared by
California Health Benefits Review Program

www.chbrp.org

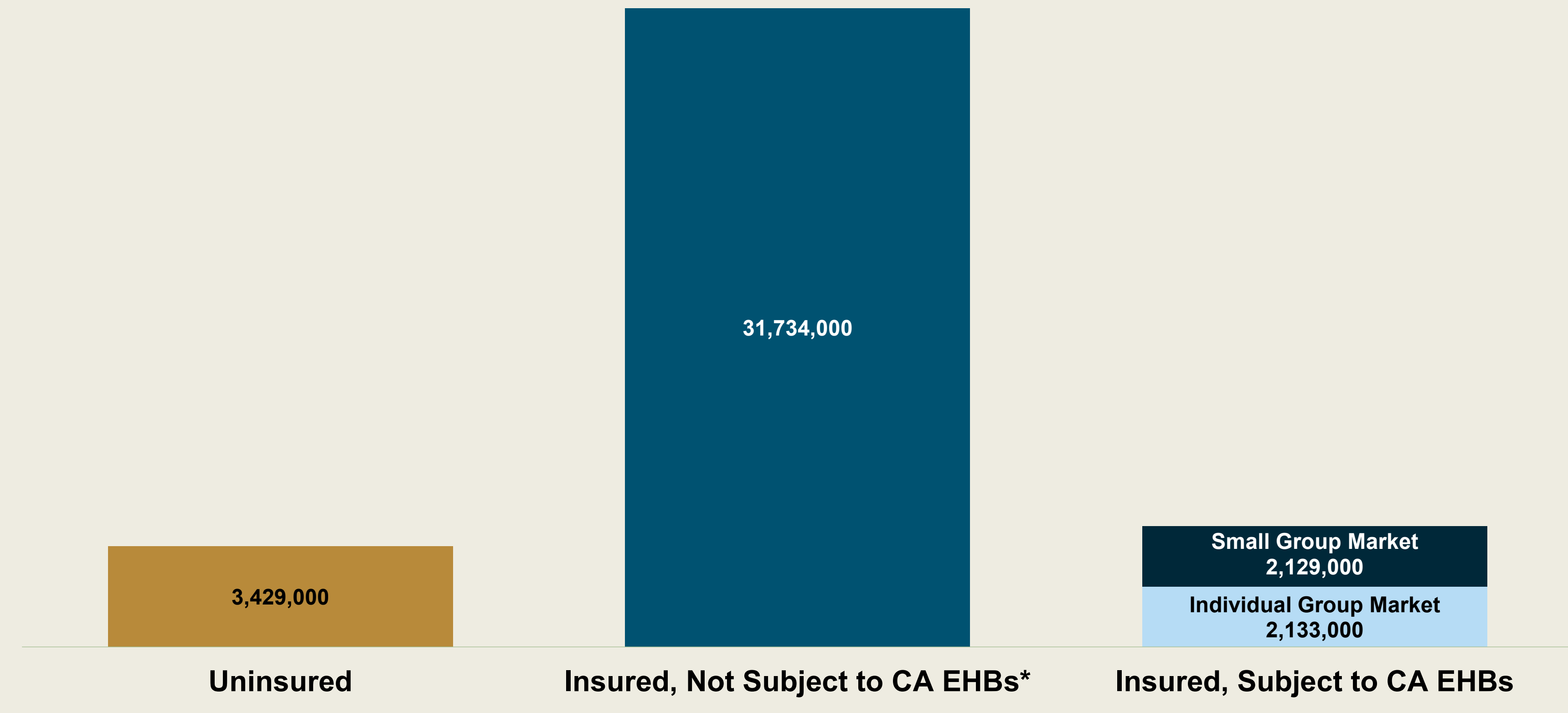
Suggested Citation: *California Health Benefits Review Program (CHBRP). (2022). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA*

ESSENTIAL HEALTH BENEFITS

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



Notes: "Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies, and enrollees in grandfathered individual and small group plans/policies

Source: California Health Benefits Review Program, 2022

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January 20, 2022

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Overview: CHBRP

Providing Evidence-Based Analysis to the California Legislature

Garen Corbett, MS
Director

January 20, 2022

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
- 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 (often researchers w specialized expertise on topic being analyzed)
- 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 staff manage and facilitates:
  - the teams, policy context, ensures reports come together as a cohesive whole.
  - CHBRP staff manage external relationships, contracts, administrative operations.

CHBRP ANALYSES PROVIDE:

Policy Context

Whose health insurance would have to comply?

Are related laws already in effect?

Medical Effectiveness

Which services and treatments are most relevant?

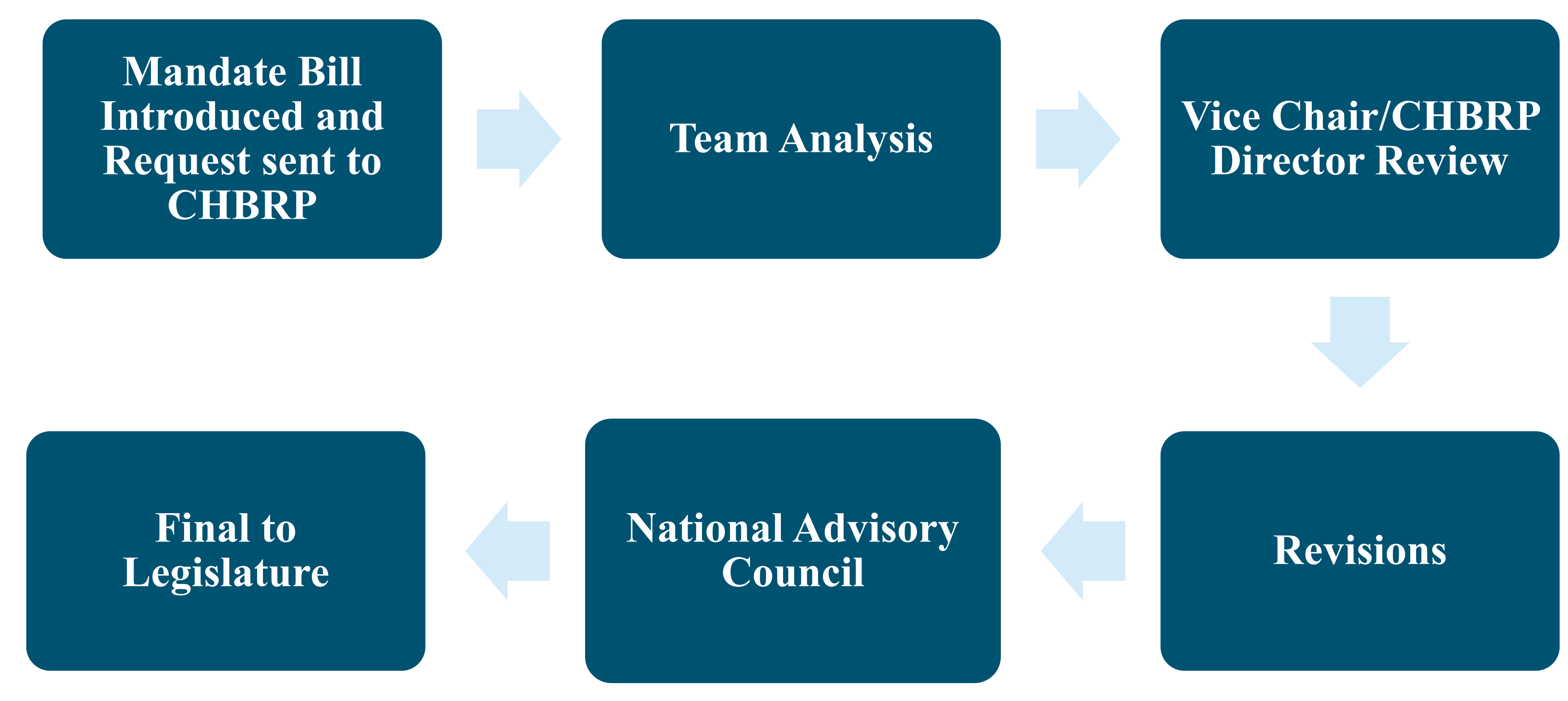
Does evidence indicate impact on outcomes?

Impacts

Would benefit coverage, utilization, or cost change?

Would the public's health change?

CHBRP'S 60 DAY OR LESS TIMELINE



CHBRP’S WEBSITE: [WWW.CHBRP.ORG](http://www.chbrp.org)

CHBRP'S ON SOCIAL MEDIA!

PROVIDING OBJECTIVE LEGISLATIVE ANALYSIS
CALIFORNIA HEALTH
BENEFITS REVIEW PROGRAM

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

California
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Showcasing CHBRP’s Methods:

A review of AB 97 Insulin Affordability

Adara Citron, MPH

Principal Policy Analyst

January 20, 2022

2021 ANALYSIS: AB 97 INSULIN AFFORDABILITY

As introduced, AB 97 would prohibit a deductible from being applied to insulin prescriptions

- Regardless of the type or quantity prescribed
- Other cost sharing (co-payments, co-insurance) would still be permitted

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 97 Insulin Affordability

Summary to the 2021–2022 California State Legislature, April 16, 2021

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

SUMMARY

The version of California Assembly Bill (AB) 97 analyzed by CHBRP would prohibit a deductible from being applied to insulin prescriptions. Other cost sharing (copayments, coinsurance) would still be permitted.

In 2022, of the 21.9 million Californians enrolled in state-regulated health insurance, 13.9 million of them would have insurance subject to, and potentially impacted by, AB 97.

Benefit Coverage: At baseline there are 118,014 enrollees who use insulin. 81,265 of enrollees using insulin *do not* have a deductible (69%), while 36,750 enrollees using insulin *have* a deductible (31%). Postmandate, 100% of enrollees would not need to meet their deductible before paying the normal copayment or coinsurance for their insulin prescription. AB 97 appears not to exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness: CHBRP found a *preponderance of evidence* that higher cost sharing reduces adherence to insulin and lower cost sharing increases adherence to insulin. There is *insufficient evidence* on the associated effect of cost sharing for insulin on diabetes-related health outcomes, including HbA1c levels, outpatient visits, emergency department visits, hospitalizations, long-term complications, and disability/absenteeism rates.

Cost and Health Impacts[1]: In 2022, AB 97 would increase total net annual expenditures by $10,162,000 or 0.008% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase in $23,853,000 in total health insurance premiums paid by employers and enrollees due to the cost-sharing cap, adjusted by a $13,691,000 decrease in enrollee expenses.

The 31% of enrollees with a deductible at baseline would experience a 3% reduction in cost sharing, which results in a 0.26% increase in utilization of insulin postmandate for those enrollees. Average cost sharing for these enrollees decreases from $89 per prescription to $87 per prescription. Almost 10% of enrollees who use insulin and have a deductible would experience a decrease in cost-sharing of more than $20.

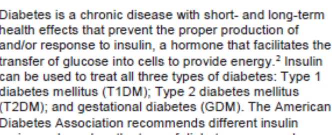
Enrollees using insulin at baseline who have a deductible tend to be users of other high-cost medications and other medical services. For example, among enrollees in health savings account (HSA)-eligible high deductible health plans (HDHPs) (and therefore with a combined medical and pharmacy deductible), almost three quarters (70%) of enrollees have expenditures for medical care and non-insulin brand name prescription medications that exceeds $2,500 annually. As a result, almost all enrollees would reach their deductible or out of pocket maximum within a plan year, regardless of whether insulin is subject to the deductible.

Due to the small decrease in cost sharing and small increase in utilization, CHBRP projects no measurable public health impact. However, at the person-level, for enrollees who would not otherwise meet their deductible or out of pocket maximum and would therefore experience a higher change in cost sharing, AB 97 may result in improved glycemic control, a reduction in healthcare utilization, a reduction in long-term complications attributable to diabetes, 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 mellitus (DM), frequently referred to as diabetes, is one of the most common chronic conditions in California and the United States. According to the 2019 data from the Behavioral Risk Factor Surveillance System, about 10% of the adult population in California has been diagnosed with diabetes. The incidence of diabetes is highest among adults aged 65 and older.

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

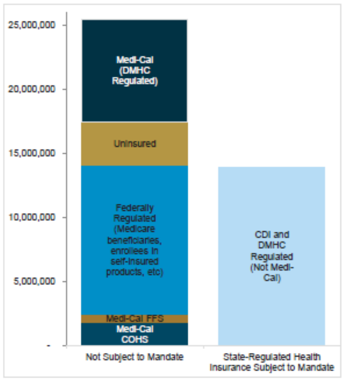


Diabetes is a chronic disease with short- and long-term health effects that prevent the proper production of and/or response to insulin, a hormone that facilitates the transfer of glucose into cells to provide energy.[2] Insulin can be used to treat all three types of diabetes: Type 1 diabetes mellitus (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

Figure A. Health Insurance in CA and AB 97



Source: California Health Benefits Review Program, 2021.

Assembly Bill (AB) 97 would prohibit a deductible from being applied to insulin prescriptions. Other cost sharing (copayments, coinsurance) would still be permitted. Figure A notes how many Californians have health insurance that would be subject to AB 97 (approximately 35% of Californians).

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates that, at baseline, there are 118,014 enrollees who use insulin in DMHC-regulated plans and CDI-regulated policies, where 81,265 enrollees (69%) using insulin do not have a deductible. CHBRP estimates 36,750 enrollees (31%) using insulin have a deductible (see estimates in Table 1). Postmandate, 100% of enrollees would not need to meet their deductible before paying the normal copayment or coinsurance for their insulin prescription.

Utilization

Postmandate, the group of enrollees with a deductible at baseline would experience an increase in utilization, because this group would experience a decrease in cost sharing due to the bill.

To estimate changes in utilization postmandate, CHBRP applied an estimate of price elasticity of demand to enrollees exceeding the cap at baseline. CHBRP bases the estimate of price elasticity on a Goldman et al. (2004) article that found use of insulin specifically decreased by 8% when copayments doubled. Based on this assumption, CHBRP estimates a 3% reduction in cost sharing for those enrollees who have a deductible at baseline, and therefore estimates a 0.26% increase in utilization of insulin postmandate for those enrollees.

Enrollees using insulin at baseline who have a deductible tend to be users of other high-cost medications and other medical services. A majority of these enrollees also have other prescription drug and medical costs that would cause them to meet their deductible or out-of-pocket maximum in a given year. Among enrollees with a pharmacy deductible, 64% have expenditures for other non-insulin brand name prescription medications that exceed $500 annually, and therefore would cause them to meet their pharmacy deductible. Among enrollees enrolled in health savings account (HSA)-eligible high deductible health plans (HDHPs) (and therefore with a combined medical and pharmacy deductible), almost three quarters (70%) of enrollees have expenditures for medical care and non-

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

MEDICAL EFFECTIVENESS IMPACTS

Key Questions:

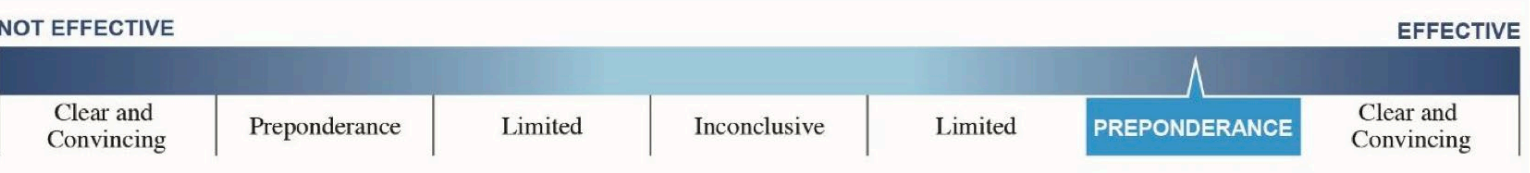
1. Effects of cost sharing on insulin use/adherence for enrollees with diabetes?
2. Associated effects of cost sharing for insulin on health outcomes and utilization?

MEDICAL EFFECTIVENESS IMPACTS, CONT.

Key Findings:

1. Preponderance of 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 4. Effect of Cost Sharing for Insulin Use & Adherence



BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

- **31%** of enrollees using insulin at baseline have a deductible
- **3%** average reduction in enrollee out-of-pocket costs
- Utilization of insulin ⬆ by **0.26%**
- Total net annual expenditures ⬆ by **$10,162,000** or **0.008%**
  - Increase in total premiums of **$23,853,000**
  - Decrease in enrollee cost sharing of **$13,691,000**

PUBLIC HEALTH IMPACTS

- Majority of enrollees have expenditures for other services through which they meet their deductible
- **9.5%** of insulin users ⬇ cost-sharing by **>$20**
- Utilization ⬆ for some
- ? glycemic control, healthcare utilization, long-term complications, quality of life

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Showcasing CHBRP's Methods:

A review of AB 97 Insulin Affordability

Adara Citron, MPH

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Pop Quiz!

Questions? Want more info?
www.chbrp.org

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