January 5, 2022

The Honorable Richard Pan
Chair, California Senate Committee on Health
State Capitol, Room 2191
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Senator Pan:

The California Health Benefits Review Program (CHBRP) was asked by the Senate Committee on Health on December 21, 2021 to analyze proposed amendments to Senate Bill (SB) 473 (Bates), *Insulin Cost Sharing*. The amendments were finalized and published on January 3, 2022. In response, CHBRP is pleased to provide updated cost projections and a high level comparison with the previous cost projections.

Bill Language

The March 10, 2021 version of SB 473 limited cost sharing for insulin to $50 per 30-day supply and no more than $100 total per month, regardless of the number or type of insulin prescriptions.[1] These cost sharing limits applied to deductibles, cost sharing, and copayments.

The January 3 amendments change the cost sharing limit per month per "each dosage form of insulin product" to $35. The cost sharing limit applies to deductibles, cost sharing, and copayments. Additionally, the cost sharing limitations only apply to "one of each dosage form and insulin type." *There is no limit total per month.*

A **dosage form** is how the insulin is delivered (e.g. a pen or a vial) and the **insulin type** is the type of insulin (e.g. short acting, long acting, or mealtime). More information about insulin products is available in the *Background* Section of CHBRP's full analysis.

CHBRP interprets this amended language to mean that per monthly insulin prescription of each type, cost sharing is limited to $35 per month. If an enrollee has two insulin prescriptions of the same dosage form and type (for example, Humalog and Novolog), they could be charged $35 for one prescription and more for the second. This scenario is highly unlikely since enrollees only receive one prescription per form and type of insulin.

As with previous versions of SB 473, if an enrollee has multiple insulin prescriptions per month (of different types), the cost sharing would stack. An enrollee with two prescriptions per month would pay $70 in cost sharing and an enrollee with three prescriptions per month would pay $105 in cost sharing.

[1] CHBRP's analysis of SB 473 Insulin Cost Sharing, published on April 19, 2021, is available at http://chbrp.com/completed_analyses/index.php.

SB 473 applies to enrollees with health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). Based on DMHC and Department of Health Care Services (DHCS) guidance, Medi-Cal managed care enrollees are not subject to SB 473 since the pharmacy benefit is carved out from DMHC-regulated plans.

Methods

As described in CHBRP's April 19th published analysis of SB 473, CHBRP examined Milliman's Consolidated Health Cost Guidelines Sources Database (CHSD) to develop baseline estimates of utilization of insulin. CHBRP calculated utilization rates for enrollees whose claims for insulin exceed the cost-sharing cap at baseline and for those who did not exceed the cap.

CHBRP's approach and assumptions remain consistent with the approach taken in CHBRP's previous analysis.

Benefit Coverage, Utilization, and Cost Impacts

Baseline and Postmandate Benefit Coverage

All of the 13,940,470 enrollees in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies would be subject to SB 473. The 13,940,470 enrollees in DMHC-regulated plans and CDI-regulated policies make up 64% of all enrollees subject to state-level benefit mandates and excludes enrollees in DMHC-regulated Medi-Cal managed care plans.

CHBRP estimates at baseline there are 118,014 enrollees who use insulin in commercial and CalPERS DMHC-regulated plans and CDI-regulated policies, where 59,810 enrollees using insulin have cost sharing that *does not exceed* the SB 473 cost-sharing cap (51%). CHBRP estimates 58,204 enrollees using insulin have cost sharing *that exceeds* the SB 473 cap (see estimates in Table 1). Postmandate, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap.

Baseline and Postmandate Utilization

Baseline utilization (measured as the number of 30-day supply insulin prescriptions per month per user) is 0.83 for enrollees whose claims *did not* exceed the cost-sharing cap at baseline and 0.87 for enrollees whose claims *did* exceed the cost-sharing cap. Postmandate, utilization among enrollees whose claims exceeded the cost-sharing cap at baseline would increase to 0.93 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 assumes that utilization increases by 8% when cost-sharing doubles.

As shown in Table 1, CHBRP estimates a 65% reduction in cost sharing for those enrollees who have cost sharing exceeding the cost-sharing cap at baseline, and therefore estimates a 6.7% increase in utilization of insulin postmandate for those enrollees.

Baseline and Postmandate Per-Unit Cost

The proposed amendments to SB 473 do not affect CHBRP's estimates of unit cost that were presented in its April 19, 2021 full report.

Baseline and Postmandate Expenditures and Premiums

Table 2 and Table 3 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

SB 473 would increase total net annual expenditures by $25,488,000 or 0.02% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase in $59,565,000 in total health insurance premiums paid by employers and enrollees due to the cost-sharing cap and a decrease of $34,077,000 in enrollee expenses.

Premiums

CHBRP estimates that SB 473 would increase premiums by about $59,565,000. Total premiums for private employers purchasing group health insurance would increase by $27,990,000, or 0.05%. Total premiums for purchasers of individual market health insurance would increase by $20,189,000, or 0.13%. Changes in premiums as a result of SB 473 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 2, and Table 3) with health insurance that would be subject to SB 473. The greatest change in premiums as a result of SB 473 is for small-group (0.14% increase) and individual (0.13%) plans in the DMHC-regulated market. Enrollees purchasing DMHC-regulated individual market plans through Covered California would experience an increase of 0.12% and enrollees purchasing DMHC-regulated individual market mirror plans would experience an increase of 0.14%.

Among publicly funded plans, DMHC-regulated Medi-Cal managed care is not subject to SB 473. For CalPERS HMO enrollees, the impact on premiums is estimated to be $0 because CalPERS already offers an insulin in each therapeutic class at cost sharing that is below $35 per 30-day fill.

Average enrollee cost-sharing expenses per user

For baseline insulin users, SB 473 caps on cost sharing only impact those enrollees who are above the cap at baseline. Overall, 49% of enrollees who use insulin at baseline would experience changes in cost sharing. For enrollees whose claims *do not exceed* the cost-sharing cap at baseline, the average monthly cost sharing for insulin is $18. For enrollees whose claims *exceed* the cost-sharing cap at baseline, the average monthly cost sharing for insulin is $84 at baseline and would decrease by 65% to $29 per month postmandate (Table 1).

It is possible that some enrollees who had deferred insulin treatment due to cost could begin using insulin postmandate; thus, this group of enrollees would incur cost sharing postmandate where they did not have cost sharing at baseline. However, this group is estimated to be relatively small. Per CHBRP's content expert, forgoing insulin completely after a physician has prescribed it is something that will occur among only those with type 2 diabetes mellitus (T2DM) where symptoms or the clinical

consequences of not having the insulin are not felt by the patient. Literature suggests approximately 2.5% of people who were prescribed insulin never started their prescription in the past year due to cost. Thus, for some enrollees, cost sharing may be the sole barrier to filling their insulin prescription; however, it is not known what the baseline cost sharing is for this group if they did fill their prescription (i.e., what proportion of non-users are above the cap), nor is it known what cost-sharing threshold would stimulate utilization among these enrollees. While CHBRP expects some demand response from this group when cost sharing is lowered postmandate, CHBRP expects it would be a relatively low utilization increase that would not substantially change the results of this analysis.

The enrollees most likely to experience the greatest cost-sharing reductions postmandate are those who are enrolled in plans that require significant deductibles to be met before coinsurance is applied to the insulin purchase, e.g., HDHPs, Bronze, and Silver plans. CHBRP estimates that for enrollees subject to SB 473, approximately 19% of large-group, 37% of small-group, and 61% of individual market enrollees are in plans or policies with prescription drug deductibles, where deductibles may have a material impact on insulin cost sharing. The estimates of cost-sharing reductions presented below include the total impact on cost-sharing incurred by the enrollee, including deductibles, coinsurance, and copays. CHBRP modeled the impact of deductibles using the underlying benefit designs for members in the CHSD data source.

Cost-sharing reductions due to SB 473 are the greatest for enrollees who have the highest cost-sharing expense for insulin at baseline. Among the enrollees impacted by the cost-sharing cap, enrollees with out-of-pocket expenditures for insulin in the top 1% at baseline have an annual savings of greater than $2,924 (Table 4). The annual savings for the top 5%, 10%, and 20% of enrollees based on cost-sharing expenditures for insulin is greater than $1,578, $959, and $468, respectively. The median annual savings for an enrollee is $112.

Table 4. Enrollee Cost Sharing Impact of SB 473 (Among Enrollees Exceeding the Cost-Sharing Cap at Baseline) - revised for 1/3/2022 amendments

Cost Sharing Expenses	Baseline (Uncapped Annual Cost)	Postmandate (Capped Annual Cost)	Annual Savings
Top 1% of enrollees have cost/savings greater than	$3,361	$840	$2,924
Top 5% of enrollees have cost/savings greater than	$1,915	$643	$1,578
Top 10% of enrollees have cost/savings greater than	$1,330	$530	$959
Top 20% of enrollees have cost/savings greater than	$855	$420	$468
Median enrollee cost/savings	$400	$215	$112

Source: California Health Benefits Review Program, 2022.
Note: Because the top 1% of uncapped enrollees are not the same exact group of people as the top 1% of capped enrollees, savings does not equal baseline cost-sharing expenses minus postmandate cost-sharing expenses. Not all members have coverage for a full 12 months, so annualized costs and savings could be greater. For the purpose of this table, CHBRP applied the induced utilization factor from Goldman (2004) and the monthly cost sharing cap to the observed experience for every enrollee using insulin. In practice, not all enrollees will follow this pattern, particularly the outliers.

Out-of-pocket spending for covered and noncovered expenses

CHBRP estimates that the 58,204 enrollees with covered expenses above the cap at baseline would receive a total $34,077,000 reduction in their out-of-pocket spending for covered and noncovered expenses associated with SB 473 (Table 1).

Potential Cost Offsets or Savings in the First 12 Months After Enactment

CHBRP assumed there would be a 10% decrease in diabetes-related ER visits due to increased insulin utilization stemming from better adherence to insulin prescription regimens for those who underuse postmandate. Offsets stemming from this reduction in diabetes-related ER visits are estimated to result in $2,571,000 lower allowed costs postmandate in 2022.

Public Health Impacts

The segment of the insured population most impacted by SB 473 would be enrollees for whom a deductible applies before the copay, or for enrollees with high-deductible plans, which require the enrollee to pay the full price for insulin until the deductible is met for the year. Also affected are enrollees with diabetes who are prescribed more than one type of insulin or a higher-tiered insulin (Cefalu et al., 2018).[2] Enrollees with type 2 diabetes mellitus (T2DM) are more likely than those with type 1 diabetes mellitus (T1DM) to increase utilization owing to the inability of patients with T1DM to limit insulin intake without adverse effects on their health.

The amended version of SB 473 likely continues to 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, although the degree to which this occurs is unknown.

Comparison of Impacts

The January 3 amendments would result in an additional 4,809 enrollees experiencing a reduction in cost sharing due to the lower cost sharing cap. The average monthly cost sharing would decrease from $84 to $29 for enrollees whose claims exceeded the $35 cost-sharing cap at baseline, compared to a decrease of $88 to $39 for enrollees whose claims exceeded the $50 cost-sharing cap and total monthly cap of $100 at baseline. The newly amended version of SB 473 would result in an average 6.7% utilization increase among enrollees whose cost sharing exceeds the limits, compared to a 6.9% utilization increase as a result of cost sharing changes due to the March 10, 2021 version. Total annual enrollee out-of-pocket expenses would decrease by an additional $6 million and the total annual expenditure increase would be approximately $2 million more as a result of the January 3 amendments.

[2] Cefalu WT, Dawes DE, Gavlak G, et al. Insulin Access and Affordability Working Group: Conclusions and Recommendations. *Diabetes Care*. 2018:41(6):1299-1311.

Thank you for allowing CHBRP the opportunity to further assist. We are happy to answer any questions.

Sincerely,

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CC:

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Assembly Member Anthony Rendon, Speaker of the Assembly
Assembly Member Chad Mayes, Vice Chair, Assembly Committee on Health
Assembly Member Chris R. Holden, Chair, Assembly Committee on Appropriations
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Table 1. SB 473 Impacts on Benefit Coverage, Utilization, and Cost, 2022 – revised for 1/3/2022 amendments

	Baseline (2022)	Postmandate Year 1 (2022)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,945,000	21,945,000	0	0.00%
Total enrollees with health insurance subject to SB 473	13,940,470	13,940,470	0	0.00%
Total percentage of enrollees with coverage subject to SB 473	64%	64%	0%	0.00%
Utilization and Cost				
Number of enrollees using insulin	118,014	118,014	-	0.00%
Enrollees whose claims **do not exceed** the cost sharing cap	59,810	118,014	58,204	97.31%
Enrollees whose claims **do exceed** the cost sharing cap	58,204	-	(58,204)	-100.00%
Utilization per insulin user (# of 30-day supply insulin prescriptions per month)	0.85	0.88	0.03	3.38%
Utilization for enrollees whose claims ***did not* exceed** the cost sharing cap at baseline	0.83	0.83	-	0.00%
Utilization for enrollees whose claims ***did* exceed** the cost sharing cap at baseline	0.87	0.93	0.06	6.66%
Average monthly cost sharing for insulin per insulin user	$50	$24	-$27	-53.21%
Average monthly cost sharing for enrollees whose claims **did not exceed** the cost-sharing cap at baseline	$18	$18	$0	0.00%
Average monthly cost sharing for enrollees whose claims ***did* exceed** the cost-sharing cap at baseline	$84	$29	-$54	-64.92%
Average cost of insulin per prescription per month	$491	$491	$0	0.00%
Expenditures				
Premium (expenditures) by Payer				
Private Employers for group insurance	$55,032,803,000	$55,060,793,000	$27,990,000	0.05%
CalPERS HMO employer expenditures (b) (c)	$5,765,017,000	$5,765,017,000	$0	0.00%
Medi-Cal Managed Care Plan expenditures	$24,150,529,000	$24,150,529,000	$0	0.00%
Enrollee Premiums (expenditures)				
Enrollees for individually purchased insurance	$15,847,507,000	$15,867,696,000	$20,189,000	0.13%
Individually Purchased – Outside Exchange	$4,890,852,000	$4,897,317,000	$6,465,000	0.13%
Individually Purchased – Covered California	$10,956,655,000	$10,970,379,000	$13,724,000	0.13%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	$20,753,446,000	$20,764,832,000	$11,386,000	0.05%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copayments, etc.)	$13,168,032,000	$13,133,955,000	-$34,077,000	-0.26%
Expenses for noncovered benefits (d) (e)	$0	$0	$0	0.00%
Total Expenditures	$134,717,334,000	$134,742,822,000	$25,488,000	0.02%

Source: California Health Benefits Review Program, 2022.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees.
(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care
(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(e) Although enrollees with newly compliant benefit coverage may have paid for some tests before SB 473, CHBRP cannot estimate the frequency with which such situations may have occurred and therefore cannot estimate the related expense. Postmandate, such expenses would be eliminated, though enrollees with newly compliant benefit coverage might, postmandate, pay for some tests for which coverage is denied (through utilization management review), as some enrollees who always had compliant benefit coverage may have done and may continue to do, postmandate.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems, OPD = Outpatient Prescription Drug

Table 2. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022 – revised for 1/3/2022 amendments

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB 473	8,405,000	2,086,000	1,989,000	889,000	0	0	384,000	43,470	144,000	13,940,470
Premiums										
Average portion of premium paid by employer	$426.28	$374.49	$0.00	$540.40	$226.61	$478.87	$530.80	$421.81	$0.00	$84,948,349,000
Average portion of premium paid by employee	$141.02	$180.89	$624.47	$96.86	$0.00	$0.00	$186.55	$212.07	$545.57	$36,600,954,000
Total premium	**$567.30**	**$555.38**	**$624.47**	**$637.27**	**$226.61**	**$478.87**	**$717.35**	**$633.88**	**$545.57**	**$121,549,303,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	$43.61	$121.70	$173.51	$50.75	$0.00	$0.00	$134.75	$197.13	$184.11	$13,168,032,000
For noncovered benefits (e)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$610.91**	**$677.07**	**$797.97**	**$688.02**	**$226.61**	**$478.87**	**$852.10**	**$831.01**	**$729.68**	**$134,717,335,000**

Source: California Health Benefits Review Program, 2022.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) As of January 2021, approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 3. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022 – revised for 1/3/2022 amendments

	DMHC-Regulated						CDI-Regulated			
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**Total**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB 473	8,405,000	2,086,000	1,989,000	889,000	0	0	384,000	43,470	144,000	13,940,470
Premiums										
Average portion of premium paid by employer	$0.1340	$0.5423	$0.0000	$0.0000	$0.0000	$0.0000	$0.1355	$0.5352	$0.0000	$27,990,000
Average portion of premium paid by employee	$0.0443	$0.2620	$0.8021	$0.0000	$0.0000	$0.0000	$0.0476	$0.2691	$0.6048	$31,575,000
Total premium	$0.1783	$0.8043	$0.8021	$0.0000	$0.0000	$0.0000	$0.1831	$0.8043	$0.6048	**$59,566,000**
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	-$0.0862	-$0.4929	-$0.4917	$0.0000	$0.0000	$0.0000	-$0.0883	-$0.4929	-$0.3759	-$34,077,000
For noncovered benefits (e)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0921	$0.3113	$0.3104	$0.0000	$0.0000	$0.0000	$0.0948	$0.3113	$0.2289	**$25,489,000**
Percent change										
Premiums	0.0314%	0.1448%	0.1284%	0.0000%	0.0000%	0.0000%	0.0255%	0.1269%	0.1109%	0.0490%
Total expenditures	0.0151%	0.0460%	0.0389%	0.0000%	0.0000%	0.0000%	0.0111%	0.0375%	0.0314%	0.0189%

Source: California Health Benefits Review Program, 2022.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) As of January 2021, approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.