Date of Hearing: June 2, 2020

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Lorena Gonzalez, Chair
AB 2203 (Nazarian) – As Amended May 20, 2020

Policy Committee: Health Vote: 12 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill establishes a copayment cap for insulin and prohibits health plans and insurers from imposing cost-sharing on a covered insulin prescription, except for a copayment not to exceed $50 per 30-day supply of insulin, and no more than $100 total per month for all insulin prescriptions, regardless of the amount or type of insulin.

It also authorizes the Attorney General to investigate insulin prices and publish a public report with the findings.

FISCAL EFFECT:

1) According to the California Health Benefits Review Program (CHBRP), this bill has no cost to Medi-Cal (GF/federal) nor CalPERS.

2) CHBRP reports the following private market costs:

   a) Increased employer-funded premium costs in the private insurance market of approximately $20.3 million.

   b) Reduced out-of-pocket expenses among insured individuals of $17.8 million.

3) Minor and absorbable one-time costs to the California Department of Insurance (Insurance Fund) and Department of Managed Health Care (Managed Care Fund) to verify compliance.

4) Unknown GF cost pressure to the Department of Justice to investigate insulin prices.

COMMENTS:

1) **Purpose**. According to the author, people with type 1 diabetes and some with type 2 diabetes must have insulin to live, but price increases for those whose coverage requires significant cost-sharing have made insulin unaffordable. The author states this bill is a concrete solution to the high cost of insulin that is a burden to people with diabetes.

2) **Background**. Insulin, a hormone that facilitates the transfer of glucose into cells to provide energy, was developed nearly a century ago as a biologic drug. Individuals who have diabetes use regular injections of insulin to keep blood sugar levels in a normal range.

3) **High Cost of Insulin**. The high cost of insulin is a concern for health care advocacy groups, health plans, insurers and consumers. There are no generic, or more accurately, "biosimilar,"

versions of insulin available. According to a discussion paper published in the Mayo Clinic Proceedings in January 2020, "The High Cost of Insulin in the United States: An Urgent Call to Action," "Insulin pricing in the United States is the consequence of the exact opposite of a free market: extended monopoly on a lifesaving product in which prices can be increased at will, taking advantage of regulatory and legal restrictions on market entry and importation." According to CHBRP, the average list price of brand-name insulin nearly tripled between 2007 and 2018, increasing by 262%. While the average net price also increased, the increase was smaller (51%) and was offset by discounts such as those paid by manufacturers.

4) **Drug Co-pay Cap**. The issue of high patient cost-sharing for drugs was recently addressed in a comprehensive manner by SB 1021 (Weiner), Chapter 787, Statutes of 2018, which set a cap of $250 for a 30-day drug supply of all drugs, in effect until January 1, 2024.

5) Governor's Proposals. As part of the Governor's 2020-21 January budget, the administration introduced several prescription drug-related proposals. One proposal that would authorize the state to negotiate contracts with drug makers to manufacture selected generic drugs on behalf of the state. According to the Governor, this proposal would increase competition in the generic market, resulting in lower generic drug prices for all purchasers. Insulin was one of the products discussed in relation to this proposal. The Governor's 2020-21 January budget also assumes the state transitions all Medi-Cal enrollees to the statewide, centrally administered fee-for-service pharmacy benefit to better leverage the state's market power.

6) **Impact of This Bill**. This bill will generally raise premiums for plans that currently have less generous prescription drug coverage. It would lower costs for the minority of enrollees on insulin who have cost-sharing of over $50 per month, about 46,000 enrollees out of 121,000, by an average of $38 per month. For a smaller number of people who have to meet a deductible before coverage kicks in, this first-dollar coverage for insulin could result in dramatically lower costs.

   Based on a review of the literature, 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 insulin based on costs. Offsets stemming from this reduction in diabetes-related emergency department visits are estimated to result in $1.1 million lower allowed costs post-mandate in 2021.

7) **Support**. According to the American Diabetes Association, sponsor of this bill, this bill is needed to protect people living with diabetes who need insulin to survive from high out-of-pocket costs. The California Academy of Family Physicians writes that making insulin more affordable will help keep patients who use this lifesaving drug healthy and out of health care settings where they can be exposed to the COVID-19 virus, which poses increased risks for people with diabetes.

8) **Opposition**. America's Health Insurance Plans contends this legislation is potentially unworkable and does nothing to prevent drug manufacturers, the source of high insulin prices, from continuing to increase prescription drug prices. The Association of California Life and Health Insurance Companies and the California Association of Health Plans contend the prescription drug copay cap in existing law was carefully and thoughtfully negotiated to

protect all consumers from the high cost of specialty drugs while ensuring that the cost of health care remained affordable.

9) **Fiscal and Policy Considerations**.

a) **Limited Evidence of Public Health Benefit from Lower Cost-sharing.** Although there is a large body of literature on the effects of cost sharing and adherence to prescribed drug regimens, CHBRP found limited evidence on the effect of cost sharing on insulin use for diabetes treatment. Limited evidence indicates that the studies have limited generalizability to the population of interest or, in some instances, the studies have a fatal flaw in research design or implementation. According to CHBRP, this bill's limits on cost-sharing 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. For those patients who attain good glycemic control through increased adherence to insulin, diabetes-related comorbidities that are known to lead to premature death could be prevented, delayed, or ameliorated.

b) **Special Treatment of Insulin**. High cost-sharing for prescription drugs is a concern for many people, and it has been addressed broadly by prior legislation that limited cost-sharing to $250 per month. This bill singles out insulin for lower maximum co-payments than other high-cost drugs, meaning a greater portion of the cost will be borne by all enrollees while there is growing concern about cost increases by manufacturers of insulin specifically. Conditions like rheumatoid arthritis, lupus, multiple sclerosis, HIV and many more are also associated with high-cost drugs and, depending upon the design of an enrollee's plan, high cost-sharing. On balance, it appears reasonable to treat similarly situated drugs similarly with a consistent policy rationale.

c) **Lowering Cost-sharing for Drugs Does Not Lower Drug Costs**. Lower cost-sharing does not address the problem of high drug prices— it just spreads the cost around differently. The approach taken by this bill protects individual consumers who use insulin from high costs for insulin. It does not lower drug costs generally – the costs are still paid by individuals and employers in the form of premiums.

d) **Different Levels of Coverage Offer Different Cost-sharing by Design**. According to CHBRP, most enrollees who use insulin have cost-sharing under $50, and of those individuals the average cost-sharing per month is $18. These individuals generally have plans or policies that offer relatively more generous coverage for all products and services. According to CHBRP, most individuals with high cost-sharing for insulin have high-deductible plans that have high cost-sharing generally. High-deductible plans are designed to have lower-cost premiums and less generous coverage, which means high cost-sharing is a foundational feature of such plans. This bill makes an exception, for insulin only, that no other deductible, copayment or coinsurance may apply, even in plans and policies explicitly designed to offer lower premiums and less generous coverage.