

AB339 Health Care Coverage: Outpatient Drugs (Gordon) *Protecting Patients from Discriminatory Benefit Design*

[AB339](#) (Gordon) protects Californians with chronic conditions like asthma, hepatitis, HIV/AIDS, multiple sclerosis, or other conditions for which the standard of care may call for high-cost specialty medications. Reflecting recent federal guidance and going further, the bill does several things:

- It requires insurers to cover medically necessary prescription drugs, including those for which there is no therapeutic equivalent. If a single tablet regimen is the standard of care, as it is for certain HIV/AIDS drug cocktails that, too, must be covered.
- Requires *formularies* (list of medications covered by a health plan) to be based on clinical guidelines and peer-reviewed scientific evidence first and foremost—not only on cost.
- Prohibits placing most or all of the drugs to treat a condition on the highest cost tiers of a formulary—this is inherently discriminatory.
- Caps out of pocket drug costs at no more than \$275 for a 30 day prescription, 1/24th the annual out of pocket limit—because people who need drugs this expensive usually need other drugs, doctor visits, lab tests, and other care.

The Need for AB339

For those who buy coverage on their own as individuals or who have health insurance benefits through their small business employer, the ACA requires for the first time that prescription drugs be covered. Insurers can no longer deny coverage or charge higher premiums to people with pre-existing conditions. But what they can do is make it costly for people with chronic conditions to get the specialty medications they need. For example, they can place the drugs on the fourth “specialty tier” tier of a drug formulary and charge “coinsurance” of up to 20% or 30% as opposed to a fixed co-payment. This leaves patients facing high out-of-pocket costs. Some will hit their out of pocket spending limit of \$6,600 in a single month; some might skip a dose or avoid filling prescriptions entirely.ⁱ Others seeking to enroll or switch plans may take one look at the formulary and run the other way—in this instance the health plan’s formulary has the same discriminatory effect as pre-ACA insurance practices. On November 26, 2014 the Federal Government released the HHS Notice of Benefit and Payment Parameters for 2016 proposed rule and reiterated the prohibition on discrimination found in Section 1302(b)(4) of the Affordable Care Act and 45 CFR 156.125.ⁱⁱ According to that guidance, the following industry practices may be discriminatory:

- Putting most or all drugs that treat a specific condition on the highest cost tiers;
- Refusal to cover a single-tablet drug regimen or extended-release product;
- Not following clinical guidelines and medical evidence when designing formularies.

The Bottom Line

California law already required that if prescription drugs were covered, the health plan must cover medically necessary drugs, including those for which there is no therapeutic equivalent; but it did not protect people from having all the drugs they needed placed on the highest cost tier. AB339 implements and improves upon federal and state law and ensures that benefit and cost sharing standards are based on clinical guidelines as well as cost.



Melanie's Story...

I have MS - a lifelong disease involving degeneration of the nervous system. I was diagnosed at age 30 - I'm 37 now, and still doing pretty well and have been taking disease-modifying drugs all along. But these drugs are very expensive! When I was first diagnosed, my insurance required me to pay 30% of the cost of my MS medication. This added up to \$900 per month—the same as my rent!

Frequently Asked Questions

How do we know this is a problem in California?

Some insurance products in the California individual market in 2014 failed to cover the AIDS drug cocktail, a single-tablet drug regimen that is the standard of care. Some individuals have stayed on the AIDS Drug Assistance Program (ADAP) program rather than transition to comprehensive coverage in the individual market precisely because some plans do not cover the cocktail drug. That's just one example.

Why aren't we dealing with the real problem—the high cost of the drugs in the first place?

Great question! Alongside his budget proposal allocating \$300 million in 2015-16 for Medi-Cal and prison spending on hepatitis C treatments, the Administration has convened a task force to seek longer term solutions to the high cost of specialty medications. The Legislature is also looking into the issue—and there is one bill ([AB463](#) by Assembly Member Chiu) that seeks full transparency on pricing of all pharmaceuticals sold in the state. It may take time to get to the root of this problem—but at least the interest is there on the part of policymakers.

Why not let Covered California deal with this?

Covered California can only address a small portion of the insurance marketplace, part of the individual market. The Covered California Board recently recommended these changes in benefit standards:

- Develop a definition of drug formulary tiers that is mostly consumer friendly but allows plans to place high cost drugs on a “specialty” tier based purely on the cost of the drug to the plan.
- Make at least one drug for a chronic condition available on a lower tier if at least three treatment options would otherwise be on Tier 4.

AB339 will protect consumers regardless of whether they get their plan from Covered California or through their employer.

Please share YOUR story: send email to jhilman@health-access.org

¹ CHBRP, “Analysis of Assembly Bill 1917: Outpatient Prescription Drugs Cost Sharing,” http://chbrp.ucop.edu/index.php?action=read&bill_id=159&doc_type=2.

ⁱⁱ Patient Protection and Affordable Care Act; *HHS Notice of Benefit and Payment Parameters for 2016*, proposed rule, Vol. 79, No. 228 of the Federal Register at p. 70722, published on Wednesday, November 26, 2014.