Assembly Bill 310 (Ma):
On February 10, 2011, the Assembly Health Committee requested that CHBRP undertake an analysis of Assembly Bill 310 (Ma) per its authorizing statute. On February 18, 2011, CHBRP received amendments that will be taken to the bill. CHBRP analysis reflects the amended version of the bill language received on February 18, 2011 included directly below, followed by the language as introduced.

Amended version of AB 310 submitted to CHBRP for analysis on February 18, 2011:

SEC. 2. Section 1367.225 is added to the Health and Safety Code, to read:

1367.225. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, that covers *outpatient* prescription drugs shall not ~~provide for specialty tiers that require payment of a percentage cost of prescription drugs by enrollees.~~ *require co-insurance as a basis for cost-sharing with the enrollee for outpatient prescription drug benefits.*

(b) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, shall not require an enrollee to pay a copayment for *outpatient* prescription drugs in excess of *$150 dollars per one month supply of medication, or its equivalent for prescriptions for longer periods, as adjusted for inflation.* ~~500 percent of the lowest copayment required by the plan for prescription drugs in the plan's formulary.~~

(c) If a health care service plan provides for a limit on enrollees' annual out-of-pocket expenses, enrollees' out-of-pocket costs of covered prescription drugs shall be included in that limit.

~~(c) If a health care service plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the plan shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the enrollee:~~

~~(1) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan.~~

~~(2) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars ($1,000) per enrollee or, in the case of covered dependents, two thousand dollars ($2,000) including dependents of the enrollee, as adjusted for inflation.~~

(d) For purposes of this section, "copayment" means a flat dollar amount an enrollee ~~pays, out of pocket, at the time of receiving a health care service or when paying for a prescription drug,~~ *is required in cost sharing for covered health services, items and supplies including prescription drugs* after any applicable deductible. The term shall not be construed to include any other forms of cost sharing.

(e) For purposes of this section, "co-insurance" means a cost sharing payment by an enrollee that is based on a percentage of the cost for a prescription.

(f) ~~(e)~~ Nothing in this section shall be construed to require a health care service plan contract to provide coverage not otherwise required by law for any prescription drug.

(g) ~~(f)~~ This section shall become inoperative upon a determination by the department that the requirements of this section would result in the assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care

Act (Public Law 111-148), as amended by Section 10104(e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.

SEC. 3. Section 10123.197 is added to the Insurance Code, to read:

10123.197. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2012, that covers *outpatient* prescription drugs shall not ~~provide for specialty tiers that require payment of a percentage cost of prescription drugs by insureds.~~ *require co-insurance as a basis for cost-sharing with the insured for outpatient prescription drug benefits.*

(b) A health insurance policy issued, amended, or renewed on or after January 1, 2012, shall not require an insured to pay a copayment for *outpatient* prescription drugs in excess of *$150 dollars per one month supply of medication, or its equivalent for prescriptions for longer periods, as adjusted for inflation.* ~~500 percent of the lowest copayment required by the plan for prescription drugs in the plan's formulary.~~

(c) If a health insurance policy provides for a limit on insureds' annual out-of-pocket expenses, insureds' out-of-pocket costs of covered prescription drugs shall be included in that limit.

~~(c) If a health insurance policy provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the policy shall include one of the following provisions in the policy that would result in the lowest out-of-pocket prescription drug cost to the insured:~~

~~(1) Out-of-pocket expenses for prescription drugs shall be included under the policy's total limit for out-of-pocket expenses for all benefits provided under the policy.~~

~~(2) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars ($1,000) per insured or, in the case of covered dependents, two thousand dollars ($2,000) including dependents of the insured, as adjusted for inflation.~~

(d) For purposes of this section, "copayment" means a flat dollar amount an enrollee ~~pays, out of pocket, at the time of receiving a health care service or when paying for a prescription drug,~~ *is required in cost sharing for covered health services, items and supplies including prescription drugs* after any applicable deductible. The term shall not be construed to include any other forms of cost sharing.

(e) For purposes of this section, "co-insurance" means a cost sharing payment by an enrollee that is based on a percentage of the cost for a prescription.

(f) ~~(e)~~ Nothing in this section shall be construed to require a health insurance policy to provide coverage not otherwise required by law for any prescription drug.

(g) ~~(f)~~ This section shall become inoperative upon a determination by the commissioner that the requirements of this section would result

in the assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104 (e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.

AB 310 as introduced on February 9, 2011:

BILL NUMBER: AB 310 INTRODUCED
BILL TEXT

INTRODUCED BY Assembly Member Ma

FEBRUARY 9, 2011

An act to add Section 1367.225 to the Health and Safety Code, and to add Section 10123.197 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 310, as introduced, Ma. Prescription drugs.

(1) Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides that the willful violation of provisions regulating health care service plans is a crime. Existing law provides for the licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plans and health insurers to provide certain benefits, but generally does not require plans and insurers to cover prescription drugs. Existing law imposes various requirements on plans and insurers if they offer coverage for prescription drugs.

This bill would prohibit health care service plans and health insurers that offer prescription drug coverage from creating specialty tiers for prescription drugs that require payment by an enrollee or insured of a percentage cost of the drugs. The bill would also impose certain limitations on copayments and out-of-pocket expenses. The bill would make these provisions inoperative upon a determination by the department and commissioner that these provisions would result in additional costs to the state as a result of laws governing federal health care reform.

Because this bill would impose new requirements on health care service plans, the willful violation of which would be a crime, it would thereby impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that

reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) California, along with other states, has experienced the creation of a new cost-sharing mechanism by some health plans known as prescription drug specialty tiers.

(b) Specialty tiers include prescription drugs for which some health care service plans and health insurers are requiring patients to pay a percentage cost of the drug instead of a copayment. These drugs are typically new, infusible, or injectible biologics or plasma-derived therapies produced in lesser quantities than other drugs and not available as less costly brand name or generic prescription drugs.

(c) The specialty drugs found on the fourth tier are used to treat conditions that affect less than 5 percent of the population, but that number is expected to grow as new drugs are approved and the drugs that are already on the market are used to treat an expanding number of conditions. Many of these specialty drugs are used to treat conditions such as cancer; autoimmune conditions, such as Crohn's disease, lupus, multiple sclerosis, myasthenia gravis, myositis, scleroderma, and rheumatoid arthritis; hemophilia and other bleeding disorders; hepatitis; primary and secondary immune deficiencies; neuropathy; and transplant patients. These drugs are used to treat complex and chronic conditions and require special administration, handling, and care management.

(d) Plans and insurers are also increasing prescription drug copayments to amounts beyond the reach of most patients. The amounts charged for drug copayments should not have the effect of unfairly denying access to medicine. This has resulted in some patients paying more than $3,000 for one month's supply of medication. For example, currently a person with multiple sclerosis might pay a $55 copayment for medication. But, if the person's drug plan had specialty tiering and charged 25 percent to 33 percent in coinsurance, the same medication would cost between $750 and $990 for one month. In another example, for cancer patients, in one year the coinsurance increased for one of the most-used therapies from $854 per month to $1,366 per month.

(e) Paying hundreds or even thousands of dollars each month for

prescription drugs would be a strain for any person, but for people with chronic illnesses and life-threatening conditions, this unfortunate social policy has the potential to destroy a family's financial solvency or end the ability to take a necessary medication.

(f) The practice of specialty tiers violates the basic principle of insurance whereby individuals and employers purchase health insurance plans so that they are protected from the risk of needing to pay for highly expensive medical treatments. Specialty tier coinsurance rates can change unpredictably, which makes it impossible for patients to anticipate and budget for health care costs. Those rate changes also impede patients from having informed discussions with their doctors about containing the cost of their treatment.

(g) Where the practice of specialty tiering is allowed, the out-of-pocket costs for medications are high enough to preclude patients from complying with the treatment protocols prescribed by their doctors and force patients to choose between paying for basic living expenses or taking their medications. As patients forgo treatment because of cost concerns, their health deteriorates, often necessitating more expensive emergency care.

(h) Many patients who cannot afford their copayments have been forced to go on disability, resulting in additional costs to the state.

(i) Specialty tiers are contrary to the original purpose of insurance, which was the spreading of costs. Specialty tiers create a structure where those who are sickest pay more, and those who are healthy pay less. Additionally, this type of cost-sharing arrangement will not keep health care costs down because there are no generic alternatives available for the biologic treatments that make up the vast majority of drugs placed on specialty tiers. Therefore, the creation of specialty tiers is a discriminatory practice.

SEC. 2. Section 1367.225 is added to the Health and Safety Code, to read:

1367.225. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, that covers prescription drugs shall not provide for specialty tiers that require payment of a percentage cost of prescription drugs by enrollees.

(b) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, shall not require an enrollee to pay a copayment for prescription drugs in excess of 500 percent of the lowest copayment required by the plan for prescription drugs in the plan's formulary.

(c) If a health care service plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the plan shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost

to the enrollee:

(1) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan.

(2) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars ($1,000) per enrollee or, in the case of covered dependents, two thousand dollars ($2,000) including dependents of the enrollee, as adjusted for inflation.

(d) For purposes of this section, "copayment" means a flat dollar amount an enrollee pays, out of pocket, at the time of receiving a health care service or when paying for a prescription drug, after any applicable deductible. The term shall not be construed to include any other forms of cost sharing.

(e) Nothing in this section shall be construed to require a health care service plan contract to provide coverage not otherwise required by law for any prescription drug.

(f) This section shall become inoperative upon a determination by the department that the requirements of this section would result in the assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104(e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.

SEC. 3. Section 10123.197 is added to the Insurance Code, to read:

10123.197. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2012, that covers prescription drugs shall not provide for specialty tiers that require payment of a percentage cost of prescription drugs by insureds.

(b) A health insurance policy issued, amended, or renewed on or after January 1, 2012, shall not require an insured to pay a copayment for prescription drugs in excess of 500 percent of the lowest copayment required by the policy for prescription drugs in the policy's formulary.

(c) If a health insurance policy provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the policy shall include one of the following provisions in the policy that would result in the lowest out-of-pocket prescription drug cost to the insured:

(1) Out-of-pocket expenses for prescription drugs shall be included under the policy's total limit for out-of-pocket expenses for all benefits provided under the policy.

(2) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars ($1,000) per insured or, in the case of covered dependents, two thousand dollars ($2,000)

including dependents of the insured, as adjusted for inflation.

(d) For purposes of this section, "copayment" means a flat dollar amount an insured pays, out of pocket, at the time of receiving a health care service or when paying for a prescription drug, after any applicable deductible. The term shall not be construed to include any other forms of cost sharing.

(e) Nothing in this section shall be construed to require a health insurance policy to provide coverage not otherwise required by law for any prescription drug.

(f) This section shall become inoperative upon a determination by the commissioner that the requirements of this section would result in the assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104 (e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.