Policy Options for Limiting Patient Cost-Sharing for Prescription Drugs

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California Health Benefits Review Program (CHBRP)

- Legislatively established
- Analyze legislation per request of the assembly/senate health committees related to insurance benefits
- Staffed with central staff at UCOP; researchers at UCSD, UCLA, UCSF, and UC Davis; and actuarial firm (PWC)
- Funded through a health plan tax
- 60 day timeline
- Address Effectiveness, Cost, and Public Health Impacts
How Clinton Hopes to Make American Drug Prices Sane Again

After a week of denouncing unaffordable medications, she laid out her plan to cap their costs to patients.
Objective

Present results from 4 CHBRP analyses of policy options to reduce patient cost-sharing in California:

• AB 310 (2011)
• AB 1800 (2012)
• AB 1917 (2014)
• AB 339 (2015)
Methods

- CHBRP analyzed 4 bills during 2011-2015 related to patient OOP for drugs
- CHBRP conducted surveys of California health insurers to determine the current levels of coverage and cost-sharing for each analysis.
- Actuarial firm used claims database to estimate utilization
- Population Studied: 11.1 - 21.7 million individuals with insurance in California subject to state regulation.
Policy Options

1. Prohibiting coinsurance cost-sharing for outpatient prescription drug benefits,
2. Limiting copayments to a specified dollar amount for a specified supply of medication,
3. Requiring drug benefit cost sharing to be included in the annual out-of-pocket maximum,
4. Prohibiting separate deductible for prescription drugs,
5. Prohibiting placing all or most of the medications used to treat a certain condition in the highest cost-sharing tier, and
6. Regulating the determination of placing drugs in the specialty tier.
Assembly Bill 310 (2011)

**Content**
- Prohibits **coinsurance** for prescription drugs,
- Limits **copayments** to $150 per one month supply;
- Drug cost sharing must be included in OOP max *(no limit specified)*
- Applies to 21.7 million Californians

**Results**
- Baseline 67% of enrollees have non-compliant coverage
- Reduction in average cost of Rx from $271 to $150
- Increase in drug utilization of 4.0%
- $189 million decrease in enrollee OOP costs
- No impact based on OOP max provision
Assembly Bill 1800 (2012)

Content
• Drug cost sharing must be included in OOP max
  Set OOP Max at $6,050/$12,500
• Prohibit separate deductible for prescription drugs
• Applies to 21.7 million Californians

Results
• Baseline 64% of enrollees have non-compliant coverage
• $276 million decrease in enrollee OOP costs
• Average decrease in cost sharing of $213
• Decrease driven by cap on OOP Max
Assembly Bill 1917 (2014)

Content
• $265 Cap on cost-sharing per 30-day prescription (1/24 of annual OOP limit)
• Applies to 11.7 million Californians
  • Excludes Medical MCOs and CalPers

Results
• $22 million decrease in enrollee OOP costs
• Reduction in average cost of Rx from $325 to $189
• 3% Increase in drug utilization
Assembly Bill 339 (2015)

Content (As Introduced)

- Cost sharing for prescription drugs needs to be reasonable.
- Must cover single tablet multi-drug regimens unless it is proven to be more effective if taken individually.
- Must cover extended release drugs unless the non extended release equivalent is proven to be more effective.
- Drugs to treat a specific condition may not be placed in the highest cost tier.
- Department of Managed Health Care to define "specialty" drugs.
Assembly Bill 339 (2015)

Content (As Amended)
- Added $265 Cap on cost-sharing per 30-day prescription (1/24 of annual OOP limit)
- Applies to 21.7 million Californians

Results
- Baseline 12% of enrollees have non-compliant coverage
- $65 million decrease in enrollee OOP costs
- No change modeled based on “reasonable” clause
Assembly Bill 339 (2015)

Content (As Passed)

• Drug formulary may not discriminate against or discourage enrollment of people with specific conditions;
• Must cover single tablet combo drugs for HIV/AIDS,
• $250 Cap on cost-sharing per 30-day prescription ($500 for bronze plans)

Results

• TBD
Implications

As of January 1, 2016, there were 12 states who had enacted legislation to limit cost-sharing for prescription drugs.
Thank You!

For more information on the California Health Benefits Review Program see www.chbrp.org