Key Findings:

Analysis of California Senate Bill 1021 Prescription Drugs

Summary to the 2017–2018 California State Legislature, April 9, 2018

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Senate (SB) Bill 1021 analyzed by CHBRP would eliminate the sunset of January 1, 2020, for provisions enacted through the passage of Assembly Bill (AB) 339 in 2015; would require plans and policies regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CD) to cover medications to prevent HIV/AIDS; and includes other cost-sharing provisions.

1. CHBRP estimates that, in 2019, of the 23.4 million Californians enrolled in state-regulated health insurance, a maximum of 15.9 million of them would have insurance subject to SB 1021.
2. **Benefit coverage.** 100% of enrollees subject to SB 1021 currently have coverage for medications to prevent HIV/AIDS. CHBRP assumes health plans and policies are in compliance with the cost-sharing limits as introduced by AB 339.
3. **Utilization.** Because benefit coverage is 100%, CHBRP estimates there will be no change in utilization.
4. **Expenditures.** Because benefit coverage is 100%, CHBRP estimates there will be no change in expenditures.
5. **Medical effectiveness.**
   a. Clear and convincing evidence that pre-exposure prophylaxis (PrEP) is effective at preventing HIV transmission.
   b. Limited evidence that post-exposure prophylaxis (PEP) is effective at preventing HIV transmission.
   c. Preponderance of evidence that persons who face higher cost sharing for a prescription drug are less likely to maintain meaningful levels of adherence than persons who face lower cost sharing.
6. **Public health.** SB 1021 would have no short-term public health impact.
7. **Long-term impacts.**
   a. Utilization of PrEP and PEP may increase if SB 1021 were to pass and awareness continues to increase among providers and consumers.
   b. The $250 out-of-pocket cost-sharing limits are fixed; therefore, as drug costs increase, more drugs and enrollees will get closer to the out-of-pocket cost-sharing limit.

BILL SUMMARY

SB 1021 amends existing law put into place by the passage of AB 339 in 2015. AB 339 impacted the outpatient prescription drug coverage of Californians with health insurance regulated by DMHC or CDI, except Medi-Cal.[1]

SB 1021 eliminates the sunset of January 1, 2020, for the provisions included in AB 339, extending this law indefinitely. Major provisions of AB 339 include:

- Copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed $250.
- If a nongrandfathered individual or small-group market plan or policy maintains a drug formulary grouped into tiers that includes a fourth tier, specific definitions apply.

SB 1021 includes new provisions:

- Requires plans and policies to cover combination antiretroviral drug treatments that are medically necessary for the *prevention* of HIV/AIDS.
- Prohibits plans and policies from having more than four drug formulary tiers.
- Codifies existing DMHC regulation that states if a pharmacy's retail price for a prescription is less than the applicable copayment or coinsurance

[1] Refer to CHBRP's full report for full citations and references.

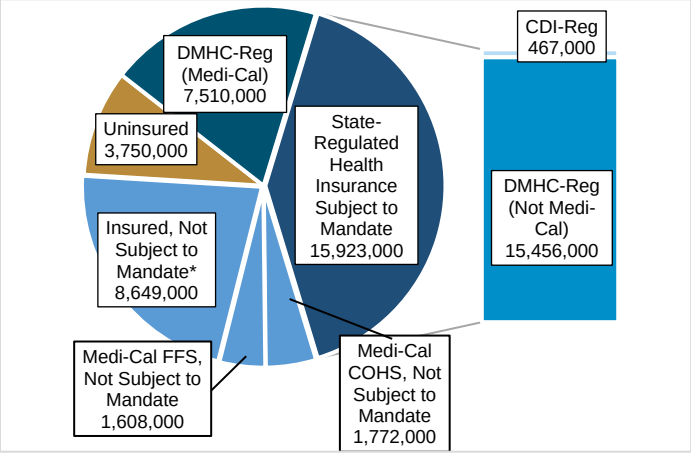
amount, the enrollee shall not be required to pay more than the retail price.

A full list of all provisions included in SB 1021 is included in the *Policy Context* Section.

The provisions of SB 1021 apply to various numbers of Californians, dependent upon through which health insurance market a plan or policy is obtained.

Figure 1 notes the maximum number of Californians who have health insurance that would be subject to SB 1021.

Figure 1. Health Insurance in CA and SB 1021



Source: CHBRP 2018.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

CONTEXT

The analysis of SB 1021 is divided into two main sections: medications to prevent HIV/AIDS and cost-sharing provisions.

Two FDA-approved prescription drug regimens are relatively new additions to the public health prevention of HIV transmission strategies: pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Both regimens are anti-retroviral treatments that prevent HIV from penetrating the CD4 cells. By protecting the cells, this regimen eliminates the ability of HIV to replicate and destroy the immune system.

Payment for covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium payments).

IMPACTS: MEDICATIONS TO PREVENT HIV/AIDS

Benefit Coverage, Utilization, and Cost

CHBRP found through a survey of the largest (by enrollment) providers of health insurance in California that 100% of enrollees subject to this provision of SB 1021 currently have coverage for preventive HIV/AIDS medications. Thus, there is no change in the benefit coverage of HIV/AIDS medications for prevention postmandate.

Utilization of PrEP and PEP would remain constant post-implementation. Similarly, expenditures would not be expected to increase since benefit coverage and utilization will not change.

Medi-Cal

Medi-Cal is exempt from the provisions of SB 1021.

CalPERS

No measurable impact is projected for enrollees who receive health insurance through CalPERS.

Number of Uninsured in California

No change in the number of uninsured persons is expected due to the enactment of SB 1021.

Medical Effectiveness

- There is clear and convincing evidence from 13 fair- and high-quality RCTs and three observational studies that PrEP is effective in preventing HIV transmission and lowering the risk of HIV among users with moderate or high adherence.
- There is limited evidence from a single historical case-control study among hospital workers, low-quality observational studies, and animal studies

that PEP is effective in preventing HIV transmission following occupational and non-occupational exposures. Adherence and follow-up in PEP studies is overall low and therefore limits CHBRP's ability to draw conclusions about the relationship between adherence and effectiveness for PEP as well as the frequency of PEP failures.

- There is limited evidence (PrEP) or insufficient evidence (PEP) that health insurance coverage is effective in increasing use and adherence to preventive HIV/AIDS medications.

Public Health

CHBRP concludes that passage of SB 1021 would have no short-term public health impact because carriers report that 100% of enrollees currently have coverage for these benefits or that these provisions are required by current law; thus, no change in coverage or utilization would occur within the first 12 months of implementation.

Long-Term Impacts

Recent studies have reported that there is an upward trend in utilization of drugs for the prevention of HIV/AIDS. It is reasonable to assume that this increase in utilization would continue beyond the first 12 months of implementation of SB 1021 if it passes, as awareness continues to increase among providers and consumers.

IMPACTS: COST-SHARING PROVISIONS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP assumes health plans and policies are in compliance with the cost-sharing limits as introduced by AB 339. While SB 1021 does not change the cost-sharing limits currently in law, given the increasing trend in drug prices, CHBRP assumes more enrollees will hit the cost-sharing limits over time assuming no other changes to the market.

Utilization

In its analysis of AB 339 in 2015, CHBRP estimated 0.8% of enrollees in plans and policies subject to AB 339 had outpatient prescription drug claims that would exceed the cost sharing limitations. CHBRP estimated a utilization increase of an additional 3,174 enrollees who previously did not use prescription drugs (increase of 2.43%) but who would with the passage of AB 339. Utilization is not projected to change should SB 1021 pass since this bill eliminates the sunset included in current law.

Medi-Cal

Medi-Cal is exempt from the provisions of SB 1021.

CalPERS

No measurable impact is projected for enrollees who receive health insurance through CalPERS.

Number of Uninsured in California

No change in the number of uninsured persons is expected due to the enactment of SB 1021.

Medical Effectiveness

- There is a preponderance of evidence from studies with strong research designs that persons who face higher cost sharing for a prescription drug are less likely to maintain meaningful levels of adherence than persons who face lower cost sharing.

- There is a preponderance of evidence from studies with moderate research designs that poorer adherence to prescription drugs therapy for chronic conditions is associated with higher rates of hospitalization and emergency department visits and poorer health outcomes.

Public Health

CHBRP concludes that passage of SB 1021 would have no short-term public health impact because carriers report that 100% of enrollees currently have coverage for these benefits or these provisions are required by current law;

thus, no change in coverage or utilization would occur within the first 12 months of implementation.

Long-Term Impacts

The $250 out-of-pocket cost-sharing limits are fixed; therefore, as drug costs increase, more drugs and enrollees will get closer to the out-of-pocket cost-sharing limit. CHBRP completed a 3-year projection of the number of enrollees hitting the cost-sharing limit of $250 per prescription for up to a 30-day supply, assuming all else remains constant (i.e., number of approved drugs and utilization and formulary structure).

Table 1. Maximum Projected Share of Enrollees Who Hit the Cost- Sharing Limit as Included in SB 1021

Year	Maximum projected number (#) of enrollees who hit cost-sharing limit	Maximum projected percent (%) of enrollees who hit the cost-sharing limit
2019	834,500	5.24%
2020	967,700	6.08%
2021	1,097,100	6.89%

Source: California Health Benefits Review Program, 2018.
Note: Based on MarketScan claims database sample data.

ESSENTIAL HEALTH BENEFITS AND THE AFFORDABLE CARE ACT

SB 1021 would require coverage for preventive HIV/AIDS medications and specifies terms of outpatient prescription drug coverage, and therefore appears not to exceed the definition of EHBs in California.