AB 339: NEW RULES FOR FULLY INSURED RX PLANS

On October 8, 2015, Governor Brown signed AB 339, which sets limits on cost-sharing for prescription drugs in fully-insured plans, and limits the ways in which insurers can set the tiers of their drug formularies for fully-insured individual and small group plans. The new law will also adopt standards for access to in-network retail pharmacies. None of the changes in this new law affect self-funded plans. Details on the new law, along with effective dates, are set forth below.

GENERAL RULES AND PROHIBITIONS

Effective for all nongrandfathered plans for plan years beginning on or after January 1, 2017, the new law requires the following:

- A plan that provides coverage for outpatient prescription drugs shall cover medically necessary prescription drugs.
- Consistent with federal law, the formulary for outpatient prescription drugs shall not discourage the enrollment of individuals with health conditions and shall not reduce the generosity of the benefit for individuals with a specific condition in a manner that is not based on clinical indication or reasonable medical management practices.
- Plans must ensure the placement of prescription drugs on formulary tiers based on clinically indicated, reasonable medical management practices.
- For combination antiretroviral drug treatments that are medical necessary for the treatment of HIV/AIDS, a plan must cover a single-tablet regimen in most circumstances.

COST-SHARING LIMITS

For individual or group plans providing coverage for Essential Health Benefits, the law will require the following limits on cost-sharing for plan years beginning on or after January 1, 2017:

- Copayment, coinsurance or any other cost-sharing (not including deductible) for a covered outpatient prescription drug will be limited to $250 for an individual prescription for a supply of up to 30 days.
- For plans with an actuarial value at the Bronze level (60%), the limit is $500.
- For a High Deductible Health Plan (HDHP), these limits will apply only after the enrollee's deductible has been satisfied for the year.
- For a nongrandfathered individual or small group plan, the annual deductible for outpatient prescription drugs shall not exceed $500 (or $1000 for a Bronze level plan).

These cost-sharing limits would sunset on January 1, 2020.

Tiering Limitations for Individual and Small Group Plans

AB 339 also prescribes the types of drugs to be placed on different tiers for a non-grandfathered individual or small group plan that maintains a 4-tier drug formulary. Plans must also ensure that the placement of drugs on formulary tiers is based on clinically-indicated, reasonable medical management practices. These tiering limitations are also effective for plan years beginning on or after January 1, 2017 and expire on January 1, 2020.

Access to In-Network Retail Pharmacy

For plan years beginning on or after January 1, 2017, plans that provide Essential Health Benefits must allow an enrollee to access prescription drug benefits at an in-network retail pharmacy for most drugs. Nongrandfathered individual or small group plans may charge different cost sharing for obtaining a covered drug at a retail pharmacy, but that cost sharing will count toward the insured's annual cost sharing limits on prescription drugs under the plan.

Other Provisions

The new law clarifies that health plans may still utilize formulary, prior authorization, step therapy, or other reasonable medical management practices in the provision of outpatient prescription drug coverage. It also requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to include additional information in the formulary template that they are required to devise no later than January 1, 2017.

Potential Impact on Plans

Although AB 339 limits what insured patients will pay out of pocket for prescription drugs, this bill will not impact the prices charged by drug manufacturers. Throughout the debate on this bill, there has been a concern that the cap on cost-sharing could increase the cost of coverage more broadly, as insurance carriers absorb more of the cost of expensive drugs and then spread that cost among all insureds. There is also a concern that carriers may limit formularies in order to control costs. Because the implementation of this law is a full year away, we do not expect these impacts to be felt immediately, but they may affect some plans with non-calendar plan years as early as 2016.

To discuss the potential impact of this new law on your plan, please contact your Keenan HealthCare Account Manager.