Fact Sheet
AB 310 – Assemblywoman Fiona Ma
Fair Specialty Drug Payments

Summary: AB 310 would prohibit health plans and insurers from using "co-insurance" and cap out-of-pocket co-pay costs for patients.

Background & Problem:
When patients pay for drug medications, many health care plans include a pricing structure. The tiers are often labeled 'generic,' 'preferred,' and 'non-preferred' and each have a set cost-sharing amount. For example, $10 for generic, $30 for preferred and $60 for non-preferred.

In 2006, Medicare Part D plans (PDPs) started introducing a fourth level known as a "specialty tier," which provides the plan with the ability to use a co-insurance to share the costs of the most expensive medications with the patient

Many private healthcare and drug plans have copied this model for the most expensive medications, but instead of a fixed amount like in Medicare, plans may now require enrollees to pay co-insurance, which is a percentage of the cost of medications. These plans have been charging patients, on average, 25 to 33 percent, which can end up costing the patient thousands of dollars a month out of pocket. These extortionate co-insurance charges can be as high as over $8,000 per month.

The Kaiser Family Foundation Employer Health Benefits 2010 survey reports a dramatic increase in specialty tiers, using the co-insurance method of payment. Nationwide, in 2004, only 3% of workers were in a plan with four or more tiers of coverage. However, in 2010 that number increased to 13%, covering more than 20 million Americans. Data also indicates that in 2006, 50% of Medicare drug plans used specialty tiers. In 2008, specialty tiers were represented in 81% of Medicare plans.

In addition, Prime Therapeutics released a study in 2009 that measured multiple sclerosis medication OOP expense association with decline to fill rate. It showed that when MS medication OOP expenses were greater than $200 the decline to fill rate compared was six times greater than if the co-payment was less than $100.

Many of the drugs on specialty tiers are used to treat conditions such as: cancer, autoimmune conditions like Crohn's disease, lupus, multiple sclerosis, myasthenia gravis, myositis, psoriasis, scleroderma, rheumatoid arthritis, hemophilia and other bleeding disorders, hepatitis, primary and secondary immune deficiencies, neuropathy, and transplant patients.

Drugs found on specialty tiers have been in the marketplace for over twenty years and have been covered by insurance plans without charging co-insurance. Many of these therapies have remained at the same price, with the exception of new generations of these drugs. These drugs have no generic alternatives, are used to treat rare diseases, genetic disorders, and chronic conditions that without treatment will lead to disability and death.

Solution:
Beginning January 1, 2012 AB 310 prevents health plans and insurers from using the co-insurance method of payment. The bill also places $150 dollar out-of-pocket cap for a one month supply of medication, or its equivalent for prescriptions for longer periods, as adjusted for inflation.

In addition, AB 310 makes sure that if a health care service plan provides for a limit on patients' annual out-of-pocket expenses, the patients' out-of-pocket costs of covered prescription drugs shall be included in that limit.

Support:
The National Multiple Sclerosis Society (Sponsor)
The Alliance for Plasma Therapies (Sponsor)

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