

California Health Benefits Review Program

Analysis of California Assembly Bill 1353 Utilization Management Process for Outpatient Prescription Drugs

A Report to the 2017–2018 California State Legislature

April 21, 2017



Key Findings:

Analysis of California Assembly Bill 1353 Drug Utilization Management Exceptions

Summary to the 2017–2018 California State Legislature, April 21, 2017



AT A GLANCE

The version of California Assembly Bill (AB) 1353 analyzed by CHBRP would require a compliant exceptions request process in regard to some utilization management techniques that may be applicable to an outpatient prescription drug (OPD) benefit. CHBRP estimates that, in 2018, all of the 24 million Californians enrolled in health insurance regulated by DMHC or CDI will have insurance subject to AB 1353.

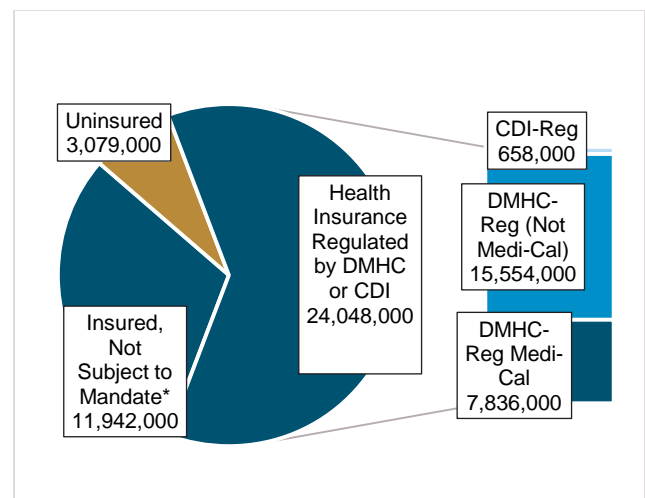
- 1. Benefit coverage.** The percentage of enrollees with fully AB 1353–compliant coverage would rise from 92% to 100%.
- 2. Utilization.** In the first year postmandate, AB 1353 would be particularly relevant among enrollees which chronic conditions switching from one health plan/policy to another. By increasing granted exception requests, AB 1353 would increase (as a percentage of drugs used) the use of more expensive drugs.
- 3. Expenditures.** Total expenditures (premiums and enrollee expenses for covered benefits) would increase by \$8,960,000 (0.0061%).
- 4. Medical effectiveness.** There is *insufficient* evidence to determine whether utilization management exceptions affect health outcomes. There is *conflicting* evidence on the impact of step therapy requirements and prior authorization requirements on health outcomes. There is a *preponderance* of evidence that generic substitutions are equivalent to the brand-name drugs with regard to medical effectiveness.
- 5. Public Health.** As evidence is insufficient or conflicting, the impact on health outcomes of the utilization changes AB 1353 would prompt are unknown.
- 6. Long term.** In the long term, as enrollees, providers, and pharmacist become aware of AB 1353, annual impacts could increase. In particular, impacts associated with Medi-Cal beneficiaries in DMHC-regulated plans could increase because other inducements (such as greater cost sharing for more expensive drugs) are less likely to be present

BILL SUMMARY

A set of current California laws, similar to what AB 153 would require, may require continued coverage of a particular drug (or a compliant exceptions request process) for most enrollees in DMHC-regulated plans and many enrollees in CDI-regulated policies.

AB 1353 would require that all DMHC-regulated plans and CDI-regulated policies that include an outpatient prescription drug (OPD) benefit have a process by which exceptions to utilization management techniques can be granted and would, in some circumstances, require that the exception be granted. AB 1353 would be relevant to the benefit coverage of some more enrollees in DMHC-regulated plans and CDI-regulated policies than is the set of current laws, but a key difference is that it would extend the possibility of a granted exception to enrollees switching from one health plan or policy to another.

Figure 1. Health Insurance in CA and AB 1353



Source: CHBRP 2017.

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

Benefit Coverage, Utilization and Cost

For this analysis, CHBRP has focused on the impact an AB 1353 could have regarding granted exceptions to three utilization management techniques: step therapy

requirements, prior authorization requirements, and mandatory generic substitution requirements. Because AB 1353 addresses continued coverage, CHBRP has focused on use of drugs related to chronic conditions.

Benefit Coverage

At baseline, approximately 92% of enrollees have benefit coverage fully compliant with AB 1353. Noncompliance would limit granted utilization management technique exceptions for enrollees switching from one plan or policy to another Post mandate, the figure would rise to 100%.

Utilization

AB 1353 would not impact the total utilization of prescription drugs. However, CHBRP would anticipate an increased number of exception requests and an increased rate of exception approvals. The resulting increase in exemption approvals would alter the mix of average cost per prescription, from the lower cost associated with exceptions being denied toward the higher cost associated with exceptions being approved (because many exceptions would extend coverage for a more expensive drug).

Expenditures

Total expenditures (premiums and enrollee expenses for covered benefits) would increase by \$8,960,000 (0.0061%). Variation between market segments would be primarily driven by rates of enrollees switching from one health plan or policy to another - which is most common in the individual market and more common in the small group market than in the large group market or among Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Medi-Cal

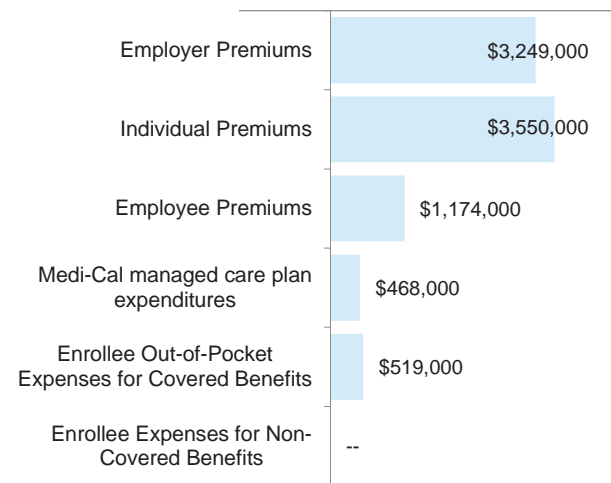
Premiums for Medi-Cal beneficiaries enrolled in DMHC-regulated plans would increase by \$468,000 (0.0017%).

CalPERS

Premium for enrollees in DMHC-regulated plans associated with CalPERS would increase by \$114,000 (0.0023%).¹

¹ Approximately 58.82% of enrollees in DMHC-regulated plans associated with were state retirees, state employees, or their

Figure 2. Expenditure Impacts of AB 1353



Source: CHBRP 2017.

Number of Uninsured in California

The projected impacts would not be expected to alter the number of uninsured Californians.

Medical Effectiveness

There is *insufficient* evidence to determine whether utilization management exceptions directly affect health outcomes.

There is *conflicting* evidence on the impact of step therapy requirements on health outcomes. There is *limited* evidence that step therapy requirements impact rates of discontinuation and interruption of drug use. There is *conflicting* evidence on the impact of step therapy requirements on hospital admissions, emergency department use, and outpatient visits.

There is *conflicting* evidence on the impact prior authorization requirements on health outcomes. There is *insufficient* evidence that prior authorization requirements affect utilization of drugs or other health services.

dependents. About a quarter of these enrollees have an OPD benefit not subject to DMHC, so CHBRP has projected no impact for those enrollees, but is aware that CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

There is a *preponderance* of evidence that generic substitutions are equivalent to the brand-name drugs with regard to medical effectiveness.

Public Health

In the first year postmandate, the public health impact of AB 1353 is unknown due to insufficient or conflicting evidence regarding the effect of prior authorization, step therapy, and generic substitution requirements on health outcomes related to discontinuities in OPD treatments for a range of illnesses and conditions. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact — positive or negative — could result, but current evidence is insufficient to inform an estimate.

Long-Term Impacts

Although CHBRP projects that AB 1353 would cause a 5% increase in the number of exception requests in the first year, in the long run, this figure may increase as more enrollees, providers, and pharmacists become aware of the conditions under which AB 1353 would require that exceptions be granted. At baseline, it is likely that some enrollees who would be affected by AB 1353 do not file for exceptions because they are unaware that it is possible to do so or do not believe it is likely that their exception would be granted. Additionally, the current laws that are similar to what AB 1353 would require do not apply to the benefit coverage of quite as many enrollees as would AB 1353.

Utilization management exists for purposes besides controlling costs. Utilization management is also used to discourage the use of drugs with potentially dangerous side effects, or drugs that are inferior to newer drugs on the market. However, as new generic drugs and other lower cost alternatives come onto the market, AB 1353 will limit inducements to enrollees with ongoing prescriptions for higher cost drugs to switch to lower cost alternatives. This impact is likely to be most notable among Medi-Cal beneficiaries enrolled in DMHC-regulated plans, as other inducements, such as higher cost-sharing requirements for more expensive drugs, are less likely to be present.

Just as utilization impacts may increase over time, so may the cost impacts of greater utilization of more expensive drugs. As with utilization impacts, the related cost impact of AB 1353 would be likely to be greater

among Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Essential Health Benefits and the Affordable Care Act

Because AB 1353 specifies terms of existing benefit coverage, it appears that AB 1353 would not exceed essential health benefits (EHBs), and so would not trigger the ACA requirement that the state defray the cost of additional benefit coverage.