AB 2752 HEALTH CARE COVERAGE: CONTINUITY OF CARE
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Background:
Covered California has made changes to help consumers better understand and manage their prescription drug costs. Beginning January 1, 2016, all Covered California qualified health plans will:

- Charge no more than up to $250 per month for one 30-day supply for Silver, Gold and Platinum plan members and no more than up to $500 per 30-day supply for Bronze plan members. These costs apply to Tier 4 (specialty drugs). Drugs in lower tiers have lower costs.
- Maintain a dedicated prescription drug customer service line where current and prospective members can call for help.
- Describe the appeals and exception process clearly on the formulary, so members understand what to do if a drug they need is not covered.
- Provide current and prospective members with an estimate of the out-of-pocket cost for specific drugs.

Despite these increased protections provided to consumers, significant gaps in awareness and notification still exist. Health plans and health insurers can still modify their formularies quarterly. Often times, consumers are unaware of a change to their formulary until arriving at the pharmacy, only to notice that the costs for filing a prescription could have significantly increased since the last time they filled their necessary prescription.

Additionally, an enrollee's or insured's provider may drop out of a network midyear or choose not to renew with the health plan or policy for the following benefit year. Fortunately, steps to improve provider directories have recently been made, both through the promulgation of regulation and the enactment of legislation, to ensure health plans and insurers establish accurate information for consumers.

The Department of Insurance adopted emergency regulations in 2015 that require an insurer to promptly notify patients seen by a provider within the past year when the provider, for any reason, leaves the insurer's network. This may include, but is not limited to, the provider's decision to retire or stop practicing medicine for other reasons, relocating to an area outside the service area, leaving a group practice that is included as a participant in the network, or withdrawing from a network for any other reason.

SB 137 (Hernández), Chapter 649, Statutes of 2015, made significant strides to standardize health plans' and health insurers' provider directories. Provider directories are updated much more often and a consistent effort to maintain accurate information is required of health plans, health insurers, and providers themselves. Additionally, consumers now have a process to report inaccuracies in the provider network to allow plans/insurers to investigate and make the necessary changes to the printed and digital directories.

Existing law:
Every health plan shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the plan by major therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs (H&S § 1367.20)

Until January 1, 2020, all health plans and health insurers must use the same names for drug tiers no matter which health plan is chosen. The drugs will be labeled as Tier 1 (generic drugs), Tier 2 (preferred drugs), Tier 3 (non-preferred drugs) or Tier 4 (specialty drugs). (H&S § 1342.71; Ins. § 10123.193).

Beginning January 1, 2017, an enrollee or insured may access prescription drug benefits at an in-network retail pharmacy. A nongrandfathered individual or small group health plan or health insurer may charge a different cost sharing for obtaining a covered drug at a retail pharmacy, but all cost sharing shall count toward the plan's or policy's annual limitation on cost sharing. (H&S § 1367.42; Ins. §10123.201)

A health plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies shall update the formularies posted on the carriers' website with any change to those formularies on a monthly basis. (H&S § 1367.205; Ins. § 10123.192)

This bill:
Requires a health care service plan or a health insurer to annually, every October 1, notify an enrollee or insured that the enrollee's or insured's drug treatment is no longer covered by the plan or policy, if that is the case.

Requires a health plan or health insurer to annually, every October 1, include in renewal materials a notice to an enrollee or insured that the enrollee's or insured's current provider is no longer part of the health care service plan's provider network, if that is the case.

Purpose:
Prescription drug formularies are changed frequently, often quarterly. According to Covered California, for the most current information, a consumer should confirm coverage and out-of-pocket cost with their specific health insurance plan before filling prescriptions. Anecdotal

information suggests that continuing the status quo of placing the burden on the consumer to check his or her formulary, potentially every month, is not working. Consumers are often unaware of the changes in costs until they reach the pharmacy counter which can lead to delays in treatment. This bill takes the first step to ensure consumers are aware of formulary changes that affect their specific prescription drugs by ensuring that, at least at the point of plan/policy renewal, an enrollee or insured is notified of a change if one has taken place.

Similarly, the onus to ensure that a provider remains in-network for the new benefit year is placed on the consumer. The Department of Insurance requires an insurer to notify all insureds that have seen the (now out-of-network) provider in the last year only if the provider moves out-of-network midyear. This bill ensures health plan enrollees and health policy insureds will receive notification with their renewal materials that their provider has moved out-of-network for the new benefit year, if that is the case.

Support:
California Chronic Care Coalition (sponsor)

Opposition:
None on file 02/22/16

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