

AMENDED IN SENATE MAY 31, 2016  
AMENDED IN SENATE MARCH 30, 2016

**SENATE BILL**

**No. 1010**

---

---

**Introduced by Senator Hernandez**

February 11, 2016

---

---

An act to amend Section 1385.045 of, to add Section 1367.245 to, and to add Chapter 9 (commencing with Section 127675) to Part 2 of Division 107-*of*, the Health and Safety Code, and to amend Section 10181.45 of, and to add Section 10123.204 to, the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1010, as amended, Hernandez. Health care: prescription drug costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC) and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance (DOI). Existing law requires health care service plans and health insurers to file specified rate information with DMHC or DOI, as applicable, for health care service plan contracts or health insurance policies in the individual or small group markets and for health care service plan contracts and health insurance policies in the large group market.

This bill would require health care service plans or health insurers that file the above-described rate information to report to DMHC or DOI, on a date no later than the reporting of the rate information, specified cost information regarding covered prescription drugs,

including generic drugs, brand name drugs, ~~specialty drugs, and prescription drugs provided in an outpatient setting or sold in a retail~~ *and specialty drugs provided in an outpatient setting*. The information reported would include, but not be limited to, the 25 most frequently prescribed drugs and the average wholesale price for each drug and the 25 most costly drugs by total plan or insurer spending ~~and the average wholesale price for each drug, and the 25 most costly drugs by total plan or insurer spending~~. DMHC and DOI would be required to compile the reported information into a ~~consumer-friendly report~~ *report for the public and legislators* that demonstrates the overall impact of drug costs on health care premiums and publish the reports on their Internet Web sites by ~~January 1~~ *October 1* of each year. Except for the report, DMHC and DOI would be required to keep confidential all information provided pursuant to these provisions.

Because a willful violation of the Knox-Keene Act is a crime, this bill would impose a state-mandated local program.

This bill would require a manufacturer of a branded prescription drug to notify *in writing* state purchasers, health care service plans, health insurers, *pharmacy benefit managers*, and the chairs of specified Senate and Assembly committees if it is increasing the wholesale acquisition cost of the drug by more than 10% *or by more than \$10,000* during any 12-month period ~~or if it intends to introduce to market a prescription drug that has a wholesale acquisition cost of \$10,000 or more annually or per course of treatment~~. *period*. The bill would require a manufacturer of a generic prescription drug with a specified ~~price~~ *wholesale acquisition cost* to notify state purchasers, health care service plans, health insurers, *pharmacy benefit managers*, and the chairs of specified Senate and Assembly committees if it is increasing the wholesale acquisition cost of the drug by more than ~~10%~~ *25%* during any 12-month period. *The bill would require a manufacturer of a prescription drug to notify in writing, within 3 days of approval by the federal Food and Drug Administration, state purchasers, health care service plans, health insurers, pharmacy benefit managers, and the chairs of specified Senate and Assembly committees if it is introducing a new prescription drug to market at a wholesale acquisition cost of \$10,000 or more annually or per course of treatment.* The bill would require a manufacturer, within 30 days of notification of a price increase, or *notification* of the introduction to market of a prescription drug that has a wholesale acquisition cost of \$10,000 or more annually or per course of treatment, to report specified information regarding the drug price to each state

purchaser, health care service plan, ~~and~~ health insurer, *or pharmacy benefit manager* and would require a manufacturer who fails to provide the required information within the 30 days to be subject to a civil penalty of \$1,000 per day. The bill would also require the Legislature to conduct an annual public hearing regarding the ~~price increases and information reported,~~ *aggregate trends in prescription drug pricing*, as prescribed. *Except for the hearing, the Legislature would be required to keep confidential all information provided pursuant to these provisions.*

Existing law requires, for large group health care service plan contracts and health insurance policies, each health care service plan or health insurer to file with DMHC or DOI the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year, and to also disclose specified information for the aggregate rate information for the large group market.

This bill would add to that disclosure of information for the aggregate rate information for the large group market, the requirement for health care service plans or health insurers to disclose specified cost information regarding covered prescription drugs, including generic ~~drugs,~~ *drugs but excluding generic specialty drugs*, brand name drugs excluding specialty drugs, and specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 1367.245 is added to the Health and  
 2 Safety Code, immediately preceding Section 1367.25, to read:  
 3 1367.245. (a) (1) A health care service plan that reports rate  
 4 information pursuant to Section 1385.03 or 1385.045 shall report  
 5 the information described in paragraph (2) to the department on a  
 6 date no later than it reports the rate information.  
 7 (2) For all covered prescription drugs, including generic drugs,  
 8 brand name drugs, ~~specialty drugs, and prescription drugs provided~~  
 9 ~~in an outpatient setting or sold in a retail and specialty drugs~~  
 10 *provided in an outpatient setting*, all of the following shall be  
 11 reported:  
 12 (A) ~~The 25 most frequently prescribed drugs and the average~~  
 13 ~~wholesale price for each drug. *drugs.*~~  
 14 (B) ~~The 25 most costly drugs by total plan spending and the~~  
 15 ~~average wholesale price for each drug. *spending.*~~  
 16 (C) ~~The 25 drugs with the highest year-over-year increase and~~  
 17 ~~the average wholesale price for each drug. *in spending.*~~  
 18 (b) The department shall compile the information reported  
 19 pursuant to subdivision (a) into a ~~consumer-friendly report~~ *report*  
 20 *for the public and legislators* that demonstrates the overall impact  
 21 of drug costs on health care premiums. The data in the report shall  
 22 be aggregated and shall not reveal information specific to  
 23 individual health care service plans.  
 24 (c) For the purposes of this section, a “specialty drug” is one  
 25 that exceeds the threshold for a specialty drug under the Medicare  
 26 Part D program (Medicare Prescription Drug, Improvement, and  
 27 Modernization Act of 2003 (Public Law 108-173)).  
 28 (d) ~~By January 1~~ *October 1* of each year, the department shall  
 29 publish on its Internet Web site the report required pursuant to  
 30 subdivision (b).  
 31 (e) After the report required in subdivision (b) is released, the  
 32 department shall include the report as part of the public meeting  
 33 required pursuant to subdivision (b) of Section 1385.045.  
 34 (f) Except for the report required pursuant to subdivision (b),  
 35 the department shall keep confidential all of the information  
 36 provided to the department pursuant to this section, and that  
 37 information shall be exempt from disclosure under the California

1 Public Records Act (Chapter 3.5 (commencing with Section 6250)  
2 of Division 7 of Title 1 of the Government Code).

3 SEC. 2. Section 1385.045 of the Health and Safety Code is  
4 amended to read:

5 1385.045. (a) For large group health care service plan  
6 contracts, each health plan shall file with the department the  
7 weighted average rate increase for all large group benefit designs  
8 during the 12-month period ending January 1 of the following  
9 calendar year. The average shall be weighted by the number of  
10 enrollees in each large group benefit design in the plan's large  
11 group market and adjusted to the most commonly sold large group  
12 benefit design by enrollment during the 12-month period. For the  
13 purposes of this section, the large group benefit design includes,  
14 but is not limited to, benefits such as basic health care services  
15 and prescription drugs. The large group benefit design shall not  
16 include cost sharing, including, but not limited to, deductibles,  
17 copays, and coinsurance.

18 (b) (1) A plan shall also submit any other information required  
19 pursuant to any regulation adopted by the department to comply  
20 with this article.

21 (2) The department shall conduct an annual public meeting  
22 regarding large group rates within three months of posting the  
23 aggregate information described in this section in order to permit  
24 a public discussion of the reasons for the changes in the rates,  
25 benefits, and cost sharing in the large group market. The meeting  
26 shall be held in either the Los Angeles area or the San Francisco  
27 Bay area.

28 (c) A health care service plan subject to subdivision (a) shall  
29 also disclose the following for the aggregate rate information for  
30 the large group market submitted under this section:

31 (1) For rates effective during the 12-month period ending  
32 January 1 of the following year, number and percentage of rate  
33 changes reviewed by the following:

34 (A) Plan year.

35 (B) Segment type, including whether the rate is community  
36 rated, in whole or in part.

37 (C) Product type.

38 (D) Number of enrollees.

39 (E) The number of products sold that have materially different  
40 benefits, cost sharing, or other elements of benefit design.

1 (2) For rates effective during the 12-month period ending  
2 January 1 of the following year, any factors affecting the base rate,  
3 and the actuarial basis for those factors, including all of the  
4 following:

- 5 (A) Geographic region.
- 6 (B) Age, including age rating factors.
- 7 (C) Occupation.
- 8 (D) Industry.
- 9 (E) Health status factors, including, but not limited to,  
10 experience and utilization.
- 11 (F) Employee, and employee and dependents, including a  
12 description of the family composition used.
- 13 (G) Enrollees' share of premiums.
- 14 (H) Enrollees' cost sharing.
- 15 (I) Covered benefits in addition to basic health care services,  
16 as defined in Section 1345, and other benefits mandated under this  
17 article.
- 18 (J) Which market segment, if any, is fully experience rated and  
19 which market segment, if any, is in part experience rated and in  
20 part community rated.
- 21 (K) Any other factor that affects the rate that is not otherwise  
22 specified.

23 (3) (A) The plan's overall annual medical trend factor  
24 assumptions for all benefits and by aggregate benefit category,  
25 including hospital inpatient, hospital outpatient, physician services,  
26 prescription drugs and other ancillary services, laboratory, and  
27 radiology for the applicable 12-month period ending January 1 of  
28 the following year. A health plan that exclusively contracts with  
29 no more than two medical groups in the state to provide or arrange  
30 for professional medical services for the enrollees of the plan shall  
31 instead disclose the amount of its actual trend experience for the  
32 prior contract year by aggregate benefit category, using benefit  
33 categories, to the maximum extent possible, that are the same as,  
34 or similar to, those used by other plans.

35 (B) The amount of the projected trend separately attributable  
36 to the use of services, price inflation, and fees and risk for annual  
37 plan contract trends by aggregate benefit category, including  
38 hospital inpatient, hospital outpatient, physician services,  
39 prescription drugs and other ancillary services, laboratory, and  
40 radiology. A health plan that exclusively contracts with no more

1 than two medical groups in the state to provide or arrange for  
2 professional medical services for the enrollees of the plan shall  
3 instead disclose the amount of its actual trend experience for the  
4 prior contract year by aggregate benefit category, using benefit  
5 categories that are, to the maximum extent possible, the same or  
6 similar to those used by other plans.

7 (C) A comparison of the aggregate per enrollee per month costs  
8 and rate of changes over the last five years for each of the  
9 following:

- 10 (i) Premiums.
- 11 (ii) Claims costs, if any.
- 12 (iii) Administrative expenses.
- 13 (iv) Taxes and fees.

14 (D) Any changes in enrollee cost sharing over the prior year  
15 associated with the submitted rate information, including both of  
16 the following:

17 (i) Actual copays, coinsurance, deductibles, annual ~~out-of-pocket~~  
18 *out-of-pocket* maximums, and any other cost sharing by the benefit  
19 categories determined by the department.

20 (ii) Any aggregate changes in enrollee cost sharing over the  
21 prior years as measured by the weighted average actuarial value,  
22 weighted by the number of enrollees.

23 (E) Any changes in enrollee benefits over the prior year,  
24 including a description of benefits added or eliminated, as well as  
25 any aggregate changes, as measured as a percentage of the  
26 aggregate claims costs, listed by the categories determined by the  
27 department.

28 (F) Any cost containment and quality improvement efforts since  
29 the plan's prior year's information pursuant to this section for the  
30 same category of health benefit plan. To the extent possible, the  
31 plan shall describe any significant new health care cost containment  
32 and quality improvement efforts and provide an estimate of  
33 potential savings together with an estimated cost or savings for  
34 the projection period.

35 (G) The number of products covered by the information that  
36 incurred the excise tax paid by the health plan.

37 (4) (A) For covered prescription drugs, including generic ~~drugs,~~  
38 *drugs but excluding specialty generic drugs*, brand name drugs  
39 excluding specialty drugs, and specialty drugs dispensed at a plan

1 pharmacy, network pharmacy, or mail order pharmacy for  
2 outpatient use all of the following shall be disclosed:

3 (i) The percentage of the premium attributable to prescription  
4 drug costs for the prior year for each category of prescription drugs.  
5 *drugs as defined in subparagraph (A).*

6 (ii) ~~The year-over-year increase in the percentage of the~~  
7 ~~premium attributable to each category of prescription drugs.~~  
8 *increase, as a percentage, in total spending for each category of*  
9 *prescription drugs as defined in subparagraph (A).*

10 (iii) The year-over-year increase in per member, per month costs  
11 for drug prices compared to other components of the health care  
12 premium.

13 (iv) The specialty tier formulary list.

14 (B) The plan shall include the percentage of the premium  
15 attributable to prescription drugs administered in a doctor’s office  
16 that are ~~part of~~ *covered under* the medical benefit as separate from  
17 the pharmacy benefit, if available.

18 (d) The information required pursuant to this section shall be  
19 submitted to the department on or before October 1, 2016, and on  
20 or before October 1 annually thereafter. Information submitted  
21 pursuant to this section is subject to Section 1385.07.

22 (e) *For the purposes of this section, a “specialty drug” is one*  
23 *that exceeds the threshold for a specialty drug under the Medicare*  
24 *Part D program (Medicare Prescription Drug, Improvement, and*  
25 *Modernization Act of 2003 (Public Law 108-173)).*

26 SEC. 3. Chapter 9 (commencing with Section 127675) is added  
27 to Part 2 of Division 107 of the Health and Safety Code, to read:

28

29 CHAPTER 9. PRESCRIPTION DRUG PRICING FOR-STATE  
30 PURCHASERS

31

32 127675. (a) This chapter shall apply to any manufacturer of  
33 a prescription drug that is purchased or reimbursed by any of the  
34 following:

35 (1) A state purchaser in California, including, but not limited  
36 to, the Public Employees’ Retirement System, the State Department  
37 of Health Care Services, the Department of General Services, and  
38 the Department of Corrections and Rehabilitation, or an entity  
39 acting on behalf of a state purchaser.

40 (2) A health care service plan licensed pursuant to Section 1353.

1 (3) A health insurer holding a valid outstanding certificate of  
2 authority from the Insurance Commissioner.

3 (4) *A pharmacy benefit manager as defined in subdivision (j)*  
4 *of Section 4430 of the Business and Professions Code.*

5 (b) (1) A manufacturer of a branded prescription drug shall  
6 notify each state purchaser, health care service plan, ~~or health~~  
7 ~~insurer insurer, or pharmacy benefit manager~~ if it is increasing  
8 the wholesale acquisition cost of a prescription drug by more than  
9 10 percent *or by more than ten thousand dollars (\$10,000)* during  
10 any 12-month ~~period or if it intends to introduce to market a~~  
11 ~~prescription drug that has a wholesale acquisition cost of ten~~  
12 ~~thousand dollars (\$10,000) or more annually or per course of~~  
13 ~~treatment.~~ *period.* The notice shall be provided in writing at least  
14 60 days prior to the planned effective date of the increase. A copy  
15 of the notice shall be provided concurrently to the Chairs of the  
16 Senate Committee on Appropriations, the Senate Committee on  
17 Budget and Fiscal Review, the Assembly Committee on  
18 Appropriations, and the Assembly Committee on Budget.

19 (2) A manufacturer of a generic prescription drug with a ~~price~~  
20 *wholesale acquisition cost* of one hundred dollars (\$100) or more  
21 ~~per 30-day month~~ supply shall notify a state purchaser, health care  
22 service plan, ~~or health insurer insurer, or pharmacy benefit~~  
23 ~~manager~~ if it is increasing the wholesale acquisition cost of the  
24 prescription drug by more than ~~10~~ 25 percent during a 12-month  
25 period. The notice shall be provided in writing at least 60 days  
26 prior to the planned effective date of the increase. A copy of the  
27 notice shall be provided concurrently to the Chairs of the Senate  
28 Committee on Appropriations, the Senate Committee on Budget  
29 and Fiscal Review, the Assembly Committee on Appropriations,  
30 and the Assembly Committee on Budget.

31 (3) ~~(A) Within 30 days of notification of a price increase, or of~~  
32 ~~the introduction to market of a prescription drug that has a~~  
33 ~~wholesale acquisition cost of ten thousand dollars (\$10,000) or~~  
34 ~~more annually or per course of treatment, increase under~~  
35 ~~paragraph (1) or (2), a manufacturer shall report all of the~~  
36 following information to each state purchaser, health care service  
37 plan, ~~or health insurer:~~ *health insurer, or pharmacy benefit*  
38 *manager:*

39 (i)

1 (A) A justification for the proposed increase in the price of the  
 2 drug, including all information and supporting documentation as  
 3 to why the increase is justified. *price increase. The manufacturer*  
 4 *may limit the information in the justification to that which is*  
 5 *publicly available.*

6 ~~(ii) The total dollar amount of public funding received by the~~  
 7 ~~manufacturer for the development and marketing, including, but~~  
 8 ~~not limited to, state and federal tax credits, grants, and all other~~  
 9 ~~public subsidies.~~

10 ~~(iii)–~~

11 (B) The expected *previous year's* marketing budget for the drug.

12 ~~(iv)~~

13 (C) The date the drug was purchased if it and price of acquisition  
 14 if the drug was not developed by the manufacturer.

15 ~~(v)~~

16 (D) A schedule of ~~past~~ price increases for the ~~drug~~. *drug for the*  
 17 *previous five years.*

18 (4) (A) A manufacturer of a prescription drug shall notify in  
 19 writing each state purchaser, health care service plan, health  
 20 insurer, or pharmacy benefit manager if it is introducing a new  
 21 prescription drug to market at a wholesale acquisition cost of ten  
 22 thousand dollars (\$10,000) or more annually or per course of  
 23 treatment. The notice shall be provided in writing within three  
 24 days of the federal Food and Drug Administration approval. A  
 25 copy of the notice shall be provided concurrently to the Chairs of  
 26 the Senate Committee on Appropriations, the Senate Committee  
 27 on Budget and Fiscal Review, the Assembly Committee on  
 28 Appropriations, and the Assembly Committee on Budget.

29 (B) Within 30 days of notification of a new drug under this  
 30 paragraph, a manufacturer shall report all of the following  
 31 information to each state purchaser, health care service plan,  
 32 health insurer, or pharmacy benefit manager:

33 (i) A justification for the introductory price. The manufacturer  
 34 may limit the contents of the justification to publicly available  
 35 information.

36 (ii) The expected marketing budget for the drug.

37 (iii) The date and price of acquisition if the drug was not  
 38 developed by the manufacturer.

39 ~~(B)~~

1 (5) Failure to report the information *required pursuant to*  
2 *paragraph (3) or subparagraph (B) of paragraph (4) to state*  
3 *purchasers, health care service plans, or health insurers insurers,*  
4 *or pharmacy benefit managers shall result in a civil penalty of one*  
5 *thousand dollars (\$1,000) per day for every day after the 30-day*  
6 *notification period.*

7 (c) ~~The Legislature shall conduct an annual public hearing~~  
8 ~~regarding the price increases and information reported pursuant~~  
9 ~~to this section. The hearing shall provide for public discussion of~~  
10 ~~the reasons for the price increases, emerging trends, decreases in~~  
11 ~~drug prices, and the impact on health care affordability and~~  
12 ~~premiums. on aggregate trends in prescription drug pricing. The~~  
13 ~~hearing shall provide for public discussion of overall price~~  
14 ~~increases, emerging trends, decreases in drug spending, and the~~  
15 ~~impact of prescription drug spending on health care affordability~~  
16 ~~and premiums.~~

17 (d) *Except for the hearing required pursuant to subdivision (c),*  
18 *the Legislature shall keep confidential all of the information*  
19 *provided to the Legislature pursuant to this section, and that*  
20 *information shall be exempt from disclosure under the California*  
21 *Public Records Act (Chapter 3.5 (commencing with Section 6250)*  
22 *of Division 7 of Title 1 of the Government Code).*

23 ~~(d)~~

24 (e) This chapter shall not restrict the legal ability of a  
25 pharmaceutical manufacturer to change prices as permitted under  
26 federal law.

27 SEC. 4. Section 10123.204 is added to the Insurance Code,  
28 immediately preceding Section 10123.206, to read:

29 10123.204. (a) (1) A health insurer that reports rate  
30 information pursuant to Section 10181.3 or 10181.45 shall report  
31 the information described in paragraph (2) to the department on a  
32 date no later than it reports the rate information.

33 (2) For all covered prescription drugs, including generic drugs,  
34 brand name drugs, specialty drugs, and prescription drugs provided  
35 ~~in an outpatient setting or sold in a retail and specialty drugs~~  
36 *provided in an outpatient setting*, all of the following shall be  
37 reported:

38 (A) The 25 most frequently prescribed ~~drugs and the average~~  
39 ~~wholesale price for each drug. drugs.~~

1 (B) The 25 most costly drugs by total insurer ~~spending and the~~  
2 ~~average wholesale price for each drug.~~ *spending.*

3 (C) The 25 drugs with the highest year-over-year increase ~~and~~  
4 ~~the average wholesale price for each drug.~~ *in spending.*

5 (b) The department shall compile the information reported  
6 pursuant to subdivision (a) into a ~~consumer-friendly report~~ *report*  
7 *for the public and legislators* that demonstrates the overall impact  
8 of drug costs on health care premiums. The data in the report shall  
9 be aggregated and shall not reveal information specific to  
10 individual health insurers.

11 (c) For the purposes of this section, a “specialty drug” is one  
12 that exceeds the threshold for a specialty drug under the Medicare  
13 Part D program (Medicare Prescription Drug, Improvement, and  
14 Modernization Act of 2003 (Public Law 108-173)).

15 (d) By ~~January 1~~ *October 1* of each year, the department shall  
16 publish on its Internet Web site the report required pursuant to  
17 subdivision (b).

18 (e) After the report required in subdivision (b) is released, the  
19 department shall include the report as part of the public meeting  
20 required pursuant to subdivision (b) of Section 10181.45.

21 (f) Except for the report required pursuant to subdivision (b),  
22 the department shall keep confidential all of the information  
23 provided to the department pursuant to this section, and that  
24 information shall be exempt from disclosure under the California  
25 Public Records Act (Chapter 3.5 (commencing with Section 6250)  
26 of Division 7 of Title 1 of the Government Code).

27 SEC. 5. Section 10181.45 of the Insurance Code is amended  
28 to read:

29 10181.45. (a) For large group health insurance policies, each  
30 health insurer shall file with the department the weighted average  
31 rate increase for all large group benefit designs during the 12-month  
32 period ending January 1 of the following calendar year. The  
33 average shall be weighted by the number of insureds in each large  
34 group benefit design in the insurer’s large group market and  
35 adjusted to the most commonly sold large group benefit design by  
36 enrollment during the 12-month period. For the purposes of this  
37 section, the large group benefit design includes, but is not limited  
38 to, benefits such as basic health care services and prescription  
39 drugs. The large group benefit design shall not include cost sharing,  
40 including, but not limited to, deductibles, copays, and coinsurance.

1 (b) (1) A health insurer shall also submit any other information  
2 required pursuant to any regulation adopted by the department to  
3 comply with this article.

4 (2) The department shall conduct an annual public meeting  
5 regarding large group rates within three months of posting the  
6 aggregate information described in this section in order to permit  
7 a public discussion of the reasons for the changes in the rates,  
8 benefits, and cost sharing in the large group market. The meeting  
9 shall be held in either the Los Angeles area or the San Francisco  
10 Bay area.

11 (c) A health insurer subject to subdivision (a) shall also disclose  
12 the following for the aggregate rate information for the large group  
13 market submitted under this section:

14 (1) For rates effective during the 12-month period ending  
15 January 1 of the following year, number and percentage of rate  
16 changes reviewed by the following:

17 (A) Plan year.

18 (B) Segment type, including whether the rate is community  
19 rated, in whole or in part.

20 (C) Product type.

21 (D) Number of insureds.

22 (E) The number of products sold that have materially different  
23 benefits, cost sharing, or other elements of benefit design.

24 (2) For rates effective during the 12-month period ending  
25 January 1 of the following year, any factors affecting the base rate,  
26 and the actuarial basis for those factors, including all of the  
27 following:

28 (A) Geographic region.

29 (B) Age, including age rating factors.

30 (C) Occupation.

31 (D) Industry.

32 (E) Health status factors, including, but not limited to,  
33 experience and utilization.

34 (F) Employee, and employee and dependents, including a  
35 description of the family composition used.

36 (G) Insureds' share of premiums.

37 (H) Insureds' cost sharing.

38 (I) Covered benefits in addition to basic health care services,  
39 as defined in Section 1345 of the Health and Safety Code, and  
40 other benefits mandated under this article.

1 (J) Which market segment, if any, is fully experience rated and  
2 which market segment, if any, is in part experience rated and in  
3 part community rated.

4 (K) Any other factor that affects the rate that is not otherwise  
5 specified.

6 (3) (A) The insurer’s overall annual medical trend factor  
7 assumptions for all benefits and by aggregate benefit category,  
8 including hospital inpatient, hospital outpatient, physician services,  
9 prescription drugs and other ancillary services, laboratory, and  
10 radiology for the applicable 12-month period ending January 1 of  
11 the following year. A health insurer that exclusively contracts with  
12 no more than two medical groups in the state to provide or arrange  
13 for professional medical services for the health insurer’s insureds  
14 shall instead disclose the amount of its actual trend experience for  
15 the prior contract year by aggregate benefit category, using benefit  
16 categories, to the maximum extent possible, that are the same or  
17 similar to those used by other insurers.

18 (B) The amount of the projected trend separately attributable  
19 to the use of services, price inflation, and fees and risk for annual  
20 policy trends by aggregate benefit category, including hospital  
21 inpatient, hospital outpatient, physician services, prescription drugs  
22 and other ancillary services, laboratory, and radiology. A health  
23 insurer that exclusively contracts with no more than two medical  
24 groups in the state to provide or arrange for professional medical  
25 services for the insureds shall instead disclose the amount of its  
26 actual trend experience for the prior contract year by aggregate  
27 benefit category, using benefit categories that are, to the maximum  
28 extent possible, the same or similar to those used by other insurers.

29 (C) A comparison of the aggregate per insured per month costs  
30 and rate of changes over the last five years for each of the  
31 following:

- 32 (i) Premiums.
- 33 (ii) Claims costs, if any.
- 34 (iii) Administrative expenses.
- 35 (iv) Taxes and fees.

36 (D) Any changes in insured cost sharing over the prior year  
37 associated with the submitted rate information, including both of  
38 the following:

1 (i) Actual copays, coinsurance, deductibles, annual ~~out-of-pocket~~  
2 *out-of-pocket* maximums, and any other cost sharing by the benefit  
3 categories determined by the department.

4 (ii) Any aggregate changes in insured cost sharing over the prior  
5 years as measured by the weighted average actuarial value,  
6 weighted by the number of insureds.

7 (E) Any changes in insured benefits over the prior year,  
8 including a description of benefits added or eliminated as well as  
9 any aggregate changes as measured as a percentage of the aggregate  
10 claims costs, listed by the categories determined by the department.

11 (F) Any cost containment and quality improvement efforts made  
12 since the insurer's prior year's information pursuant to this section  
13 for the same category of health insurer. To the extent possible, the  
14 insurer shall describe any significant new health care cost  
15 containment and quality improvement efforts and provide an  
16 estimate of potential savings together with an estimated cost or  
17 savings for the projection period.

18 (G) The number of products covered by the information that  
19 incurred the excise tax paid by the health insurer.

20 (4) (A) For covered prescription drugs, including generic ~~drugs,~~  
21 *drugs but excluding specialty generic drugs*, brand name drugs  
22 excluding specialty drugs, and specialty drugs dispensed at a  
23 pharmacy, network pharmacy, or mail order pharmacy for  
24 outpatient use all of the following shall be disclosed:

25 (i) The percentage of the premium attributable to prescription  
26 drug costs for the prior year for each category of prescription ~~drugs.~~  
27 *drugs as defined in subparagraph (A).*

28 (ii) ~~The year-over-year increase in the percentage of the~~  
29 ~~premium attributable to each category of prescription drugs.~~  
30 *increase, as a percentage, in total spending for each category of*  
31 *prescription drugs as defined in subparagraph (A).*

32 (iii) The year-over-year increase in per member, per month costs  
33 for drug prices compared to other components of the health care  
34 premium.

35 (iv) The specialty tier formulary list.

36 (B) The insurer shall include the percentage of the premium  
37 attributable to prescription drugs administered in a doctor's office  
38 that are ~~part of~~ *covered under* the medical benefit as separate from  
39 the pharmacy benefit, if available.

1 (d) The information required pursuant to this section shall be  
2 submitted to the department on or before October 1, 2016, and on  
3 or before October 1 annually thereafter. Information submitted  
4 pursuant to this section is subject to Section 10181.7.

5 (e) *For the purposes of this section, a “specialty drug” is one*  
6 *that exceeds the threshold for a specialty drug under the Medicare*  
7 *Part D program (Medicare Prescription Drug, Improvement, and*  
8 *Modernization Act of 2003 (Public Law 108-173)).*

9 SEC. 6. The Legislature finds and declares that Sections ~~1 and~~  
10 *1, 3, and 4* of this act, which add ~~Section 1367.245~~ *Sections*  
11 *1367.245 and 127675* to the Health and Safety Code and Section  
12 10123.204 to the Insurance Code, impose a limitation on the  
13 public’s right of access to the meetings of public bodies or the  
14 writings of public officials and agencies within the meaning of  
15 Section 3 of Article I of the California Constitution. Pursuant to  
16 that constitutional provision, the Legislature makes the following  
17 findings to demonstrate the interest protected by this limitation  
18 and the need for protecting that interest:

19 In order to protect proprietary, confidential information reported  
20 by prescription drug manufacturers, health care service plans, and  
21 health insurers, and to protect the integrity of the competitive  
22 market, it is necessary that this act limit the public’s right of access  
23 to that information.

24 SEC. 7. No reimbursement is required by this act pursuant to  
25 Section 6 of Article XIII B of the California Constitution because  
26 the only costs that may be incurred by a local agency or school  
27 district will be incurred because this act creates a new crime or  
28 infraction, eliminates a crime or infraction, or changes the penalty  
29 for a crime or infraction, within the meaning of Section 17556 of  
30 the Government Code, or changes the definition of a crime within  
31 the meaning of Section 6 of Article XIII B of the California  
32 Constitution.

O