AMENDED IN ASSEMBLY AUGUST 2, 2016

AMENDED IN SENATE MAY 31, 2016

AMENDED IN SENATE MARCH 30, 2016

SENATE BILL No. 1010

Introduced by Senator Hernandez
(Principal coauthor: Assembly Member Chiu)

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, 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 25 most costly drugs by total plan or insurer spending. DMHC and DOI would be required to compile the reported information into a 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 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~~ *bill, except as provided,* 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. The ~~bill~~ *bill, except as provided,* would require a manufacturer of a generic prescription ~~drug~~ *drug, as defined,* with a specified 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 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, 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 aggregate trends in prescription drug pricing, as prescribed. Except for the hearing, the~~ *The bill would also require a pharmacy benefit manager that receives notice of a price increase consistent with these provisions to provide notice of the price increase to its contracting public and private purchasers, as provided. 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 *the cost of* covered prescription drugs, including generic 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.~~ *use and regarding the use of a pharmacy benefit manager, as prescribed.*

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:

SECTION 1. Section 1367.245 is added to the Health and Safety Code, immediately preceding Section 1367.25, to read:

1367.245. (a) (1) A health care service plan that reports rate information pursuant to Section 1385.03 or 1385.045 shall report the information described in paragraph (2) to the department on a date no later than it reports the rate information.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs provided in an outpatient setting, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total plan spending.

(C) The 25 drugs with the highest year-over-year increase in spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health care service plans.

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

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

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 1385.045.

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

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

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

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

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

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

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

(A) Plan year.

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

(C) Product type.

(D) Number of enrollees.

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

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

(A) Geographic region.
(B) Age, including age rating factors.
(C) Occupation.
(D) Industry.
(E) Health status factors, including, but not limited to, experience and utilization.
(F) Employee, and employee and dependents, including a description of the family composition used.
(G) Enrollees' share of premiums.
(H) Enrollees' cost ~~sharing.~~ *sharing, including prescription drugs.*
(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.
(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.
(K) Any other factor that affects the rate that is not otherwise specified.
(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.
(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the

prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

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

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

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

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

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

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

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

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

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

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

(ii) The year-over-year increase, as a percentage, in total spending for each category of prescription drugs as defined in subparagraph (A).

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

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including the components of the prescription drug coverage described in subparagraphs (A) and (B) for which the pharmacy benefit manager is responsible.

(ii) The plan shall also include the name of the pharmacy benefit manager.

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

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

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

Chapter 9. Prescription Drug Pricing for Purchasers

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

(1) A state purchaser in California, including, but not limited to, the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, and

the Department of Corrections and Rehabilitation, or an entity acting on behalf of a state purchaser.

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

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

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

(b) (1) A manufacturer of a branded prescription drug shall notify each state purchaser, health care service plan, health insurer, or pharmacy benefit manager if it is increasing the wholesale acquisition cost of a prescription drug by more than 10 percent or by more than ten thousand dollars ($10,000) during any 12-month period. The notice shall be provided in writing at least ~~60~~ *30* days prior to the planned effective date of the increase. A copy of the notice shall be provided concurrently to the Chairs of the Senate Committee on Appropriations, the Senate Committee on Budget and Fiscal Review, the Assembly Committee on Appropriations, and the Assembly Committee on Budget.

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

(B) For purposes of this section, a generic prescription drug is any product that qualifies as a "noninnovator multi-source drug" as defined by Section 1396r–8 (k)(7)(A)(iii) of Title 42 of the United States Code, excluding any product approved by the federal Food and Drug Administration under Section 262(k) of Title 42 of the United States Code. Prescription drugs that do not meet this definition are subject to reporting requirements pursuant to paragraph (1).

(3) Within 30 days of notification of a price increase under paragraph (1) or (2), a manufacturer shall report all of the following information to each state purchaser, health care service plan, health insurer, or pharmacy benefit manager:

(A) A justification for the proposed price increase. The manufacturer may limit the information in the justification to that which is publicly available.

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

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

(D) A schedule of price increases for the drug for the previous five ~~years.~~ *years if it was manufactured by the company, or if the drug was acquired by the manufacturer within the previous five years, the price of the drug at the time of the acquisition and in the calendar year prior to acquisition.*

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

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

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

(ii) The expected marketing budget for the drug.

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

(5) Failure to report the information required pursuant to paragraph (3) or subparagraph (B) of paragraph (4) to state purchasers, health care service plans, health insurers, or pharmacy benefit managers shall result in a civil penalty of one thousand

dollars ($1,000) per day for every day after the 30-day notification period.

~~(c) The Legislature shall conduct an annual public hearing on aggregate trends in prescription drug pricing. The hearing shall provide for public discussion of overall price increases, emerging trends, decreases in drug spending, and the impact of prescription drug spending on health care affordability and premiums.~~

~~(d) Except for the hearing required pursuant to subdivision (c),~~ ~~the~~

(c) Except for prescription drugs subject to paragraph (4) of subdivision (b), notice shall not be required for a prescription drug that is not already purchased or reimbursed by a purchaser described in subdivision (a).

(d) The Legislature shall keep confidential all of the information provided to the Legislature pursuant to this section, and that information shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government ~~Code).~~ *Code) and the Legislative Open Records Act (Article 3.5 (commencing with Section 9071) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code).*

(e) If a pharmacy benefit manager receives a notice of a price increase consistent with subdivision (b), the pharmacy benefit manager shall provide notice of the price increase to its contracting public and private purchasers. Upon request of the purchaser, the pharmacy benefit manager shall also provide the purchaser the justification provided by the pharmaceutical manufacturer consistent with subdivision (b).

~~(e)~~

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

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

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

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs provided in an outpatient setting, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total insurer spending.

(C) The 25 drugs with the highest year-over-year increase in spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health insurers.

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

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

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

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

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

10181.45. (a) For large group health insurance policies, each health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited

to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

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

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

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

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

(A) Plan year.

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

(C) Product type.

(D) Number of insureds.

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

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

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

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

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

(G) Insureds' share of premiums.

(H) Insureds' cost ~~sharing.~~ *sharing, including for prescription drugs.*

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

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

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

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

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

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

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

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

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

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

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

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

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

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

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

(ii) The year-over-year increase, as a percentage, in total spending for each category of prescription drugs as defined in subparagraph (A).

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

(iv) The specialty tier formulary list.

(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office

that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including the components of the prescription drug coverage described in subparagraphs (A) and (B) for which the pharmacy benefit manager is responsible.

(ii) The insurer shall also include the name of the pharmacy benefit manager.

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

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

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

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

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

the meaning of Section 6 of Article XIII B of the California Constitution.

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