

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:

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, and specialty drugs provided in an outpatient
9 setting, all of the following shall be reported:
10 (A) The 25 most frequently prescribed drugs.
11 (B) The 25 most costly drugs by total plan spending.
12 (C) The 25 drugs with the highest year-over-year increase in
13 spending.
14 (b) The department shall compile the information reported
15 pursuant to subdivision (a) into a report for the public and
16 legislators that demonstrates the overall impact of drug costs on
17 health care premiums. The data in the report shall be aggregated
18 and shall not reveal information specific to individual health care
19 service plans.
20 (c) For the purposes of this section, a “specialty drug” is one
21 that exceeds the threshold for a specialty drug under the Medicare
22 Part D program (Medicare Prescription Drug, Improvement, and
23 Modernization Act of 2003 (Public Law 108-173)).
24 (d) By October 1 of each year, the department shall publish on
25 its Internet Web site the report required pursuant to subdivision
26 (b).
27 (e) After the report required in subdivision (b) is released, the
28 department shall include the report as part of the public meeting
29 required pursuant to subdivision (b) of Section 1385.045.
30 (f) Except for the report required pursuant to subdivision (b),
31 the department shall keep confidential all of the information
32 provided to the department pursuant to this section, and that
33 information shall be exempt from disclosure under the California
34 Public Records Act (Chapter 3.5 (commencing with Section 6250)
35 of Division 7 of Title 1 of the Government Code).
36 SEC. 2. Section 1385.045 of the Health and Safety Code is
37 amended to read:

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

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

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

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

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

30 (A) Plan year.

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

33 (C) Product type.

34 (D) Number of enrollees.

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

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

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

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

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

- 7 (i) Premiums.
- 8 (ii) Claims costs, if any.
- 9 (iii) Administrative expenses.
- 10 (iv) Taxes and fees.

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

- 14 (i) Actual copays, coinsurance, deductibles, annual out-of-pocket
15 maximums, and any other cost sharing by the benefit categories
16 determined by the department.
- 17 (ii) Any aggregate changes in enrollee cost sharing over the
18 prior years as measured by the weighted average actuarial value,
19 weighted by the number of enrollees.

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

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

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

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

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

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

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

10 (iv) The specialty tier formulary list.

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

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

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

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

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

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

31
32 CHAPTER 9. PRESCRIPTION DRUG PRICING FOR PURCHASERS
33

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 ~~(e)~~

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

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

35 10123.204. (a) (1) A health insurer that reports rate
36 information pursuant to Section 10181.3 or 10181.45 shall report
37 the information described in paragraph (2) to the department on a
38 date no later than it reports the rate information.

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

4 (A) The 25 most frequently prescribed drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (A) Plan year.

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

23 (C) Product type.

24 (D) Number of insureds.

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

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

31 (A) Geographic region.

32 (B) Age, including age rating factors.

33 (C) Occupation.

34 (D) Industry.

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

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

39 (G) Insureds' share of premiums.

1 (H) Insureds' cost-sharing, ~~sharing~~, including for prescription
2 drugs.

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

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

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

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

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

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

37 (i) Premiums.

38 (ii) Claims costs, if any.

39 (iii) Administrative expenses.

40 (iv) Taxes and fees.

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

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

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

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

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

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

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

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

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

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

37 (iv) The specialty tier formulary list.

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

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

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

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

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

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

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

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

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

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

O