

AMENDED IN ASSEMBLY AUGUST 16, 2016

AMENDED IN ASSEMBLY AUGUST 2, 2016

AMENDED IN SENATE MAY 31, 2016

AMENDED IN SENATE MARCH 30, 2016

**SENATE BILL**

**No. 1010**

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

February 11, 2016

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An act to amend Section 1385.045 of, to add Section 1367.245 to, and to add *and repeal* Chapter 9 (commencing with Section 127675) ~~to~~ of 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~~, *dispensed as provided*. 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, *effective January 1, 2018*, except as provided, would require a manufacturer of a ~~branded~~ prescription drug to notify in writing state purchasers, health care service plans, health insurers, *and* pharmacy benefit managers, ~~and the chairs of specified Senate and Assembly committees~~ *managers* 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, except as provided, would require a manufacturer of a generic prescription 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 during any 12-month period by 25% or more based upon the wholesale acquisition cost of the drug and pursuant to a specified schedule, or by more than \$10,000. The bill, effective January 1, 2018, would require a manufacturer of a prescription drug to notify in writing, within 3 days of approval by the federal Food and Drug Administration, writing, 3 days before the commercial availability of the drug, state purchasers, health care service plans, health insurers, and pharmacy benefit managers, and the chairs of specified Senate and Assembly committees~~ *managers* 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 *the Office of Statewide Health Planning and Development* and would require a manufacturer who fails to provide the required information within the 30 days to be subject to a civil *an administrative* penalty of \$1,000 per day *day for every day after the 30-day notification period*. 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. The bill would define “pricing information,” as specified, would deem it to be confidential information, as specified, would provide that the information is exempt from disclosure under the California Public Records Act, and would require or authorize, as specified, other entities to disclose the information under a certain condition. The bill would make the Office of Statewide Health Planning and Development the entity charged with implementing and enforcing these provisions and would require that office to publish specified information collected pursuant to these provisions on its Internet Website. The bill would repeal these provisions by January 1, 2022.~~

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 information regarding the cost of covered prescription drugs, including generic drugs but excluding generic specialty drugs, brand name ~~drugs~~ *drugs*, excluding *brand name* specialty drugs, and *brand name and generic* specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient 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, dispensed at a plan pharmacy, network pharmacy, or mail~~
- 10 ~~order pharmacy for outpatient use,~~ all of the following shall be
- 11 reported:
- 12 (A) The 25 most frequently prescribed drugs.
- 13 (B) The 25 most costly drugs by total plan spending.
- 14 (C) The 25 drugs with the highest year-over-year increase in
- 15 spending.
- 16 (b) The department shall compile the information reported
- 17 pursuant to subdivision (a) into a report for the public and
- 18 legislators that demonstrates the overall impact of drug costs on
- 19 health care premiums. ~~The data in the report shall be aggregated~~
- 20 ~~and shall not reveal information specific to individual health care~~
- 21 ~~service plans.~~
- 22 (1) *The data in the report shall be aggregated and shall not*
- 23 *reveal information specific to individual health care service plans.*

1 (2) *The report shall compare, for the large group market,*  
2 *aggregate prescription drug spending among health care service*  
3 *plans that use a pharmacy benefit manager with aggregate*  
4 *prescription drug spending among health care service plans that*  
5 *do not use a pharmacy benefit manager.*

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

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

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

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

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

24 1385.045. (a) For large group health care service plan  
25 contracts, each health plan shall file with the department the  
26 weighted average rate increase for all large group benefit designs  
27 during the 12-month period ending January 1 of the following  
28 calendar year. The average shall be weighted by the number of  
29 enrollees in each large group benefit design in the plan’s large  
30 group market and adjusted to the most commonly sold large group  
31 benefit design by enrollment during the 12-month period. For the  
32 purposes of this section, the large group benefit design includes,  
33 but is not limited to, benefits such as basic health care services  
34 and prescription drugs. The large group benefit design shall not  
35 include cost sharing, including, but not limited to, deductibles,  
36 copays, and coinsurance.

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

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

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

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

14 (A) Plan year.

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

17 (C) Product type.

18 (D) Number of enrollees.

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

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

25 (A) Geographic region.

26 (B) Age, including age rating factors.

27 (C) Occupation.

28 (D) Industry.

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

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

33 (G) Enrollees' share of premiums.

34 (H) Enrollees' cost sharing, including prescription drugs.

35 (I) Covered benefits in addition to basic health care services,  
36 as defined in Section 1345, and other benefits mandated under this  
37 article.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (iv) The specialty tier formulary list.

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

38 (C) (i) The plan shall include information on its use of a  
39 pharmacy benefit manager, if any, including the components of  
40 the prescription drug coverage described in subparagraphs (A) and

1 (B) ~~for which the pharmacy benefit manager is responsible. that~~  
2 ~~are managed by the pharmacy benefit manager.~~

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

5 (d) The information required pursuant to this section shall be  
6 submitted to the department on or before October 1, ~~2016,~~ 2017,  
7 and on or before October 1 annually thereafter. Information  
8 submitted pursuant to this section is subject to Section 1385.07.

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

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

15

16 CHAPTER 9. PRESCRIPTION DRUG PRICING FOR PURCHASERS

17

18 127675. (a) This chapter shall apply to any manufacturer of  
19 a prescription drug that is purchased or reimbursed by any of the  
20 following:

21 (1) A state purchaser in California, including, but not limited  
22 to, the Public Employees’ Retirement System, the State Department  
23 of Health Care Services, the Department of General Services, and  
24 the Department of Corrections and Rehabilitation, or an entity  
25 acting on behalf of a state purchaser.

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

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

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

31 (b) (1) ~~A~~ *Effective January 1, 2018, a manufacturer of a branded*  
32 *prescription drug with a wholesale acquisition cost per month*  
33 *supply or per a course of treatment that lasts less than a month*  
34 *that comes within the schedule set forth in paragraph (2) shall*  
35 *notify each state purchaser, health care service plan, health insurer,*  
36 *or pharmacy benefit manager if it is increasing the wholesale*  
37 *acquisition cost of a prescription drug by more than 10 percent or*  
38 *by more than ten thousand dollars (\$10,000) during any 12-month*  
39 *period. during any 12-month period by 25 percent or more, or by*  
40 *more than ten thousand dollars (\$10,000). The notice shall be*

1 provided in writing at least 30 days prior to the planned effective  
2 date of the increase. ~~A copy of the notice shall be provided~~  
3 ~~concurrently to the Chairs of the Senate Committee on~~  
4 ~~Appropriations, the Senate Committee on Budget and Fiscal~~  
5 ~~Review, the Assembly Committee on Appropriations, and the~~  
6 ~~Assembly Committee on Budget.~~

7 ~~(2) (A) A manufacturer of a generic prescription drug with a~~  
8 ~~wholesale acquisition cost of one hundred dollars (\$100) or more~~  
9 ~~per month supply or per a course of treatment that lasts less than~~  
10 ~~a month shall notify a state purchaser, health care service plan,~~  
11 ~~health insurer, or pharmacy benefit manager if it is increasing the~~  
12 ~~wholesale acquisition cost of the prescription drug by more than~~  
13 ~~25 percent during a 12-month period. The notice shall be provided~~  
14 ~~in writing at least 30 days prior to the planned effective date of~~  
15 ~~the increase. A copy of the notice shall be provided concurrently~~  
16 ~~to the Chairs of the Senate Committee on Appropriations, the~~  
17 ~~Senate Committee on Budget and Fiscal Review, the Assembly~~  
18 ~~Committee on Appropriations, and the Assembly Committee on~~  
19 ~~Budget.~~

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

28 ~~(2) A manufacturer shall provide the notice required pursuant~~  
29 ~~to paragraph (1) if the prescription drug wholesale acquisition~~  
30 ~~cost per month supply or per a course of treatment that lasts less~~  
31 ~~than a month is within the following amounts:~~

32 ~~(A) For the 2018 calendar year: one hundred dollars (\$100) or~~  
33 ~~more.~~

34 ~~(B) For the 2019 calendar year: one hundred five dollars (\$105)~~  
35 ~~or more.~~

36 ~~(C) For the 2020 calendar year: one hundred ten dollars (\$110)~~  
37 ~~or more.~~

38 ~~(D) On and after January 1, 2021: one hundred sixteen dollars~~  
39 ~~(\$116) or more.~~

1 (3) (A) Within 30 days of notification of a price increase under  
2 paragraph ~~(1) or (2)~~; *(1)*, a manufacturer shall report all of the  
3 following information to ~~each state purchaser, health care service~~  
4 ~~plan, health insurer, or pharmacy benefit manager~~: *the Office of*  
5 *Statewide Health Planning and Development*:

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

9 ~~(B)~~

10 *(i) The previous year's marketing budget for the drug. The*  
11 *manufacturer may limit the information to that which is publicly*  
12 *available.*

13 ~~(C)~~

14 *(ii) The date and price of acquisition if the drug was not*  
15 *developed by the manufacturer.*

16 ~~(D)~~

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

22 *(B) The Office of Statewide Health Planning and Development*  
23 *shall publish data collected pursuant to this paragraph publicly*  
24 *on its Internet Web site no less than quarterly.*

25 (4) (A) ~~A~~*Effective January 1, 2018, a manufacturer of a*  
26 *prescription drug shall notify in writing each state purchaser, health*  
27 *care service plan, health insurer, or pharmacy benefit manager if*  
28 *it is introducing a new prescription drug to market at a wholesale*  
29 *acquisition cost of ten thousand dollars (\$10,000) or more annually*  
30 *or per course of treatment. The notice shall be provided in writing*  
31 ~~within three days of the federal Food and Drug Administration~~  
32 ~~approval. A copy of the notice shall be provided concurrently to~~  
33 ~~the Chairs of the Senate Committee on Appropriations, the Senate~~  
34 ~~Committee on Budget and Fiscal Review, the Assembly Committee~~  
35 ~~on Appropriations, and the Assembly Committee on Budget.~~ *three*  
36 *days before the commercial availability of a drug approved by the*  
37 *Federal Food and Drug Administration (FDA). In a case in which*  
38 *the commercial availability is expected within three days of FDA*  
39 *approval, a manufacturer may provide a notice pending FDA*  
40 *approval in order to ensure approved drugs are commercially*

1 available without delay, unless any other law prohibits that  
2 notification, in which case the notice shall be provided as soon as  
3 practicable, but no later than three days after FDA approval.

4 (B) Within 30 days of notification of a new drug under this  
5 paragraph, a manufacturer shall report ~~all~~ both of the following  
6 information to ~~each state purchaser, health care service plan, health~~  
7 ~~insurer, or pharmacy benefit manager:~~ *the Office of Statewide*  
8 *Health Planning and Development:*

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

12 ~~(ii)~~

13 ~~(i)~~ The expected marketing budget for the drug.

14 ~~(iii)~~

15 ~~(ii)~~ The date and price of acquisition if the drug was not  
16 developed by the manufacturer.

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

23 ~~(C) The Office of Statewide Health Planning and Development~~  
24 ~~shall publish data collected pursuant to this paragraph publicly~~  
25 ~~on its Internet Web site no less than quarterly.~~

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

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

38 (e) If a pharmacy benefit manager receives a notice of a price  
39 increase consistent with subdivision (b), the pharmacy benefit  
40 manager shall provide notice of the price increase to its contracting

1 ~~public and private purchasers. Upon request of the purchaser, the~~  
2 ~~pharmacy benefit manager shall also provide the purchaser the~~  
3 ~~justification provided by the pharmaceutical manufacturer~~  
4 ~~consistent with subdivision (b).~~

5 *(d) The Office of Statewide Health Planning and Development*  
6 *may adopt regulations or issue guidance for the implementation*  
7 *of this chapter.*

8 *(e) The Office of Statewide Health Planning and Development*  
9 *may consult with the Department of Managed Health Care, the*  
10 *Department of Insurance, the California State Board of Pharmacy,*  
11 *or any state purchaser of prescription drugs, or entity acting on*  
12 *behalf of a state purchaser, in issuing guidance under subdivision*  
13 *(d), in adopting necessary regulations, in posting information on*  
14 *its Internet Web site under this chapter, and in taking any other*  
15 *action for the purpose of implementing this chapter.*

16 *(f) The Office of Statewide Health Planning and Development*  
17 *shall be responsible for the enforcement of these provisions.*

18 *(g) (1) Any manufacturer of a prescription drug subject to this*  
19 *section shall comply with the provisions of this chapter.*

20 *(2) Any manufacturer of a prescription drug subject to this*  
21 *section that does not report the information required pursuant to*  
22 *this section to state purchasers, health care service plans, health*  
23 *insurers, or pharmacy benefit managers is liable for an*  
24 *administrative penalty of one thousand dollars (\$1,000) a day for*  
25 *every day after the 30-day notification period.*

26 *(3) An administrative penalty shall be assessed by the Office of*  
27 *Statewide Health Planning and Development. The office may order*  
28 *the penalty to be paid after appropriate notice and an opportunity*  
29 *for a hearing.*

30 ~~(f)~~

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

34 *(i) (1) For purposes of this subdivision, “pricing information”*  
35 *means advanced notification of a price increase pursuant to*  
36 *paragraph (1) of subdivision (b) or advanced notification of the*  
37 *price of a new drug pursuant to subparagraph (A) of paragraph*  
38 *(4) of subdivision (b).*

39 *(2) Until the effective date of the increase, pricing information*  
40 *shall be deemed confidential information that shall not be made*

1 *public by an entity described in paragraph (1) of subdivision (a)*  
2 *and is exempt from disclosure under the California Public Records*  
3 *Act (Chapter 3.5 (commencing with Section 6250) of Division 7*  
4 *of Title 1 of the Government Code).*

5 (3) (A) *Until the effective date of the increase, pricing*  
6 *information shall be deemed confidential information that shall*  
7 *not be made public by an entity described in paragraph (2), (3),*  
8 *or (4) of subdivision (a).*

9 (B) *Notwithstanding subparagraph (A), an entity described in*  
10 *paragraph (2) or (3) of subdivision (a) may, and an entity described*  
11 *in paragraph (4) of subdivision (a) shall, disclose pricing*  
12 *information to its contracting public and private purchasers that*  
13 *agree to maintain the confidentiality of the pricing information*  
14 *until the effective date of the increase. Pricing information received*  
15 *by a contracting public or private purchaser pursuant to this*  
16 *chapter shall be deemed confidential information that shall not*  
17 *be made public by a contracting public or private purchaser and*  
18 *is exempt from disclosure under the California Public Records*  
19 *Act (Chapter 3.5 (commencing with Section 6250) of Division 7*  
20 *of Title 1 of the Government Code).*

21 (4) *Disclosure of pricing information by a pharmaceutical*  
22 *manufacturer pursuant to this chapter shall not constitute a waiver*  
23 *of any protection of the information provided by any other law.*

24 (j) *This chapter shall remain in effect only until January 1, 2022,*  
25 *and as of that date is repealed, unless a later enacted statute, that*  
26 *is enacted before January 1, 2022, deletes or extends that date.*

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, and specialty drugs ~~provided in an outpatient~~  
35 ~~setting~~, *dispensed at a pharmacy, network pharmacy, or mail order*  
36 *pharmacy for outpatient use*, all of the following shall be reported:

37 (A) The 25 most frequently prescribed drugs.

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

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

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

7 *(1) The data in the report shall be aggregated and shall not*  
8 *reveal information specific to individual health insurers.*

9 *(2) The report shall compare, for the large group market,*  
10 *aggregate prescription drug spending among health insurers that*  
11 *use a pharmacy benefit manager with aggregate prescription drug*  
12 *spending among health insurers that do not use a pharmacy benefit*  
13 *manager.*

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.

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

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

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

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

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

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

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

- 35 (i) Premiums.
- 36 (ii) Claims costs, if any.
- 37 (iii) Administrative expenses.
- 38 (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~~ *drugs in each of the follow categories, generic drugs* excluding  
25 specialty generic drugs, brand name drugs excluding specialty  
26 drugs, and *brand name and generic* specialty drugs dispensed at  
27 a pharmacy, network pharmacy, or mail order pharmacy for  
28 outpatient use all of the following shall be disclosed:

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

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

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

38 (iv) The specialty tier formulary list.

39 (B) The insurer shall include the percentage of the premium  
40 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) and  
6 (B) ~~for which the pharmacy benefit manager is responsible.~~ *that*  
7 *are managed by the pharmacy benefit manager.*

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

10 (d) The information required pursuant to this section shall be  
11 submitted to the department on or before October 1, ~~2016,~~ 2017,  
12 and on or before October 1 annually thereafter. Information  
13 submitted pursuant to this section is subject to Section 10181.7.

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

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

33 SEC. 7. No reimbursement is required by this act pursuant to  
34 Section 6 of Article XIII B of the California Constitution because  
35 the only costs that may be incurred by a local agency or school  
36 district will be incurred because this act creates a new crime or  
37 infraction, eliminates a crime or infraction, or changes the penalty  
38 for a crime or infraction, within the meaning of Section 17556 of  
39 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.

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