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2017 CA S 17	Author: Hernandez Version: Chaptered Version Date: 10/09/2017
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Senate Bill No. 17

CHAPTER 603

An act to amend Sections 1385.045 and 127280 of, to add Section 1367.243 to, to add Chapter 9 (commencing with Section 127675) to Part 2 of Division 107 of, and to repeal Section 127686 of, the Health and Safety Code, and to amend Section 10181.45 of, and to add Section 10123.205 to, the Insurance Code, relating to health care.

[Approved by Governor October 09, 2017. Filed with Secretary of State October 09, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

SB 17, Hernandez. Health care: prescription drug costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, 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. Existing law requires health care service plans and health insurers to also disclose specified supporting information for the rate information described above. Existing law requires the DMHC and DOI, as applicable, to conduct an annual public meeting regarding large group rates within 3 months of posting that information.

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, dispensed as provided. 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 January 1 of each year. Except for the report, DMHC and DOI would be required to keep confidential all information provided pursuant to these provisions. The bill would also require health care service plans or health insurers that file the above-described rate information to disclose to DMHC and DOI with the rate information specified information regarding the relation of prescription drug costs to plan or insurer spending and premium charges. The bill would instead require DMHC and DOI to conduct an annual public meeting within 4 months of posting the rate information described above. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require a manufacturer of a prescription drug with a wholesale acquisition cost of more than \$40 that is purchased or reimbursed by specified purchasers, including state agencies, health care service plans, health insurers, and pharmacy benefit managers, to notify the purchaser of an increase in the wholesale acquisition cost of a prescription drug if the increase in the wholesale acquisition cost for a course of therapy, as defined, exceeds a specified threshold. The bill would require that notice to be given at least 60 days prior to the planned effective date of the increase. Commencing no earlier than January 1, 2019, the bill would require the manufacturer to notify the Office of Statewide Health Planning and Development (OSHPD) of specified information relating to that increase in wholesale acquisition cost on a quarterly basis at a time and in a format prescribed by the office. The bill would require the manufacturer to notify OSHPD of specified information relating to the wholesale acquisition cost, marketing, and usage of a new prescription drug if the cost exceeds a specified threshold, and would require OSHPD to publish that information on its Internet Web site, as specified. The bill would require OSHPD to enforce the provisions requiring manufacturer reporting to OSHPD and would subject a manufacturer to liability for a civil penalty if the information described above is not reported. The bill would authorize OSHPD to adopt regulations or issue guidance for the implementation of these provisions. The bill would require the California Research Bureau to report to the Legislature on the implementation of these provisions, and would subject these provisions to review by the appropriate policy committees of the Legislature, as specified.

Existing law establishes the California Health Data and Planning Fund within the office for the purpose of receiving and expending certain fee revenues. Existing law establishes the Managed Care Fund for the purpose of supporting the administration of DMHC. Existing law establishes the Insurance Fund for, among other things, the support of DOI as authorized in the annual Budget Act.

This bill would prohibit the use of any moneys in the fund from being used for the implementation of these provisions. The bill would provide that funding for the office to conduct the activities described above shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund, as specified.

This bill would provide that the above-described provisions are severable.

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 Required: MAJORITY Appropriation: NO Fiscal Committee: YES Local Program: YES Immediate Effect NO Urgency: NO Tax Levy: NO Election: NO Usual Current Expenses: NO Budget Bill: NO Prop 25 Trailer Bill: NO

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

SECTION 1. Section 1367.243 is added to the Health and Safety Code, to read:

1367.243. (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 no later than October 1 of each year, beginning October 1, 2018.

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

(A) The 25 most frequently prescribed drugs.

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

(C) The 25 drugs with the highest year-over-year increase in total annual plan 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 January 1 of each year, beginning January 1, 2019, 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 the information shall be protected from public disclosure.

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 four 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, including cost sharing for 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 generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic 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 this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health plan spending for each category of prescription drugs as defined in this subparagraph.

(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 which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, 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. Section 127280 [§](#) of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents (\$0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents (\$0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents (\$0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents (\$0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents (\$0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar (\$1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge. In no event, however, shall those amounts be used for programs administered by the office pursuant to Sections 127676, 127679, 127681, 127683, and 127685, that become effective on or after January 1, 2019.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

SEC. 4. 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 a 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 licensed health care service plan.

(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) For the purposes of this chapter, the term "office" shall mean the Office of Statewide Health Planning and Development.

127676. (a) The Legislature finds and declares that the State of California has a substantial public interest in the price and cost of prescription drugs. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. California also provides major tax expenditures through

the tax exclusion of employer sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) (1) It is the intent of the Legislature in enacting this chapter to provide notice and disclosure of information relating to the cost and pricing of prescription drugs in order to provide accountability to the state for prescription drug pricing.

(2) It is further the intent of the Legislature to permit a manufacturer of a prescription drug to voluntarily make pricing decisions regarding a prescription drug, including any price increases. It is further the intent of the Legislature to permit purchasers, both public and private, as well as pharmacy benefit managers, to negotiate discounts and rebates consistent with existing state and federal law.

127677. (a) A manufacturer of a prescription drug with a wholesale acquisition cost of more than forty dollars (\$40) for a course of therapy shall notify each purchaser described in Section 127675 if the increase in the wholesale acquisition cost of a prescription drug is more than 16 percent, including the proposed increase and the cumulative increases that occurred within the previous two calendar years prior to the current year. For purposes of this section, a "course of therapy" is defined as either of the following:

(1) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for 30 days.

(2) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for a normal course of treatment that is less than 30 days.

(b) The notice required by subdivision (a) shall be provided in writing at least 60 days prior to the planned effective date of the increase.

(c) (1) The notice required by subdivision (a) shall include the date of the increase, the current wholesale acquisition cost of the prescription drug, and the dollar amount of the future increase in the wholesale acquisition cost of the prescription drug.

(2) The notice required by subdivision (a) shall include a statement regarding whether a change or improvement in the drug necessitates the price increase. If so, the manufacturer shall describe the change or improvement.

(d) The notice required by subdivision (a) shall be provided to each state purchaser and other purchasers described in paragraphs (2) to (4), inclusive, of subdivision (a) of Section 127675 if a purchaser registers with the office for the purpose of this notification. The office shall make available to manufacturers a list of registered purchasers for the purpose of this notification.

(e) If a pharmacy benefit manager receives a notice of an increase in wholesale acquisition cost consistent with subdivision (a), it shall notify its large contracting public and private purchasers of the increase. For the purposes of this section, a "large purchaser" means a purchaser that provides coverage to more than 500 covered lives.

127679. (a) On a quarterly basis at a time prescribed by the office and in a format prescribed by the office, commencing no earlier than January 1, 2019, a manufacturer shall report to the office all of the following information for each drug for which an increase in wholesale acquisition cost is described in Section 127677:

(1) A description of the specific financial and nonfinancial factors used to make the decision to increase the wholesale acquisition cost of the drug and the amount of the increase, including, but not limited to, an explanation of how these factors explain the increase in the wholesale acquisition cost of the drug.

(2) A schedule of wholesale acquisition cost increases for the drug for the previous five years if the drug was manufactured by the company.

(3) If the drug was acquired by the manufacturer within the previous five years, all of the following information:

(A) The wholesale acquisition cost of the drug at the time of acquisition and in the calendar year prior to acquisition.

(B) The name of the company from which the drug was acquired, the date acquired, and the purchase price.

(C) The year the drug was introduced to market and the wholesale acquisition cost of the drug at the time of introduction.

(4) The patent expiration date of the drug if it is under patent.

(5) If the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug, as defined in subparagraph (A) of paragraph (7) of subdivision (k) of Section 1396r-8 of Title 42 of the United States Code.

(6) A description of the change or improvement in the drug, if any, that necessitates the price increase.

(7) Volume of sales of the manufacturer's drug in the United States for the previous year.

(b) The manufacturer may limit the information reported pursuant to subdivision (a) to that which is otherwise in the public domain or publicly available.

(c) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a quarterly basis. The information shall be published within 60 days of receipt from a manufacturer. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(d) The office shall be responsible for the enforcement of this section.

(e) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars (\$1,000) per day for every day after the reporting period described in this section that the required information is not reported.

(f) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(g) Any money received by the office pursuant to this section shall be paid into the Managed Care Fund.

127681. (a) A manufacturer of a prescription drug shall notify the office in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)). The notice shall be provided in writing within three days after the release of the drug in the commercial market. A manufacturer may make this notification pending approval by the federal Food and Drug Administration, if commercial availability is expected within three days of approval.

(b) No later than 30 days after notification pursuant to this section, a manufacturer shall report all of the following information to the office in a format prescribed by the office:

(1) A description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally.

(2) The estimated volume of patients that may be prescribed the drug.

(3) If the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval.

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

(c) The manufacturer may limit the information reported pursuant to subdivision (b) to that which is otherwise in the public domain or publicly available.

(d) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a quarterly basis. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(e) The office shall be responsible for the enforcement of this section.

(f) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars (\$1,000) per day for every day after the notification period described in this section that the required information is not reported.

(g) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(h) Any money received by the office pursuant to this section shall be paid into the Managed Care Fund.

127683. (a) Funding for the actual and necessary expenses of the office to conduct the activities described in this section and in Sections 127676, 127679, 127681, and 127685, shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care, as determined by the Department of Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance,

including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state.

127685. (a) The office may adopt regulations or issue guidance for the implementation of this chapter. All information that is required to be reported to the office pursuant to this chapter shall be reported in a form prescribed by the office, commencing in the first calendar quarter of 2019.

(b) The office may consult with the Department of Managed Health Care, the Department of Insurance, the California State Board of Pharmacy, and any state purchaser of prescription drugs, or an entity acting on behalf of a state purchaser, in issuing guidance or adopting necessary regulations pursuant to subdivision (a), in posting information on its Internet Web site pursuant to this chapter, and in taking any other action for the purpose of implementing this chapter.

127686. (a) By January 1, 2022, the California Research Bureau shall report to the Legislature on the implementation of this chapter, including, but not limited to, this chapter's effectiveness in addressing the following goals:

- (1) Promoting transparency in pharmaceutical pricing for the state and other payers.
- (2) Enhancing understanding about pharmaceutical spending trends.
- (3) Assisting the state and other payers in management of pharmaceutical drug costs.

(b) A report submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(c) Notwithstanding any other law, implementation of this chapter shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed on January 1, 2023.

(d) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 5. Section 10123.205 is added to the Insurance Code, to read:

10123.205. (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 no later than October 1 of each year, beginning October 1, 2018.

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

- (A) The 25 most frequently prescribed drugs.
- (B) The 25 most costly drugs by total annual plan spending.
- (C) The 25 drugs with the highest year-over-year increase in total annual plan 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 January 1 of each year, beginning January 1, 2018, 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 the information shall be protected from public disclosure.

SEC. 6. 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 four 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, including cost sharing 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 generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic 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 this subparagraph.
- (ii) The year-over-year increase, as a percentage, in per-member, per-month total health insurer spending for each category of prescription drugs as defined in this subparagraph.
- (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 which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(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. 7. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 8. The Legislature finds and declares that Sections 1 and 5 of this act, which add Section 1367.243 to the Health and Safety Code and Section 10123.205 to the Insurance Code, respectively, 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 regarding health care service plan and health insurer prescription drug utilization and spending information that is specific to the plan or insurer 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. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIIB 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 XIIB of the California Constitution.

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