SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2021 - 2022 Regular Session

SB 524 (Skinner) - Health care coverage: patient steering

Version: May 3, 2021
Policy Vote: B., P. & E.D. 11 - 0, HEALTH 10 - 0
Urgency: No
Mandate: Yes
Hearing Date: May 17, 2021
Consultant: Janelle Miyashiro

Bill Summary: SB 524 prohibits health care service plans, self-insured employer plans, and health insurers from engaging in patient steering.

Fiscal Impact:

The Department of Managed Health Care (DMHC) anticipates the total cost of this bill to be approximately $95,000 and 0.5 personnel year (PY) in fiscal year (FY) 2021-22, $301,000 and 1.6 PYs in FY 2022-23, $288,000 and 1.6 PYs in 2023-24, and $72,000 and 0.4 PY in FY 2024-25 and ongoing annually thereafter (Managed Care Fund). A breakdown of DMHC's anticipated costs is as follows:

- Office of Legal Services short-term workload costs to conduct legal research and issue legal memorandums to clarify requirements: $226,000 and 1.2 PYs in FY 2022-23 and $216,000 and 1.2 PYs in FY 2023-24.

- Office of Plan Licensing workload costs to address review health plan documents, including Evidence of Coverages, provider contracts, and other disclosure forms: $44,000 and 0.2 PY in FY 2021-22, $22,000 and 0.1 PY in FY 2022-23, $21,000 and 0.1 PY in 2023-24 and ongoing annually thereafter.

- Office of Enforcement workload costs to address referrals: $51,000 and 0.3 PY in FY 2021-22, $53,000 and 0.3 PY in FY 2022-23, $51,000 and 0.3 PY in FY 2023-24 and ongoing annually thereafter.

The California Department of Insurance anticipates costs of $29,000 in FY 2021-22, $65,000 in FY 2022-23, and $53,000 ongoing (Insurance Fund) to address a potential increase in enforcement workload.

Background: AB 315 (Wood, Chapter 905, Statutes of 2018), requires pharmacy benefit managers (PBMs) to register with the DMHC, and to disclose, upon a purchaser's request, information with respect to prescription product benefits. AB 315 also required the DMHC to convene a task force on Pharmacy Benefit Management Reporting to determine what information related to pharmaceutical costs the DMHC should require to be report by health care service plans or their contracted PBMs.

PBMs are health care companies that contract with health plans to manage pharmacy benefits and negotiate manufacturer rebates. PBMs play no role in the physical distribution of prescription drugs. Rather, drugs move from the manufacturer, to the

distributor, to the pharmacy, to the consumer. PBMs help health plans manage their drug benefits through negotiating or contracting with manufacturers and/or pharmacies on behalf of their contracted health plans.

Proposed Law:

- Prohibits a health care service plan, a self-insured employer plan, or a health insurer to engage in patient steering.
- Defines "patient steering" as either:
    - Communicating to an enrollee or insured verbally, electronically, or in writing, that they are required to have a prescription dispensed at, or pharmacy services by, a particular pharmacy or pharmacies if there are other pharmacies in the network that may dispense medication or provide services.
    - Offering or including in contract or policy designs for purchasers of group health care coverage provisions that limit enrollee's or insureds' access to only those pharmacy providers that are owned or operated by the self-insured employer plan or self-insured employer plan's agent, or owned or operated by a corporate affiliate of the self-insured employer plan or agent.
- Specifies that patient steering does not include directing an enrollee to a specific pharmacy for a specific prescription due to the need for special handling or clinical requirements that cannot be performed by other pharmacies in the provider network of the health care service plan or agent.
- Authorizes a health care service plan or agent to offer enrollees financial incentives, such as reductions in copays, to use a particular pharmacy.
- Excludes a health service plan that is part of a fully integrated delivery system in which enrollees primarily use pharmacies that are entirely owned and operated by the health care service plan, and the plan's enrollees may use any pharmacy in the health care service plan's network.
- States findings and declarations.

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