
THIRD READING

Bill No: SB 524
Author: Skinner (D)
Amended: 5/3/21
Vote: 21

SENATE BUS., PROF. & ECON. DEV. COMMITTEE: 11-0, 4/5/21
AYES: Roth, Archuleta, Becker, Dodd, Eggman, Hurtado, Leyva, Min, Newman,
Ochoa Bogh, Pan
NO VOTE RECORDED: Melendez, Bates, Jones

SENATE HEALTH COMMITTEE: 10-0, 4/28/21
AYES: Pan, Eggman, Gonzalez, Grove, Hurtado, Leyva, Limón, Roth, Rubio,
Wiener
NO VOTE RECORDED: Melendez

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/20/21
AYES: Portantino, Bradford, Jones, Kamlager, Laird, Wieckowski
NO VOTE RECORDED: Bates

SUBJECT: Health care coverage: patient steering

SOURCE: California Pharmacists Association

DIGEST: This bill prohibits a health plan, insurer, self-insured employer plan and an agent of a health plan, health insurer, self-insured employer plan from engaging in specified activities that limit enrollees' or insureds' access to pharmacies that are part of the plan's or insurer's network, except if special handling or clinical requirements are necessary, and permits the use of financial incentives at network pharmacies.

ANALYSIS:

Existing law:

- 1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq., and INS §106, et seq.]
- 2) Establishes requirements for nongrandfathered health plans and health insurance policies that cover outpatient prescription drugs. [HSC §1342.7 and INS §10123.193]
- 3) Requires a plan or insurer that provides essential health benefits to allow an enrollee or insured to access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration (FDA) or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Permits a nongrandfathered individual or small group health plan contract or insurance policy to charge an enrollee or insured a different cost sharing for obtaining a covered drug at a retail pharmacy, but requires all cost sharing to count toward the annual limitation on cost sharing. [HSC §1367.42 and INS §10123.201]
- 4) Establishes a pilot project to assess the impact of health plan and pharmacy benefit manager (PBM) prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies. Applies the provisions to pharmacy providers located in the counties of Riverside and Sonoma. Prohibits a health plan from, or permitting any delegated PBMs to prohibit, a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or PBM allows that amount to be dispensed through a pharmacy owned or controlled by the plan or PBM, unless the prescription drug is subject to restricted distribution by the FDA or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Requires on or before July 1, 2020, health plans subject to this pilot to report annually to DMHC information and data relating to changes, if any, to costs and utilization of prescription drugs attributable to the prohibition of contract terms. Requires DMHC to summarize data received and provide the summary to the Governor and health policy committees of the Legislature on or before December 31, 2022. [HSC §1368.6]

This bill:

- 1) Prohibits a health plan or a health insurer, including a self-insured employer plan, or the agent of a health plan or health insurer from engaging in patient steering.
- 2) Defines “patient steering” as either of the following:
 - a) Communicating to an enrollee or insured, verbally, electronically, or in writing, that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy or pharmacies if there are other pharmacies in the network that have the ability to dispense the medication or provide the services.
 - b) Offering or including in contract or policy designs for purchasers of group health care coverage provisions that limit enrollees’ or insureds’ access to only those pharmacy providers that are owned or operated by the self-insured employer plan, health plan, health insurer, or an agent of the self-insured employer plan, health plan or insurer; or are owned or operated by a corporate affiliate of the health plan, health insurer, or plan’s or insurer’s agent.
- 3) Permits directing an enrollee or insured 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 plan, health insurer, or plan’s or insurer’s agent.
- 4) Permits a health plan, health insurer, self-insured employer plan, or the agent of a health plan or health insurer to offer enrollees or insureds financial incentives to use a particular pharmacy, including, but not limited to, reductions in copays or other financial incentives given to the enrollee or insured when the prescription is dispensed.
- 5) Exempts from this bill:
 - a) A health plan or insurer that is part of a fully integrated delivery system where enrollees or insureds, primarily use pharmacies that are entirely owned and operated by the health plan or insurer, and the plan’s enrollees or insureds, may use any pharmacy in the network that has the ability to dispense the medication or provide the services; and,
 - b) A self-insured employer plan administered by a health plan or its health insurer affiliate that is part of a fully integrated delivery system in which

enrollees, including enrollees in a self-insured employer plan administered by the health care service plan or its health insurer affiliate, primarily use pharmacies that are entirely owned and operated by the health plan and the enrollees, including enrollees in a self-insured employer plan administered by the health plan or its health insurer affiliate, may use any pharmacy in the self-insured employer plan's network that has the ability to dispense the medication or provide the services.

- 6) Finds and declares when a health plan, insurer, or PBM requires a patient to use a specific pharmacy provider for services that otherwise could be provided by any pharmacy in the provider network, it unjustifiably limits patient choice and may put the patient's health at risk. Evidence shows that limiting access to pharmacy providers is designed to eliminate competition and can result in higher costs, patient losing connection with trusted providers, and getting advice and consultation they need. It is necessary to limit patient steering.

Comments

Author's statement. According to the author, patients are safer and better served when they can fill their prescriptions with pharmacists they know, who are familiar with their unique medical history, and who speak their language and have cultural competency. However, through a practice known as patient steering, pharmacy PBMs inform patients that they must have their prescriptions filled at a select pharmacy or pharmacies—usually a retail or mail order pharmacy owned by the PBM or health plan—even though there are other pharmacies in the network that the patient wishes to use and which can safely fill the prescription. Patients risk not having their prescription filled or having to pay out-of-pocket if they do not use the PBM's selected pharmacy. Requiring patients to use a select retail or mail order pharmacy can harm patients, including those who do not live near the retail pharmacy and those who cannot get their prescriptions delivered due to logistical reasons or privacy concerns if their package is intercepted. This bill prohibits patients from being required to use a particular pharmacy when there is no clinical reason they must do so and ensures that patients can access whichever pharmacy in their network they prefer.

DMHC Task Force. AB 315 (Wood, Chapter 905, Statutes of 2018) required DMHC to convene a Task Force on PBM Reporting. PBMs are health care companies that contract with health plans to manage pharmacy benefits and negotiate manufacturer rebates. Throughout the Task Force meetings, various presenters discussed the role of PBMs in the complex pharmaceutical supply chain. It was noted that 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. It was established there is a lack of transparency regarding the value PBMs bring to the health care industry and how they help to reduce prescription drug costs. There is also a lack of transparency regarding how PBMs make money and how much money they make. One Task Force recommendation is to require PBM reporting on the pharmacy source for each drug reported. Pharmacy source refers to the type of pharmacy used by enrollees to obtain a prescription drug. Pharmacy source includes integrated, chain, independent, specialty, and mail order pharmacies. PBM reporting on pharmacy source would demonstrate the volume of prescription drugs filled at different types of pharmacies, whether certain types of pharmacies are dominating the market and how these market dynamics ultimately impact costs. This data could also shed light on how enrollees access pharmacies and their relationships with pharmacists.

Market concentration. Among other issues of concern that came up at the DMHC Task Force was the issue of market concentration. Not only across the marketplace, but also vertically within the supply chain. Some PBMs own their own pharmacies, referred to as an “integrated pharmacy.” This may result in misaligned incentives, as a PBM may favor an integrated pharmacy even if competing pharmacies have lower costs. Additionally, the Task Force heard from pharmacy representatives who stated PBMs may improperly utilize prescription information to steer patients who are prescribed high-cost drugs to the PBM’s integrated pharmacies. Some PBMs and health plans have common ownership which could lead to PBMs increasing drug costs to rival health plans.

Self-insured employer plan. While not defined in this bill, the term refers to state regulated self-insured plans as well as plans regulated under the Employee Retirement Income Security Act (ERISA). An ERISA plan is established by an employer or employee organization and arranges (whether through insurance or otherwise) for certain benefits, including medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, among others. ERISA preempts state regulation of self-insured plans. That regulation of a self-insured plan is one that binds the plan administrators in making determinations on eligibility or entitlement to certain benefits. So ERISA’s primary concern is over laws that require providers to structure benefit plans in particular ways, such as requiring payment of specific benefits or beneficiary determinations, or laws that force ERISA plans to adopt a certain scheme of coverage which was made clear in *Rutledge v. Pharmaceutical*

Care Management Association (2020) 141 S.Ct. 474, 480. *Rutledge* generally allows states to regulate PBMs much more than originally expected under ERISA. Under *Rutledge*, the Pharmaceutical Care Management Association (PCMA) challenged a 2015 Arkansas law that includes mandates for pharmacy reimbursement for drug costs, new requirements for PBMs, updates to maximum allowable cost lists, and administrative appeal procedures. At issue in the Supreme Court ruling is whether or not provider reimbursement requirements are preempted by ERISA and the Supreme Court held that the Arkansas law is not preempted by ERISA. Specifically, Justice Sotomayor's opinion states "the Court holds that the Act has neither an impermissible connection with nor reference to ERISA and is therefore not pre-empted." With regard to patient steering, in *Tri-City Healthcare District v. Scripps Health, Inc.* (S.D. Cal 2010) 2010 WL 11509161, the health care district sued Scripps over Scripps patient steering practice. The district court found the claims of patient steering were unrelated to the benefits ERISA covered patients would receive under the ERISA plan.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

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.

CDI 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.

SUPPORT: (Verified 5/21/21)

California Pharmacists Association (source)
Advocating for Access Specialty Pharmacy Coalition
AIDS Healthcare Foundation
APLA Health
California Chronic Care Coalition
California Nurses Association
Consumer Attorneys of California
Fremont Chamber of Commerce
National Community Pharmacy Coalition

OPPOSITION: (Verified 5/21/21)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Pharmaceutical Care Management Association

ARGUMENTS IN SUPPORT: The California Pharmacists Association, the sponsor of this bill, writes that the National Community Pharmacists Association conducted a survey which noted that, "A majority of community pharmacies have lost patients in the last six months due to unfair patient steering, and CVS Health is most often the culprit. "The AIDS Healthcare Foundation writes in support that patient steering is a concern because the pharmacy is a critical component of patient care, especially for those with chronic medical conditions like HIV who need a pharmacist who is familiar with the patient, the condition and the patient's specific needs. Additionally, the cost to the patient may be higher when steered to a pharmacy controlled by the insurer. This is a particular concern to patients who are on a fixed income. Lastly many patients with chronic conditions are unable to travel far to pick up their prescriptions and neighborhood pharmacies provide convenience and patient-physician relationship that is frequently invaluable in maintaining a patient's treatment regimen. APLA Health writes that mail-order pharmacies can also result in significant privacy and safety issues for some clients, including youth and others living in congregate settings, people experiencing domestic violence, people living in rural areas and others who may need to protect their confidential medical information. If these individuals do not have the option

to discreetly pick up their medication at their local pharmacy, medications arriving via mail-order may be intercepted by someone who is not aware of their medical condition – threatening their housing, employment or even physical security. These concerns are particularly salient for LGBTQ individuals, who may not be out to friends and family and could face stigma, discrimination, rejection and violence should their sexual orientation and/or gender identity be revealed. Mail-order pharmacy requirements have long been recognized to be inappropriate and even unlawful for people living with HIV. Numerous lawsuits have been successfully brought against insurance companies over mandatory mail-order requirements and subsequent impacts on people living with HIV. Most notably, the Ninth Circuit Court of Appeals overturning a lower court's decision, holding that five "John Doe" patients with HIV could pursue a discrimination claim against CVS Caremark for requiring people with HIV to obtain their medications by mail order or drop shipment to a CVS store.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) write by focusing on pharmacies that provide cost-effective and high-quality care, health plans and insurers are ensuring consumers receive the best value for their health care dollars. This bill threatens these safety and cost saving measures. CAHP, ACLHIC and AHIP are concerned that this bill would eliminate the use of "preferred" networks that provide patients with additional cost saving measures. Some health plans and insurers are part of vertically integrated systems – they may own or be owned by entities that also operate PBMs and/or pharmacies. CAHP, ACLHIC and AHIP are interested in the data that the author is relying on to show that these vertically integrated systems restrict patients' choice when data has shown the opposite. PCMA writes that this bill eliminates choices for employers and individuals to select a benefit plan that meets their needs. PCMA also believes this bill is not likely to apply to self-funded employer or union plans and the burden will fall on fully insured small businesses and individual who purchase coverage through Covered California. PCMA believes bill proponents are incorrectly interpreting *Rutledge*. PCMA cites *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) which concluded that the imposition of "rate regulation" did not violate ERISA's preemption clause for self-insured plans. PCMA believes this bill dictates plan choices for self-insured plans and believes it would be preempted under ERISA. PCMA writes restricting lower cost pharmacy network designs, and lower cost mail-order pharmacies will raise costs and lower quality. The California Chamber of Commerce writes this bill intends to regulate self-insured employers, which falls squarely within the province

of ERISA. This impermissible overreach is preempted by federal law and violates the objective of achieving national uniformity in self-insured benefit design.

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****** END *****