

Date of Hearing: July 6, 2021

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

Evan Low, Chair

SB 524 (Skinner) – As Amended June 28, 2021

NOTE: This bill is double referred and passed the Assembly Committee on Health on June 23, 2021, by a vote of 11-1-3.

SENATE VOTE: 39-0

SUBJECT: Health care coverage: patient steering

SUMMARY: Prohibits a health plan, a health insurer, a self-insured employer plan, or respective agent, including a pharmacy benefits manager (PBM), from engaging in patient steering, including communicating to an enrollee or insured that they are required to use a particular pharmacy or offering health care coverage contracts or policies that include provisions that limit access to only pharmacy providers that are owned or operated by the health plan, health insurer, self-insured employer plan, or agent.

EXISTING LAW:

- 1) Licenses and regulates the practice of pharmacy, including pharmacists, pharmacies, and wholesalers of medical drugs and devices under the Pharmacy Law. (Business and Professions Code (BPC) § 4000-4427.8)
- 2) Establishes the California Board of Pharmacy to administer and enforce the Pharmacy Law. (BPC § 4001)
- 3) Establishes requirements and processes for the audits of pharmacy benefits and PBMs. (BPC §§ 4430-4441)
- 4) Defines “carrier” as a health care service plan, as defined in the Health and Safety Code, or a health insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code. (BPC § 4430(a); Health and Safety Code (HSC) § 1345; Insurance Code (INS) § 106)
- 5) Defines “health benefit plan” as any plan or program that provides, arranges, pays for, or reimburses the cost of health benefits. “Health benefit plan” includes, but is not limited to, a health care service plan contract issued by a health care service plan, as defined in the HSC, and a policy of health insurance, as defined in the INS, issued by a health insurer. (BPC § 4430(d); HSC § 1345; INS § 106)
- 6) Defines “pharmacy benefit manager” as a person, business, or other entity that, pursuant to a contract or under an employment relationship with a carrier, health benefit plan sponsor, or other third-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, plan sponsor, or other third-party payer, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or

grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs. (BPC § 4430(g))

- 7) Provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. (HSC § 1340-1399.864; INS § 740-742.1)
- 8) Requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. (HSC § 1342.71(c))

THIS BILL:

- 1) Prohibits a health plan, a health insurer, a self-insured employer plan, or respective agent, including a PBM, 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 or self-insured employer plan’s agent, or owned or operated by a corporate affiliate of the self-insured employer plan or self-insured employer plan’s agent.
- 3) Excludes from the definition of “patient steering” the act of 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 care service plan, a health insurer, self-insured employer plan or self-insured employer plan’s agent.
- 4) Provides that the requirements under this bill do not prevent a health plan, a health insurer, a self-insured employer plan, or respective agent, from offering 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) Prohibits a health plan, a health insurer, a self-insured employer plan, or respective agent, from prohibiting an in-network pharmacy from offering to match the financial incentives offered to an enrollee or insured.
- 6) Excludes from the provisions of the bill a self-insured employer plan administered by a health care service 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 care service plan and the enrollees, including enrollees in a self-insured employer plan administered by the health care service 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.

- 7) Makes various finding and declarations, including that evidence shows that limiting access to pharmacy providers is designed to eliminate competition and can result in higher costs for the patient and for the health care system as a whole and can result in patients losing connection with trusted providers and being unable to get the advice and consultation they need.

FISCAL EFFECT: According to the Senate Committee on Appropriations analysis of the June 14, 2021, version of this bill:

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.

COMMENTS:

Purpose. This bill is sponsored by the *California Pharmacists Association*. 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.”

Background. A PBM is any person or entity that, pursuant to a contract or under an employment relationship with a carrier, health benefit plan sponsor, or other third-party payer, manages the prescription drug coverage provided by the carrier, plan sponsor, or other third-party payer. Coverage management includes the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

PBMs negotiate the prices of prescription drugs, create and manage formularies, and several other functions key to the management of pharmacy benefits. PBM's interact with many parties in the pharmaceutical industry, including drug manufacturers, health plans and insurers, and pharmacies. This bill would prohibit those parties from unilaterally steering patients away from certain pharmacies or towards any particular pharmacy with limited exceptions.

Specialty Drugs and Clinical Requirements. There are some drugs and pharmaceuticals that require special storage and handling conditions or active patient management. As a result, some pharmacies must maintain special equipment, pharmacists with special qualifications, or other conditions that allow for the safe dispensing of specialty drugs. This bill contains a provision that allows the steering of a patient to specified pharmacies if other in-network pharmacies are unable to meet the special handling or clinical requirements of any drug.

Prior Related Legislation. AB 1803 (Committee on Health), Chapter 114, Statutes of 2019 required a pharmacy to inform a customer at the point of sale for a covered prescription drug whether the retail price is lower than the applicable cost-sharing amount for the prescription drug, except as specified, and, if the customer pays the retail price, requires the pharmacy to submit the claim to the customer's health plan or health insurer beginning January 1, 2020.

AB 315 (Wood), Chapter 905, Statutes of 2018 required PBMs to register with the DMHC, to exercise good faith and fair dealing, and to disclose, upon a purchaser's request, information with respect to prescription product benefits, as specified.

SB 17 (Hernandez), Chapter 603, Statutes of 2017 required health plans and insurers that offer commercial products and file rate information with the DMHC or CDI to annually report specific information related to the costs of covered prescription drugs.

AB 2752 (Nazarian) of 2016, which was held in the Assembly Committee on Appropriations, would have required a health plan or a health insurer to annually notify an enrollee or insured that the enrollee's or insured's drug treatment or provider is no longer covered by the plan or policy.

AB 2400 (Nazarian) of 2016, which was held in the Assembly Committee on Appropriations, would have required health plans and health insurers to comply with a shortened internal grievance review process for formulary drugs.

AB 374 (Nazarian), Chapter 621, Statutes of 2015 authorized a request for an exception to a health plan's or health insurer's step therapy process for prescription drugs to be submitted in the same manner as a request for prior authorization for prescription drugs. Requires the health plan or insurer to treat, and respond to, the request in the same manner as a request for prior authorization for prescription drugs.

AB 339 (Gordon), Chapter 619, Statutes of 2015 required health plans and health insurers that provide coverage for outpatient prescription drugs to have formularies that do not discourage the enrollment of individuals with health conditions, and requires combination antiretrovirals drug treatment coverage of a single-tablet that is as effective as a multitablet regimen for treatment of Human immunodeficiency virus infection and acquired immune deficiency syndrome, as specified.

ARGUMENTS IN SUPPORT:

The sponsor of this bill, the *California Pharmacists Association (CPhA)*, “Patient steering occurs when a PBM moves a patient's prescription to a different pharmacy without their consent and that new pharmacy happens to be owned by the PBM – either a physical location or a mail-order pharmacy. Patients are then given a ‘choice’ of filling their covered prescriptions at the new pharmacy or pay full price out of pocket at the existing in-network pharmacy. The practice of patient steering is becoming increasingly problematic for patients who are losing their right to receive pharmacy services at locations convenient to them and/or where they have an established relationship with the pharmacist. While this practice happens primarily in the independent setting, it is increasingly happening in smaller chain settings who are not owned by PBMs.... While CPhA believes there is a role for pharmacy benefit managers, the problem lies with the inherent conflict of interest when a PBM is steering patients to their own pharmacies. It is at that point we must question whether decisions are made for the benefit of the patient or simply to increase profit margins.”

APLA Health writes in support:

Forcing patients to use a mail-order pharmacy or alternative pharmacy location can destroy the critical relationship between patients and their pharmacists who know them personally, including their medical history and any issues that may impact medication adherence. For many patients, their pharmacists are an indispensable resource to monitor drug-drug interactions and provide ongoing education and adherence support. Trusted pharmacists are also often the best source of accurate information about medication efficacy and side effects, which remain among the most persistent challenges to increasing uptake of HIV prevention medications.

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.

ARGUMENTS IN OPPOSITION:

The *Pharmaceutical Care Management Association* writes in opposition:

[This bill] seeks to expand the ability of non-specialty pharmacies to dispense specialty drugs which will increase costs for health plans and patients but, more importantly, put patients at risk.

Under the guise of prohibiting so-called ‘patient steering,’ [this bill] would expand the ability of any network pharmacy to dispense a specialty drug even though that pharmacy even though it may not be under contract as a specialty network pharmacy. Qualifying as a network specialty pharmacy entails significantly more than agreeing to financial terms. Network specialty pharmacies meet independent, nationally recognized accreditation standards established by organizations such as the Joint Commission and the Utilization Review Accreditation Commission (URAC), which ensure quality services and patient safety.

The latest amendments to the bill are confusing and deeply troublesome. First, the language confuses patient cost share with pharmacy reimbursement. First, a pharmacy (whether in network or not) has no influence over a patient's cost-sharing amounts/incentives as spelled out in their health plan. That decision is made by the health plan sponsor. Second, it is unclear as to whether the intent is to (a) allow patients to go to any pharmacy, thus eliminating the ability to create cost-saving pharmacy networks, or (b) prohibit pharmacy tiers, which lower costs for plans and patients. The amendment would eliminate any incentive for network pharmacies to offer discounted reimbursements to be in a preferred tier, resulting in higher costs for everyone.

Furthermore, [this bill] would permit a network pharmacy not accredited or contracted as a specialty network pharmacy to dispense specialty drugs, putting patients at risk. The lack of acceptance of our proposed clarifying language related to ‘specialty pharmacy,’ coupled with the author's amendment, reveals the intended expansion of scope for retail pharmacies. Not only is this bill a concerning expansion of scope from a pharmacy practice perspective, but it also fails to protect Californians. This bill would expand a pharmacy's scope without ensuring patient and drug safety as a component of dispensing specialty drugs. Simply being a network pharmacy would be sufficient to act as a network specialty pharmacy under this bill

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 in opposition, “Health plans, insurers, and their contracted pharmacy benefit managers (PBMs)

design pharmacy networks with the consumer in mind. They contract with chain, independent, and mail order pharmacies to provide consumers with the choice of services that best fit their needs. They design preferred networks that allow patients to have access to high performing, lower cost options. All of this is done with the consumer's safety in mind – the pharmacy programs created by health plans, insurers, and PBMs are able to look across all of the patients' pharmacy activity to flag potential interactions, provide counseling for patients with chronic conditions, and suggest lower-cost alternatives. 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. We are concerned that this bill would erode the use of 'preferred' networks that provide patients with additional cost saving measures."

AMENDMENTS:

- 1) *Incentive Matching*. There are questions raised about the impact of prohibiting in-network pharmacies from matching financial incentives on the overall benefit design process and downstream impacts on consumer premiums. Because those questions are largely outside the jurisdiction of this Committee, the bill should be amended to delete the language inserted after the bill passed the Assembly Committee on Health on June 28, 2021.

On pages 3-4 of the bill, strike lines 36-39 and 1-2, on page 5, strike lines 3-7, and on page 6, strike lines 3-6:

~~(2) Notwithstanding paragraph (1), a self-insured employer plan or the agent of a self-insured employer plan shall not prohibit an in-network pharmacy from offering to match the financial incentives offered to an insured of the self-insured employer by the self-insured employer plan or its agent, as set forth in this subdivision.~~

- 2) *Offering Incentives*. To clarify that financial incentives being offered to enrollees or insureds can be affirmatively communicated by the offeror, the bill should be amended as follows:

On page 3, lines 30-35, on pages 4-5, lines 37-39 and 1-2, and on pages 5-6, lines 37-39 and 1-2 insert "and communicating to" after "offering":

(d) ~~(4)~~ This chapter does not prevent a self-insured employer plan or the agent of a self-insured employer plan from offering *and communicating to* 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.

REGISTERED SUPPORT:

AfA Specialty Pharmacy Association
Aids Healthcare Foundation
APLA Health
California Chronic Care Coalition
California Dental Association
California Medical Association

California Nurses Association
Consumer Attorneys of California
Indian Pharmacists Association of California
National Multiple Sclerosis Society
United Nurses Associations of California

REGISTERED OPPOSITION:

America's Health Insurance Plans
American GI Forum Education Foundation of Santa Maria, California
Association of California Life & Health Insurance Companies
Black Chamber of Orange County
Breckpoint, Inc.
California African American Chamber of Commerce
California Association of Health Plans
California Business Roundtable
California Chamber of Commerce
California Hispanic Chambers of Commerce
California State Association of Electrical Workers
California State Pipe Trades Council
League of United Latin American Citizens
National Association for the Advancement of Colored People, Santa Maria-Lompoc Branch
National Latina Business Women Association of Los Angeles
Orange County Hispanic Chamber of Commerce
Pharmaceutical Care Management Association
San Diego County Hispanic Chamber of Commerce
Sheet Metal Workers' Local Union No. 104
Southwest California Legislative Council
Western States Council Sheet Metal, Air, Rail and Transportation

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301