SENATE THIRD READING
SB 524 (Skinner)
As Amended August 30, 2021
Majority vote

SUMMARY

Prohibits a health care service plan (health plan), a health insurer, or agent from engaging in patient steering, as specified. Defines patient steering as communicating to an enrollee or insured that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy, as specified, 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, or health insurer, or agent. Exempts a self-insured multiemployer Taft-Hartley plan or the agent of a self-insured multiemployer Taft-Hartley plan from the provisions of this bill.

COMMENTS

1) *Existing PBM law*. Pharmacy Benefit Managers (PBMs) play a major role in negotiating the prices of prescription drugs, creating and managing formularies, and several other functions key to the management of pharmacy benefits for millions of Californians. However, despite a PBM's interaction with most major players, including drug manufacturers, health plans and insurers, and pharmacies, very little is known about those relationships. AB 315 (Wood), Chapter 905, Statutes of 2018, establishes a regulatory structure for PBMs, and provides for the registration of PBMs to the Department of Managed Health Care (DMHC). AB 315 requires DMHC, by July 1, 2019, and in collaboration with other agencies, departments, advocates, experts, health plan representatives, and other entities and stakeholders that it deems appropriate, to convene a Task Force on PBM Reporting to determine what information related to pharmaceutical costs, if any, it should require to be reported by health plans or their contracted PBMs, in addition to reporting required in existing law.

2) *2020 AB 315 Task Force Report*. From July to December 2019, the DMHC facilitated a series of public Task Force meetings to develop the recommendations contained in this report. The report noted that the PBM marketplace appears to be highly concentrated, with the top three PBMs representing approximately 75% of covered lives in California. Some suggest that this concentration is evidence of a stable and functioning market, whereas others believe it is evidence that the largest PBMs have a stranglehold on the market and therefore wield too much negotiating power. Stakeholders attending the Task Force meetings asserted that dominant PBMs may negotiate higher rebates only to keep the bulk of the rebate. By not passing the rebate on to health plans, consumers may be adversely affected by higher costs. Market concentration is seen 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. The Task Force recommended gathering data to increase transparency and understand how PBMs impact the cost of prescription

drugs, including gathering information on PBMs, including revenue and expense information, to determine PBM market impact and the value PBMs provide to consumers.

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, 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. The author states that 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. The author concludes that 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.

Arguments in Support
The California Pharmacists Association (CPhA), sponsor of this bill, writes that 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. CPhA notes that while this practice happens primarily in the independent setting, it is increasingly happening in smaller chain settings who are not owned by PBMs. The U.S. Centers for Medicare & Medicaid Services has expressed concern that PBMs are using pharmacy contracts "in a way that inappropriately limits dispensing of specialty drugs to certain pharmacies" and in ways that have nothing to do with patient health. While CPhA believes there is a role for PBMs, 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.

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), in a previous version of this bill, contend that this bill takes away vital tools that health plans and insurers use to ensure patient safety and lower health care costs for consumers. CAHP, ACLHIC, and AHIP state that this bill limits benefit designs focused on lowering costs for consumers as plans design preferred networks that allow patients to have access to high performing, lower cost options. Additionally, the Federal Trade Commission has found that vertical integration can provide benefits and lower costs. Finally, this legislation may open the state to litigation because it attempts to regulate ERISA plans and overreaches as it tries to regulate self-insured employer plans and may put the state at risk of litigation.

The Department of Finance is opposed to this bill, as it creates increased costs to the Managed Care Fund not accounted for in the 2021 Budget Act.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, amendments taken in the Assembly Appropriations Committee reduce the number of plans subject to this bill's provisions, thereby reducing costs. Assuming a reduction of roughly 50%, costs for DMHC are estimated to be $60,000 in fiscal year (FY) 2021-22, $160,000 in FY 2022-23, $150,000 in FY 2023-24 and $40,000 annually thereafter (Managed Care Fund). For the Department of Insurance, costs are estimated at $15,000 in FY 2021-22, $32,000 in FY 2022-23, and $26,000 ongoing (Insurance Fund).

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Gonzalez, Grove, Hertzberg, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Melendez, Min, Newman, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Glazer

ASM HEALTH: 11-1-3
YES: Wood, Aguiar-Curry, Eduardo Garcia, Burke, Carrillo, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago
NO: Bigelow
ABS, ABST OR NV: Mayes, Flora, Waldron

ASM BUSINESS AND PROFESSIONS: 15-1-3
YES: Low, Berman, Bloom, Chiu, Fong, Gipson, Grayson, Holden, Irwin, McCarty, Medina, Mullin, Salas, Ting, Akilah Weber
NO: Megan Dahle
ABS, ABST OR NV: Flora, Chen, Cunningham

ASM APPROPRIATIONS: 13-3-0
YES: Lorena Gonzalez, Bryan, Calderon, Carrillo, Chau, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Kalra
NO: Bigelow, Megan Dahle, Davies

UPDATED

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