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

SB 853 (Wiener) - Prescription drug coverage

Version: April 25, 2022
Urgency: No
Hearing Date: May 9, 2022
Policy Vote: HEALTH 10 - 0
Mandate: Yes
Consultant: Samantha Lui

Bill Summary: Senate Bill 853 would require a health plan contract or health insurance policy, issued, amended, or renewed on or after January 1, 2023, that covers prescription drug benefits to provide coverage for a drug, dose of a drug, or dosage form during the entire duration of utilization review and any appeals of utilization review if that drug has been previously approved for coverage by a health care service plan, as specified. Would prohibit a health plan or insurance policy from seeking reimbursement, as specified, for prescription drug coverage during utilization review, as defined, if the final utilization review decision is to deny coverage.

Fiscal Impact:

- Department of Managed Healthcare. Staff estimates indeterminate, limited-term costs, potentially over $150,000 (Managed Care Fund) for workload to review and update forms ensure compliance.

- Department of Insurance. The CDI would need $7,000 (Insurance Fund) In FY 2022-23 and $16,000 (Insurance Fund) in FY 2023-24 for increased workload to conduct form reviews to revise off-label coverage provisions and add that coverage for a prescribed drug must be provided immediately and during utilization reviews and appeals, and reimbursement cannot be sought.

- CalPERS. Unknown. It would be difficult to predict or estimate potential drug utilization or changes in prescriptions during the utilization review process. CalPERS health plans have Utilization Management Programs in place with goals and methods to prevent members from being exposed to unnecessary risks.

Background: Health plans and health insurance policies that include a pharmacy benefit may apply techniques to manage utilization, such as requiring prior authorization or have formulary requirements. Should a plan or insurer review a request and then deny coverage, an employee may appeal the decision to the Department of Managed Health Care and Department of Insurance, which regulates Knox-Keene plans and health insurers, respectively. Existing law prohibits a health plan contract or insurance policy that covers prescription drug benefits from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

- The drug is approved by the FDA;
- The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or the drug is prescribed by a

participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. Requires, if the drug is not on the plan formulary, the participating subscriber's request to be considered pursuant to the expeditious process required in #11) below;
- The drug has been recognized for treatment of that condition by specified entities; and,
- Two articles from major peer reviewed medical journals present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Proposed Law: Senate Bill 853 would require a health plan contract or health insurance policy, issued, amended, or renewed on or after January 1, 2023, that covers prescription drug benefits to provide coverage for a drug, dose of a drug, or dosage form during the entire duration of utilization review and any appeals of utilization review if that drug has been previously approved for coverage by a health care service plan for a medical condition of the enrollee and has been prescribed by a health care provider.

The bill would prohibit a health plan or insurance policy from seeking reimbursement, as specified, for prescription drug coverage during utilization review, as defined, if the final utilization review decision is to deny coverage.

The bill would prohibit a health plan contract or health insurance policy from limiting or excluding coverage for a dose of a drug on the basis that the dose prescribed is different from the dose that has been approved for marketing by the FDA, provided specified conditions in existing law.

Related Legislation:

- AB 2352 (Nazarian) requires a health plan or health insurer to furnish specified information about a prescription drug upon request by an enrollee or insured, or their health care provider. Prohibits a health plan or health insurer from restricting a health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug, as specified. AB 2352 is pending in the Assembly Appropriations Committee.

- AB 742 (Nazarian of 2021) is substantially similar to AB 2352. AB 742 was held in the Assembly Appropriations Committee.

Staff Comments: The California Health Benefits Review Project analyzed this bill and assumed the reference to "utilization review and any appeals of utilization review" would include: 1) Prior authorization review and response by the plan or insurer; 2) Appeal review and response by the plan or insurer; and, 3) Appeal review and response by the regulator (DMHC or CDI). Key findings of the report:

- This bill would increase total net annual expenditures by $83.7 million for enrollees with health insurance subject to state-level benefit mandates. This is due to a $74 million increase in total health insurance premiums and a $9.5 million increase in enrollee cost-sharing. CHBRP projects no change to

copayments or coinsurance applicable to filled prescriptions for particular drugs. However, an increase utilization of specialty and brand drugs, as well as off formulary drugs (which are often associated with greater per-fill cost-sharing) are anticipated. Premiums would increase by $27.0 million in the group market.

- About 5 percent of commercial and CalPERS enrollees in policies and plans regulated by CDI and/or DMHC are without a pharmacy benefit regulated by CDI or DMHC, so this bill is not applicable to them. Of the remaining commercial/CalPERS enrollees, at baseline, none of the commercial/CalPERS enrollees have benefit coverage that is fully compliant with this bill. CHBRP's analysis indicates that approximately 13 million and 14 million enrollees depending on the provisions, post enactment would have coverage compliant with this bill.

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