Date of Hearing: August 16, 2023

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
SB 70 (Wiener) – As Amended June 29, 2023

Policy Committee: Health Vote: 12 - 3

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill prohibits a health plan or insurer from limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use for a life-threatening or chronic and seriously debilitating condition or cancer, if the health plan or insurer previously covered the drug for the patient, regardless of whether the drug, dose, or dosage form is on the plan's or insurer's formulary. This bill also prohibits a health plan contract or health insurance policy from requiring additional cost sharing for a drug that was previously approved for coverage.

FISCAL EFFECT:

1) The Department of Insurance (CDI) estimates costs of $33,000 in fiscal year (FY) 2023-24 and $134,000 in FY 2024-25 (Insurance Fund).

2) The Department of Managed Health Care (DMHC) estimates costs of approximately $2.16 million in FY 2023-24, $3.14 million in FY 2024-25, $3.45 million in FY 2025-26, and $3.78 million in FY 2026-27 and annually thereafter (Managed Care Fund). These costs are to address increases in consumer complaints and independent medical reviews (IMRs), revise survey methodology and tools to monitor compliance, review health plan filings of utilization management process and provide guidance, to engage statistical and clinical consultants to assist with medical surveys and develop methodology for compliance, address 36 additional referrals from the Help Center and Office of Plan Monitoring, and for enforcement and administrative support services. DMHC notes:

> Generally, and depending on final enrollment data, a one million dollar increase to the MCF could result in a 2-cent increase per enrollee per month on assessments to full-service health plans and a 1-cent increase per enrollee to specialized health plans. To the extent this bill and others result in additional assessments on health plans, there could be an impact to consumers in the form of increased premiums.

3) The California Health Benefits Review Program (CHBRP) estimates annual expenditures for CalPERS premiums would increase by $310,000 (General Fund, special funds). The state pays for approximately 60% of CalPERS enrollees (Public Employees Health Care Fund, special funds).

4) Although not a state cost, CHBRP estimates this bill would increase total net annual expenditures by $27 million (0.02%) for enrollees with DMHC-regulated plans and CDI-regulated policies, due to a $23 million increase in total health insurance premiums and a $4 million increase in enrollee cost sharing (including the $310,000 increase in CalPERS premiums in 3), above).

COMMENTS:

1) **Purpose.** This bill is sponsored by the Crohn's & Colitis Foundation. The author states:

> Senate Bill 70 strengthens California's prohibition on non-medical switching — when a health plan forces a patient to switch from a prescribed drug to a different drug for non-medical reasons — by clarifying that the prohibition also applies to the dose level and dosage form of a previously prescribed drug. Health plans and insurance companies should not be able to disrupt a patient's care, risking severe pain and even death, to save money. SB 70 allows patients to continue on their medication, at their optimized dosage, to ensure continuity of care and prioritize the safety of those living with chronic illnesses.

2) **Continuity of Coverage.** State law requires a plan regulated by DMHC or CDI that includes a pharmacy benefit not limit or exclude coverage for a drug for an enrollee if: i) the plan had previously approved the drug for a medical condition of the enrollee; ii) the plan's prescribing provider continues to prescribe the drug for the medical condition; and, iii) the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. This bill amends existing law from "drug" to "drug, dose of the drug, or dosage form" and specifies the requirement applies to off-label use of a drug if the criteria in the off-label mandate are met. This bill also prohibits cost sharing changes if the plan previously covered the drug for the treatment of a medical condition of the enrollee.

3) **CHBRP Report.**

Utilization. At baseline, this bill applies to 551,000 prescriptions, predominantly non-preferred brand and specialty drugs prescribed for off-label use. Postmandate, CHBRP estimates this bill will result in 18,000 fewer generic and preferred brand scripts filled and 22,000 more non-preferred brand and specialty scripts filled. At baseline, the average unit cost of a 30-day supply for a drug with coverage impacted by this bill is estimated to be approximately $2,908, with a range of less than $750 to more than $6,000. Postmandate, CHBRP projects the average unit costs of applicable prescriptions would be 0.76% higher because the postmandate mix of covered scripts filled would include a smaller proportion of generic and preferred brand drugs and a greater proportion of specialty and non-preferred brand drugs, which are generally more expensive.

***Expenditures*.** CHBRP estimates this bill will increase total net annual expenditures by $27 million (0.02%) for enrollees with health insurance subject to state-level benefit mandates. Although the proposed continuity provisions would limit cost sharing, the off-label provisions, which would be connected to the majority of additional filled scripts, would not alter applicable cost sharing. Under the off-label provisions, CHBRP projects increased utilization of specialty and non-preferred brand drugs, as well as off-formulary drugs (all of

which are often associated with greater per-fill cost sharing), and therefore an increase in total enrollee cost sharing due to greater use of scripts for which greater cost sharing is required.

CHBRP assumed the prohibition on cost sharing change is applicable only within a plan/policy year and not if the enrollee changes to another plan or policy. However, the author intends the prohibition on cost sharing to apply on a year-over-year basis, and even if an enrollee changes plans, effectively making the prohibitions on cost sharing changes for these individuals permanent. CHBRP notes that, if the prohibition on cost sharing change does apply on a year-over-over basis and when an enrollee changes to a different policy or plan impacts on premiums, the costs could, in the long term, become "orders of magnitude greater than what is projected in [its] analysis."

4) **Opposition.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write this bill negates the health plan's or insurer's ability to ensure clinically appropriate use of prescription drugs, and encourages the use of expensive specialty and brand name drugs when a generic or lower cost brand equivalent is available and clinically appropriate. The opponents state that when health plans and insurers limit or deny a drug or specific dose of a drug, it is generally for safety reasons, such as potential abuse or overuse, inconsistency with FDA-approved labeling, or to prevent use at doses that have not been shown to be efficacious. Lastly, opponents argue this bill will lead to potentially dramatic increases in health care costs in California, largely because this bill prohibits plans from adjusting the enrollee or insured's portion of the cost share if the drug had previously been covered, regardless of an increase in dosage or change in dosage form.

5) **Related Legislation.**

   a) SB 339 (Wiener) requires a health plan and health insurer to cover preexposure prophylaxis (PrEP) and postexposure prophylaxis furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist, and reimburse pharmacist services at 100% of the fee schedule for physician services and authorizes a pharmacist to furnish up to a 90-day course of PrEP, or beyond a 90-day course, under specified conditions. SB 339 is pending in this committee.

   b) SB 427 (Portantino) prohibits a health plan or insurer from subjecting certain antiretroviral drugs, devices, or products for the prevention of HIV/AIDS, to prior authorization (PA) or step therapy, but authorizes PA or step therapy if at least one therapeutically equivalent version is covered without PA or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. SB 427 is pending in this committee.

6) **Prior Legislation.** SB 853 (Wiener), of the 2021-22 Legislative Session, would have prohibited a health plan or insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed, or imposing additional cost sharing for a drug as prescribed, if specified criteria apply. SB 853 would have provided that a reduction or termination of an ongoing and approved course of treatment before the end of the treatment or the end or amendment of the policy is an adverse benefit determination, and

required a health plan or insurer to notify an enrollee or insured, and their provider, as specified. SB 853 would have required a plan or insurer that has approved an ongoing course of treatment to provide continuing coverage pending appeal or review, and would have prohibited a health plan or insurer from limiting or declining to cover a drug or dose of a drug as prescribed, or impose additional cost sharing for covering a drug as prescribed, if the drug was previously covered by the plan or insurer or the enrollees or insured's prior coverage for the enrollee's medical condition. SB 853 died on this committee's suspense file.

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