Pension and Health Benefits Committee

Agenda Item 7a

June 14, 2016

Item Name: Senate Bill 1010 (Hernandez) Prescription Drug Cost Transparency

As Amended May 31, 2016

Sponsors: California Labor Federation and Health Access California

Program: Legislation

Item Type: Action

Recommendation
Adopt a **Support** position on Senate Bill (SB) 1010 because it would provide greater transparency in prescription drug costs so purchasers can understand its impact on health care affordability and premiums.

Executive Summary
SB 1010 requires health plans and health insurers regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) to annually report by plan the 25 medications provided in an outpatient setting that: 1) are most frequently prescribed; 2) are most costly; and, 3) experienced the highest year over year increase in total plan spending, and requires each department to compile and publish the information on its website annually. It also requires large group health plans and insurers to file aggregate data for all the plans and policies they sell in the large group market: 1) the proportion of the premium dollar spent on prescription drugs during the prior year; 2) the year-over-year increase in drug costs as a percentage of total spending; 3) the year-over-year increase in drug costs on a per member per month basis compared to other premium components; and, 4) its specialty tier formulary list. The bill requires drug manufacturers to provide to state purchasers, health plans, health insurers, Pharmacy Benefit Managers (PBMs), and policymakers a 60-day notice before increasing the Wholesale Acquisition Cost (WAC) of a prescription drug by more than 10 percent or more than $10,000 for brand name drugs, and 25 percent for generics with a monthly cost of $100 or more. It also requires drug manufacturers to provide notice within three days of approval by the federal Food and Drug Administration (FDA) of a new prescription drug that will be marketed at a WAC of $10,000 or more annually or per course of treatment. For new prescription drugs that will be marketed at a WAC of $10,000 or more annually or per course of treatment, it also requires drug manufacturers to provide notice within three days of approval by the federal FDA.

The California Public Employees Retirement System (CalPERS) Legislative and Policy Engagement Guidelines recommend support for proposals that promote transparency in the reporting of cost and quality data for both for-profit and not-for-profit organizations, including health plans, insurers, health care providers, hospitals, and physicians. The Guidelines also

recommend support for proposals that will reduce the cost of prescription drugs while also maintaining appropriate quality of and access to brand name, generic, biosimilar, and interchangeable drugs. SB 1010 ensures large group health plan purchasers like CalPERS have access to prescription drug cost information to help them understand the impact of drug pricing on overall health care costs.

Strategic Plan
This item supports CalPERS 2012-17 Strategic Plan Goal A to improve long-term pension and health benefit sustainability by ensuring high-quality, accessible, and affordable health benefits.

Background
Existing Law
State law requires large group health care service plan contracts or policies, plans, and insurers to file with DMHC or CDI at least 60 days prior to implementing any rate change all required information for unreasonable rate increases. State law requires plans and insurers to submit all information required by the Affordable Care Act (ACA) and to disclose specified aggregate data related to such rate filings.

State law also requires health plans and health insurers that provide coverage in the large group market to file specified rate information including the weighted average rate increase for all large group benefit designs sold during the 12 month period ending January 1 of the following calendar year with either DMHC or the CDI. State law requires plans and insurers to file specified aggregate data for all the plans and policies they sell in the large group market on or before October 1, 2016, and annually thereafter, and requires each department to conduct an annual public meeting regarding large group rate changes within three months of posting the aggregate information.

Legislative Investigations into Drug Cost Trends
On February 4, 2015, the Senate Committee on Health held an informational hearing entitled: "Making Health Care Affordable: What's Driving Costs?" Among the topics addressed was the role of pharmaceuticals as a driver of increasing health care costs.

Pharmaceutical company representatives testifying before the Committee maintained that the high cost of these drugs is due to years of research and development, but questions have been raised about how much the price of high-cost drugs reflects their developmental costs. However, several witnesses before the Committee spoke about the Hepatitis C virus (HCV) drug called Sovaldi, which was being sold at a price of $1,000 per pill or $84,000 for a full course of treatment. For example, Kaiser Permanente presented data that while Sovaldi sold for $84,000 per course of treatment in the United States, it sold for $57,000 in the United Kingdom, $2,000 in India, and $900 in Egypt. Transparency as to research and development costs might help explain these pricing disparities.

The impact of high-cost drugs on health care costs for the State of California will be significant. The Committee overview noted that the cost of this drug was already having an effect on state finances, as Governor Brown's 2015-16 Budget included $300 million in additional funds to cover HCV treatment over the next two years. In addition, the Senate Health Committee cited a study that pegged the potential cost for HCV treatment for California's Medi-Cal enrollees and prison population at $6.6 billion.

CalPERS Prescription Drug Costs and Utilization

In 2014, CalPERS total spending for retail and mail-order prescription drugs for all of CalPERS plans was $1.8 billion for 19.67 million prescriptions. This represents approximately 23 percent of CalPERS total spend of $7.72 billion on health for that year. The average amount per prescription was $94.38 and the CalPERS member cost share for all prescriptions in 2014 was 10.2 percent. In contrast, the 2013 national average member cost share for all prescriptions for large employers was 22.1 percent.

In addition, CalPERS specialty drug cost trends from 2012 to 2014 demonstrated a sharp increase from $270 million to $438 million. Although specialty drug prescriptions represented only 0.76 percent of all prescriptions, specialty drug allowed amounts accounted for 23.6 percent of total CalPERS drug costs. In comparison, specialty drug expenditures accounted for approximately 30 percent of total prescription drug costs in 2014.

Analysis

1. Proposed Changes

   Because CalPERS self-funded preferred provider organization plans are not subject to CDI oversight, this analysis only addresses impacts on large group health maintenance organization plans regulated by the DMHC.

   Health Plan Annual Rate Filings

   - Requires all health plans that report rate information to the DMHC to report the following information by plan for all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs provided in an outpatient setting (defined as exceeding the threshold for a specialty drug under the Medicare Part D program):
     - The 25 most frequently prescribed drugs;
     - The 25 most costly drugs by total plan spending; and
     - The 25 drugs with the highest year-over-year increase in spending.
   - Requires the DMHC to compile the submitted information into a report for the public and Legislature that demonstrates the overall impact of drug costs on health care premiums; to publish the report on its Internet Web site by October 1 of each year; and to include the report as part of the public meeting required under the existing large group rate review law.
   - Requires the data in the report to be aggregated and not reveal information specific to individual health care service plans. Requires DMHC, except for the report required above, to keep confidential all of the information provided, and exempts that information from disclosure under the California Public Records Act (CPRA).
   - Requires large group health plans, as part of their annual filing of information for rate changes aggregated for the entire large group market, to disclose the following information for covered prescription drugs, including: generic drugs (excluding specialty generic drugs), brand name drugs (excluding specialty drugs), and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use. All of the following:
     - The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs;
     - The year-over-year increase, as a percentage, in total spending for each category of prescription drugs;
     - The year-over-year increase in per member, per month costs for drug prices compared to other components of the health care premium; and
     - The specialty tier formulary list.

- Requires large group health plans to also report the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

Drug Manufacturer Notice and Justification Requirements

- Requires drug manufacturers, when increasing the WAC of a branded prescription drug by more than 10 percent or by more than $10,000 during any 12-month period, or when increasing the WAC of a generic prescription drug with a WAC of $100 or more per monthly supply or by more than 25 percent during any 12-month period, to notify each state purchaser, health care service plan, health insurer, PBM, and various state legislative committees, in writing at least 60 days prior to the planned effective date of the increase.
- Requires drug manufacturers, when introducing a new prescription drug to market at a WAC of $10,000 or more annually or per course of treatment, to notify each state purchaser, health care service plan, health insurer, PBM, and various state legislative committees, in writing within three days of the FDA approval.
- Requires drug manufacturers to report, within 30 days of the notification of a price increase or new high cost drug coming to market, to report to each state purchaser, health care service plan, health insurer, PBM, and various state legislative committees, all the following information:
    - A justification for the proposed price increase or introductory price, whose information may be limited to information which is publicly available;
    - The previous year's marketing budget or the expected marketing budget for the drug;
    - The date and price of acquisition if the drug was not developed by the manufacturer; and
    - A schedule of price increases for the drug for the previous five years, if applicable.
- Defines "state purchaser" to include, but not be limited to, CalPERS, the Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, or any entity acting on behalf of a state purchaser.
- Imposes a fine of $1,000 per day for every day after the 30 day notification period for failure to report the required information to state purchasers.
- Requires the Legislature to conduct an annual public hearing regarding aggregate trends in prescription drug pricing. It also requires the hearing to provide for public discussion of overall price increases, emerging trends, decreases in drug spending, and the impact of prescription drug on health care affordability and premiums.
- Exempts the information the drug manufacturers disclose to the Legislature from CPRA.
- Prohibits this bill from restricting the legal ability of a drug manufacturer to change prices as permitted under federal law.

2. <u>Author's Intent</u>
   According to the author:
   "The ACA was a culmination of decades of movement toward health reform, and is the most fundamental transformation of the US health care system in decades. However, it lacked sufficient policy solutions on containing rising costs. The problem here is that the law now mandates coverage, but it does not include safeguards to ensure coverage is affordable. Rising drug prices certainly have contributed to an uptick in the rate of increase of spending on health care. But depending on what is counted and how it is counted, drug

spending may be an even larger problem than many thought. There is very little transparency into the process of pricing drugs, and more information is needed in order to understand the true impact."

3. Argument in Support
   According to Health Access, *"the information provided to public and private purchasers under SB 1010 would help these purchasers to better negotiate prescription drug prices. SB 1010 is a modest but important step forward in providing transparency on prescription drug costs."*

4. Argument in Opposition
   According to the California Life Sciences Association, *"the information required of biopharmaceutical companies, health plans, and insurers would create a highly inaccurate picture of how medicines affect overall healthcare costs…SB 1010 treats medication costs as solely expenditures, not an investment in more efficient care and better health for patients. The bill ignores all the benefits to patients, the healthcare system, and the economy…"*

5. Access to Additional Cost Data
   Over the past several years, both the Legislature and the health care industry have attempted to respond to demands for increased "transparency" concerning information about health care costs, utilization, and outcomes. With additional and improved data on costs and outcomes, purchasers can make better decisions and the industry can more swiftly identify and resolve problems.

   CalPERS currently contracts with a PBM, CVS Health, which negotiates with drug manufacturers to secure the most favorable drug prices and rebates. CalPERS already receives some of SB 1010's proposed reporting information as CVS Health and health plans are required to disclose the cost of the drugs and report total claims which gives CalPERS a rough estimate of how much of the premium is going towards drugs. However, SB 1010 could provide CalPERS and its health plans additional information such as causes and timing of increases in prescription drug costs.

   It is not clear what impact SB 1010 would have on pharmaceutical pricing for high-cost drugs. The bill contains no regulatory mechanisms on drug prices (which would be precluded by federal law) but simply requires the disclosure of pricing and utilization data to purchasers, policy-makers, and the public. Once this information is available, it would enable policy-makers to better evaluate possible cost-containment measures in the future.

6. Consistent with Past Transparency Legislation Supported by the Board of Administration
   Last year, the Board of Administration (Board) supported SB 546 (Leno, Chapter 801, Statutes of 2015) to among other things, require health plans and health insurers to file specified rate information including the weighted average rate increase for all large group benefit designs sold during the 12-month period ending January 1 of the following calendar year with either the DMHC or CDI. It requires the notice of changes to premium rates or coverage for large group health plans and insurance policies to provide additional information regarding whether the rate change is greater than average rate increases approved by the California Health Benefit Exchange for individual market products or by the CalPERS Board, or would be subject to the federal excise tax. The bill also modifies existing annual reporting requirements for plans and insurers to file specified aggregate data for all the plans and policies they sell in the large group market on or before

October 1, 2016, and annually thereafter, and requires each department to conduct an annual public meeting regarding large group rate changes within three months of posting the aggregate information.

SB 1010 builds upon this recently enacted legislation to require health care plans to include prescription drug utilization and cost data in their rate filings with the DMHC.

Budget and Fiscal Impacts

1. Benefit Costs
   SB 1010 increases transparency in pharmaceutical costs which could help CalPERS and its contracted health plans with integrated pharmacy and PBM better identify cost drivers and develop drug formularies that may help to lower health care premiums for CalPERS members and employers.

2. Administrative Costs
   There are no anticipated administrative costs for CalPERS. However, the reporting requirement may create new administrative workload for CalPERS contracted health plans with integrated pharmacy and PBM.

Benefits and Risks

1. **Benefits**
   - Increased transparency of prescription drug cost may help control overall cost of drugs.

2. **Risks**
   - The new reporting requirements may create new administrative workload for our health plans and PBM.

Attachments

Attachment 1 – Legislative History
Attachment 2 – Support and Opposition

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