

# Recapping the 2017-2018 California Legislative Session (Part 1): Incremental Steps Made in Targeting High Drug Costs and Achieving Single Payer

After considering 5,617 bills and resolutions, the two year California legislative cycle has come to a conclusion. As health care costs become more scrutinized, more bills than ever have emerged to target these costs. While not all of those bills passed, a significant amount of bills that did pass as well as the notable bills that failed coalesce around four themes: targeting high costs of prescription drugs, working towards a single payer system, regulating competition, and limiting high health costs. This post will focus on the first two themes: high costs of prescription drugs and efforts to implement or explore single payer. While we don't have time to cover them all, here are some notable bills that passed (and some that didn't) that have caught our attention.

## **Theme 1: Targeting High Costs of Prescription Drugs through Cost-Sharing and Regulation of Market Participants**

The 2017-2018 California Legislature intensified its focus on drug prices. As discussed in a previous California Legislative [post](#), the California Legislature has conducted numerous informational hearings about the impact of drug prices and the market players that influence them. These informational hearings have led to multiple bills that attempt to stem the high costs of prescription drugs. Bills that were considered in 2017-2018 sought to either limit out of pocket spending or regulate the market players.

### *1. Limiting Out of Pocket Expenses via Cost-Sharing*

In general, bills sought to limit out of pocket expenses for consumers by targeting cost-sharing (like copayment and coinsurance). This resulted in bills prohibiting gag clauses for pharmacists or limiting the amount consumers would pay for certain prescriptions. All the bills discussed in this section have been enacted as law.

Both [AB 315](#) and [AB 2863](#) ban gag clauses for pharmacists, allowing pharmacies to inform consumers when the retail price is lower than the applicable cost-sharing amount for the prescription drug, unless the pharmacy automatically charges the customer the lower price.<sup>[1]</sup> Additionally, **AB 315**, **AB 2863**, and [SB 1021](#)<sup>[2]</sup> mandate that an enrollee shall not be required to pay more than the retail price. The bills set the maximum amount a health plan or insurer can charge an enrollee for a covered prescription as the lesser of the following: applicable cost-sharing amount for the prescription drug or the retail price. The purpose of these bills is to prevent clawbacks, which are the excess amount of an overpayment that a health plan or insurer or pharmacy benefit manager keeps.

To further limit consumers' out of pocket costs, two bills extend the sunset dates of existing laws that cap cost-sharing. **SB 1021** continues to cap cost-sharing at \$250 for a 30-day supply of a covered outpatient prescription drug. However, if the plan is equivalent to a bronze level, the cap continues to remain at \$500. SB 1021 extends the sunset date from January 1, 2020 to January 1, 2024. Similarly, [AB 1860](#) extends the sunset date from January 1, 2019 to January 1, 2024 on a law that limits the total amount of copayment and coinsurance for up to a 30-day supply of an orally administered anticancer medication. AB 1860 raises the limit from \$200 to \$250 and removes the authorization that a health plan can adjust the limit for inflation.

Additionally, and as a response to the opioid crisis, [AB 1048](#) requires a health care service plan or an insurer to prorate an enrollee's or insured's cost-sharing for a partial fill of a prescription drug that's in an oral, solid dosage form and prohibits prorated cost-sharing payment to be considered as an overpayment. This bill would in effect allow partial fills of Schedule II controlled substances (like opioids), which will in turn reduce out of pocket costs for consumers and the availability of unused and unwanted opioids.<sup>[3]</sup>

On the other hand, [AB 265](#) bans drug manufacturer coupons, which brand name

drug manufacturers use to discount cost-sharing of their drugs. Drug coupons only decrease out of pocket costs for consumers, to induce them to buy the more expensive brand name drugs, but costs for health plans remain the same. As a result, Assemblymember Jim Wood claimed that the coupons targeted in AB 265 led to higher health care premiums.[\[4\]](#) By banning coupons, AB 265 would prevent drug manufacturers from incentivizing consumers to stay on brand name drugs when lower cost generic alternatives are available.

Overall, bills targeting cost-sharing have been very successful in the legislature. However, limits to out of pocket spending to consumers may not be enough to fully stem the high cost of prescription drugs. With health plans still paying the high cost, these bills, with the exception of AB 265, may only shield the true price of drugs, as health care premiums continue to increase.

## *2. Regulating Market Participants*

Despite the focus on limiting cost-sharing, the California Legislature has also turned its attention to market players like pharmacy benefit managers (PBMs).[\[5\]](#) **AB 315**, which was more extensively covered in a previous Source blog [post](#), requires PBMs to register with the Department of Managed Health Care, disclose information to purchasers, and exercise good faith and fair dealing. It also convened a Task Force for PBM Reporting to determine information related to pharmaceutical costs. [AB 29](#), a similar bill that failed, would have also required PBMs to disclose information to purchasers and to be licensed.

Additionally and of note for the future, **AB 315** establishes a pilot project in Riverside and Sonoma Counties. This project will shed light on whether PBMs and health plans hamper competition by forcing medications to be dispensed in only certain pharmacies. Specifically, the pilot project seeks to understand the impact when health plans and PBMs contractually prohibit other pharmacies from dispensing a prescribed medication that is already dispensed by a pharmacy owned or controlled by that health plan or PBM.

Lastly, **SB 1021** regulates drug formularies to limit the amount of costs passed on to consumers. Specifically, the bill prevents a health plan or insurer from designing a drug formulary with more than four tiers until January 1, 2024. Previously, a health

plan or insurer could theoretically design an infinite number of tiers, with higher tiers costing more out of pocket for the consumer. As health plans and insurers encourage the use of lower cost drugs on lower tiers, drugs on higher tiers with higher costs become more inaccessible. SB 1021 not only prevents this type of benefit design, but also reaffirms the standardization of tiers. By reasserting the definitions for each tier, the bill ensures that nonpreferred brand name drugs are not unjustifiably placed on a higher and consequently, costlier tier.

This prohibition and standardization comes at a time of change. The California Health Benefits Review Program stated in its analysis of SB 1021 that decisions about formularies “may change over time[,] as the health care market — namely the relationships between carriers and PBMs — is rapidly changing” due to the constant stream of mergers.[\[6\]](#) By restricting market players in this changing field from drastically changing benefit designs, SB 1021 can be seen as a preemptive measure to prevent indirect changes that affect healthcare spending.

Overall, the California Legislature has passed bills mostly concerning cost-sharing of prescription drugs but has also begun to focus on the benefit designs of health plans, as well as previously unknown market players like PBMs. This increase in focus on market players may continue in the new cycle as the legislature delves deeper into the causes of high health care costs.

## **Theme 2: The (Mostly) Unsuccessful Rise of Universal Health Care Coverage Bills**

The 2017-2018 cycle was not kind to the prospects of universal health care in California. The Senate Appropriation Committee analysis for the much-discussed but ultimately unsuccessful [SB 562](#), a bill for single payer in California, warned that “rebuilding the California health care system from a multi-payer system into a single payer, fee-for-service system” was “subject to enormous uncertainty” and would require at least \$50-\$100 billion per year in new spending, totaling \$400 billion in annual costs.[\[7\]](#)

Ultimately, the successful bills that concerned single payer were exploratory and

created through the swift budget process. [AB 1810](#), which includes many, many other provisions, establishes the Council on Health Care Delivery Systems to create a plan toward single payer (or as the bill states, a “health care delivery system . . . that provides coverage and access through a unified financing system.”[\[8\]](#)) [AB 2472](#) adds to the duties of the Council by requiring it to produce a feasibility analysis for a public health insurance plan option “to increase competition and choice for health care consumers.”[\[9\]](#) Other than the creation of the plan and feasibility analysis, the Council was given no further abilities, mandates, or powers to implement the plan.

**AB 1810**’s creation of the Council assimilates the original purpose of two abandoned bills introduced earlier in 2018: [AB 2517](#), which would have established the Advisory Panel on Health Care Delivery Systems and Universal Coverage to develop a plan for universal coverage through a unified publicly financed health care system, and [AB 2489](#), which would have resurrected the enacted language of a 1999 bill (SB 480) that required the Secretary of the California Health and Human Services Agency to report to the Legislature on the options for achieving health care coverage. Additionally, **AB 1810** improves upon the vague and ultimately unsuccessful [AB 1643](#), which would have created the Health Care for All Commission, which would have, until January 1, 2020, investigated issues related to improving health care access and affordability for all Californians.

This is not the first time California has passed bills to explore single payer options. The previously mentioned 1999 bill, SB 480, created a whole host of reports relating to single payer, but the website that hosted them no longer exists, so many of those reports are no longer available to the public. Furthermore, the reports did not seem to influence any substantial changes to the California health care system. If AB 1810 is to be successful, there must be a companion bill that provides implementation of the plan. Otherwise, it will just generate a lot of reports with nowhere to go.

In the end, the Legislature’s focus on limiting cost-sharing is successful in the short term. However, simply limiting cost-sharing for consumers acts as the equivalent of a band-aid as it does not tackle the problem of growing prescription drug prices. To achieve significant and sustainable health savings, future legislatures must focus on the sources of high health care costs, such as regulating market players who set the prices, as well exploring other health care delivery systems. But, one incremental

step is not enough. The Legislature must continue to build upon previous legislative actions to produce any long-lasting effect. In the next part of the 2017-2018 California Legislature review, we'll discuss how the legislature attempted to reduce anticompetitive behaviors and increase competition while trying to increase transparency over high healthcare costs.

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[1] The Source's Katie Gudiksen did a [marvelous and thoroughly extensive discussion](#) on the prohibition of gag clauses nationally. As she noted, the federal government has also enacted laws to ban gag clauses.

[2] SB 1021 codifies an existing Department of Managed Health Care regulation.

[3] See Sen. Com. on Bus., Prof., and Econ. Dev., Analysis of Assem. Bill No. 1048, 2017-2018 Reg. Sess. at pg. 4 (Ca. 2017) (as amended Jun. 21, 2017); *Law Will Allow Partial Fill of Schedule II Drugs, Help Reduce Unused Controlled Substances*, The Script 6 (Mar. 2018).

[4] *Assemblymember Jim Wood's Bills to Fight Escalating Prescription Drug Prices Approved by Senate Health Committee*, Assemblymember Jim Wood (Jul. 5, 2017), <https://a02.asmdc.org/press-releases/assemblymember-jim-woods-bills-fight-escalating-prescription-drug-prices-approved-0>.

[5] For a broader picture, The Source's Katie Gudiksen reviews PBM regulation nationally in this blog [post](#).

[6] California Health Benefits Review Program, A Report to the California State Legislature: Analysis of California SB 1021 Prescription Drugs 47 (Apr. 9, 2018), <http://analyses.chbrp.com/document/view.php?id=1340>.

[7] Sen. Com. on Appropriations, Analysis of Sen. Bill No. 562, 2017-2018 Reg. Sess. at pg. 1 (Ca. 2017) (as amended Apr. 17, 2017).

[8] AB 1810. 2017-2018 Reg. Sess. (Ca. 2018).

[\[9\]](#) AB 2472. 2017-2018 Reg. Sess. (Ca. 2018).