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New California Legislation Governing Health Plans' Relationships with Pharmacies and Pharmacy Benefit Managers

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Last month, California Governor Jerry Brown signed AB 315 into law. AB 315 is California's version of the growing national trend to regulate pharmacy benefit managers ("PBMs"). PBMs are entities that not only manage prescription drug benefits under health insurance plans, including drug utilization review, drug plan formulary development, selecting pharmacies for prescription drug networks, and determining reimbursements for those pharmacies, but also operate mail order and specialty pharmacies themselves. The new California law defines PBMs,, and subjects them to regulation under the Knox Keene Act and the Business & Professions Code. Notably, there are new duties imposed on PBMs for contracts entered into, amended or renewed on or after January 1, 2019. These duties include a requirement to exercise good faith and fair dealing -- a term with special legal significance in the realm of a California insurer's obligations to insureds -- and a registration requirement with the California Department of Managed Health Care ("DMHC").

But AB 315 is not limited to the regulation of PBMs: In fact, many provisions of the bill deal with network pharmacies and health plans directly, and are evidence of the Legislature's intent to exercise additional regulation over PBM's through the regulation of PBM's business partners' dealings with PBMs. And since DMHC already regulates health plans under the Knox Keene Act and the Business & Professions Code, the Legislature placed many of the health plan related provisions of the bill in the Knox Keene Act. It is these provisions that are the focus of this QuickStudy.

Definition of PBMs

For the first time, the bill adds a definition of PBM to California law, placing the statute in the Knox Keene Act provisions of the Health & Safety Code. The definition specifies that PBMs are,

> a person, business, or other entity that, pursuant to a contract with a health care service plan, manages the prescription drug coverage provided by the health care service plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

The definition also exempts licensed health care plans and their individual employees, and takes effect starting January 1, 2020.

Contractual Requirements and Disclosure Duties

The bill requires health care service plans to disclose certain prescription drug information to contracted pharmacy providers and PBMs. The bill goes on to list certain required contractual provisions for contracts between health care service plans and PBMs, including compliance obligations, registration requirements and informing pharmacists of their right to submit complaints to the DMHC. A health care service plan's failure to comply with the contractual requirements are ground for disciplinary action by the DMHC.

The bill also limits plans' ability to enter into contracts that preclude PBMs from giving patients information about less costly alternatives. Under the new law, and upon request by the purchaser, PBM's are subject to a number of disclosure requirements on a range of subjects from the acquisition costs of the pharmaceuticals, including rebates, administrative fees, to any information about exclusivity agreements with pharmaceutical manufacturers to certain utilization information. Further PBMs must not take any actions

designed to discourage purchasers from exercising their right to request the information, but Purchasers must agree in writing to maintain the confidentiality of the information before the PBMs must disclose it.

While the statute specifically exempts health care service plans and health insurers from these disclosure requirements, this exemption is limited to when those entities (or their affiliates, subsidiaries, related entities or contract medical groups) "offer, provide or administer pharmacy benefit services AND if those services are offered, provided or administered to enrollees, subscribers, policyholders or insureds who are also covered by health benefits offered, provided or administered by that health care service plan or health insurer."(emphasis added).

Pilot Project and Task Force

AB 315 establishes a pilot project (to be conducted in one southern and one northern California county) to assess the impact of the law on the dispensing of certain amounts of prescription drugs. The pilot project will require health care service plans subject to the rule to make annual reports to DMHC from July 1, 2020 until the conclusion of the project in 2023. The DMHC may also solicit additional data or information from "other interested stakeholders." The statute does not contain details about the information to be reported or the reported format. However, the statute does require the DMHC to convene a collaborative task force to determine what information related to pharmaceutical costs, if any, should be reported by health care service plans or their PBMs, so it is possible that this task force will be charged with making recommendations on reporting under the pilot. The task force must be in place by July 1, 2019. Finally, the bill requires the DMHC to submit two different reports to the Legislature. The first report is on the task force recommendations, and is due by February 1, 2020. The second report is on the costs and utilization of prescription drugs that are tracked under the pilot, and is due December 31, 2022.

Prescription Drug Claims and Contract Provisions Relating to These Claims

Under the new law, unless the pharmacy automatically charges the lesser price, pharmacies must inform consumers when the price for a covered prescription drug is lower than the cost-sharing amount. And when the customer is charged the retail price instead of the cost share, claims must be submitted in the same manner as they would if the customer had paid the cost sharing, and the amount paid must be applied to both the deductible and the out of pocket maximum. Moreover contract provisions that are entered into after January 1, 2019 and are inconsistent with these requirements are void and unenforceable.

For more information on the matters discussed in this *Locke Lord QuickStudy*, please contact the author.

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