AB 315 Prescription Drug Pilot Project Summary Report

December 15, 2022

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I. Executive Summary

The California Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets, including all of the health plans that participate in Covered California. The DMHC also regulates Medi-Cal managed care plans, Medicare Advantage plans, and specialized health plans, including dental and vision plans.

Assembly Bill (AB) 315 (Wood, Chapter 905, Statutes of 2018), as codified in part in Health and Safety Code section 1368.6, established a pilot project, effective January 1, 2020, in Riverside and Sonoma counties to assess the impact of health plan and pharmacy benefit manager (PBM) prohibitions on the dispensing of certain amounts of prescriptions drugs by network retail pharmacies. During the pilot project, health plans and PBMs were required to permit prescription drugs to be dispensed at all network pharmacies in the same quantities that are dispensed at pharmacies owned or controlled by the health plans or PBMs.

Health plans operating in Riverside and Sonoma counties were required to submit data to the DMHC detailing the impact of the pilot project on costs and utilization. The DMHC is required to submit a report to the Governor and health policy committees of the Legislature on or before December 31, 2022, summarizing the impact of the pilot program. In order to allow time for the DMHC to analyze the data and prepare a report by December 31, 2022, health plans submitted the prescription drug data for the reporting period of January 1, 2020 through April 30, 2022. The information presented in this report has been aggregated for the 28-month reporting period.

The DMHC collected data from 12 health plans that offered commercial products in Riverside and Sonoma counties. However, six of the 12 health plans did not have any prohibition on the dispensing of certain amounts of prescription drugs by a network retail pharmacy as of January 1, 2020. These six health plans either did not own or control pharmacies with prohibitions on the dispensing of prescriptions drug quantities or only owned or controlled pharmacies that were in their network. In order to assess the impact of the pilot project, these six plans have been excluded from the analysis presented in this report. The report focuses on the data collected from the six health plans that were impacted by the pilot project in Riverside and Sonoma counties and analyzes the impact of the pilot project in two categories - total prescriptions and impacted prescriptions. Impacted prescription drugs (impacted drugs) are a subset of the total prescriptions and are prescriptions that were filled by a non-owned or non-controlled pharmacy and were greater than a 30-day supply.

It is worth noting that the public health emergency related to the COVID-19 pandemic occurred not long after the start of the pilot project and likely impacted the number prescriptions filled at network pharmacies, particularly in the first year. This should be considered when drawing any conclusions from the results of the pilot project.

Key Findings[1,2]

- Based on both the total number of prescriptions dispensed and the total prescription cost (total cost)[3] for the six impacted plans, Riverside County was approximately 93% of the overall pilot project's prescription drug market, and Sonoma County was the remaining 7%. Riverside County had more enrollees and higher member months.

- The most commonly dispensed prescription drugs were generic drugs for maintenance of chronic conditions, such as high cholesterol and hypothyroidism. These drugs are frequently dispensed in 90-day supplies.

- The total prescription cost for the six health plans was approximately $170.7 million, of which 9.1%, or approximately $15.6 million, was attributed to the impacted drugs.

- In Riverside County, the impacted drugs accounted for 9.1% of the total costs and 20.3% of the total number of prescriptions. Similarly, in Sonoma County, the impacted drugs accounted for 9.3% of the total costs and 19.8% of the total number of prescriptions.

- The total cost difference for impacted drugs that switched from being dispensed at a health plan or PBM owned or controlled pharmacy to a non-owned or non-controlled pharmacy was $3.2 million or 1.9%. Given that costs were reduced during the pilot project, it appears that the average costs paid to non-owned or non-controlled pharmacies were lower than those paid to health plan or PBM owned or controlled pharmacies.

- AB 315 did not require that the out-of-pocket costs be the same for non-owned or non-controlled pharmacies, and per the information received, it appears that health plans charged enrollees higher cost sharing at non-owned or non-controlled pharmacies. In particular, the aggregate member cost appears to have been about $387,000 or 1.0% higher than it would have been without the pilot project.

[1] The information in this report relies on the data submitted by the health plans.
[2] Impacted drugs consists of prescriptions which had prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacy prior to AB 315. However, this impact is an estimation as there isn't a comparison between the cost prior to and after the pilot project.
[3] The total prescription cost is calculated from the data submitted by the health plans. It is calculated as follows:
Total Prescription Cost or Total Cost = Ingredient Cost + Dispensing Fees + Administrative Fees – Rebates.

II. Introduction/Background

In 2018, California enacted AB 315 with the goal of increasing oversight and transparency regarding Pharmacy Benefit Managers (PBMs) and established various contracting requirements between PBMs and health plans and other purchasers. Notable provisions of AB 315 include:

- Pharmacists must inform a consumer at the point of sale if the retail price for a covered prescription is less than the consumer's cost-sharing. This responds to concerns that PBMs include "gag clauses" in their contracts with pharmacies that prohibit pharmacists from providing this information.

- Establishes contracting and disclosure requirements for PBMs and purchasers. A PBM must notify a purchaser of any conflict of interest and must disclose any material changes in contract terms to a contracted pharmacy. When requested by a purchaser, PBMs must make confidential disclosures on a variety of issues, including rebates, fees, and utilization discounts.

- Codification of the existing standard that health plans are ultimately responsible for the delivery of pharmacy benefits, even when such benefits are delegated to a PBM. The bill added a variety of Knox-Keene Act provisions with specific requirements for contracts between health plans and PBMs.

- PBMs must register with the DMHC. However, this requirement does not give the DMHC the authority to regulate PBMs directly in the way that the DMHC regulates health plans. The list of the PBMs registered with the DMHC can be found on the DMHC website.

- DMHC was required to establish a Task Force on PBM Reporting and to evaluate what type of data contracted PBMs should disclose to the department and provide a report to the Legislature with the Task Force's findings by February 1, 2020. The DMHC convened the Task Force as required by AB 315 and the report from the Task Force can be found on the DMHC website.

Additionally, AB 315 established a pilot project from January 1, 2020 to January 1, 2023, in Riverside and Sonoma counties, to prohibit a health plan from limiting the quantity of a prescribed medication an enrollee can receive at a retail pharmacy. This pilot project required that health plans and PBMs permit drugs to be dispensed at all network pharmacies in the same quantities that they are dispensed at pharmacies owned or controlled by the health plans or PBMs. AB 315 required health plans operating in Riverside and Sonoma counties to submit data to DMHC detailing the impact of the pilot project on costs and utilization of prescription drugs and the DMHC to produce a summary of that data to the Governor and health policy committees of the Legislature on or before December 31, 2022.

In order to allow time for the DMHC to analyze the pilot project data and prepare a summary report on or before December 31, 2022, the pilot project data reporting period was shortened to 28 months from January 1, 2020 through April 30, 2022.

III. Summary of Pilot Project

The DMHC received the pilot project filings from 12 health plans that offered commercial products in Riverside and Sonoma counties (Table 1). However, six out of the 12 health plans reported they did not have any prohibition on the dispensing of certain amounts of prescription drugs by network pharmacies and therefore, were not impacted by the pilot project. In order to assess the impact of the pilot project, these six plans have been excluded from the analysis presented in this report. The information in this report includes the aggregated data from January 1, 2020 through April 30, 2022 across the six health plans that were impacted by the pilot project. The DMHC did not audit the data sources for accuracy; however, the DMHC reviewed them for reasonableness.

The observations from the pilot project include:

- The most commonly dispensed prescription drugs were maintenance drugs for chronic conditions, such as high cholesterol and hypothyroidism. These drugs are frequently dispensed in 90 days supplies and, therefore, quantity limits may be more likely to be used for these drugs to direct members to health plan-owned or controlled pharmacies. The average cost per prescription for the top 10 impacted drugs ranged from $2.37 to $7.77. (Table 2)

- The total number of prescriptions dispensed, and the total cost was higher for Riverside County compared to Sonoma County since Riverside County has more enrollees and higher member months. The total costs for impacted drugs for Riverside County was $14.3 million and $1.2 million for Sonoma County. (Table 3)

- The total costs for all prescription drugs and impacted drugs on a per member per month (PMPM) basis was higher for Sonoma County compared to Riverside County. (Table 4)

- Generic drugs accounted for 93.5% of the impacted drugs and 85.9% of all prescription drugs. However, generic drugs accounted for 47.6% of the total cost of the impacted drugs compared to only 31.2% of the total costs for all prescription drugs during the pilot project. While specialty drugs accounted for only 1.5% of all prescription drugs dispensed, they accounted for 19.4% of total costs. In comparison, specialty drugs accounted for 0.1% of the impacted drugs but were only 1.4% of the total cost of the impacted drugs. (Table 5)

- The total cost of the prescription drug is not paid entirely by the health plan. Member out-of-pocket costs reduce the amount paid by the health plan. AB 315 did not require out-of-pocket costs be the same for non-owned or non-controlled pharmacies, and it appears that health plans charged members higher cost sharing at non-owned or non-controlled pharmacies. In particular, the aggregate member cost appears to have been about $387,000 or 1.0% higher than it would have been without the pilot project. (Table 6)

- Payments to non-owned or non-controlled pharmacies were lower on average than those paid to their owned or controlled pharmacies. The total cost difference for impacted drugs that switched from being dispensed at a health plan-owned or controlled pharmacy to a non-owned or non-controlled pharmacy was 1.9%. This means that the pilot project reduced total costs paid by health plans for those drugs by $3.2 million, or 1.9%, during the pilot project period. (Table 7)

Table 1 shows the 12 health plans operating in Riverside and/or Sonoma counties as well as if they were impacted by the pilot project.

Table 1. Health Plans Operating in Riverside and Sonoma Counties

Health Plan	Riverside	Sonoma	Impacted/ Non-Impacted
Aetna Health of California, Inc.	Yes	Yes	Impacted
Blue Cross of California (Anthem Blue Cross)	Yes	Yes	Impacted
California Physicians' Service (Blue Shield of California)	Yes	Yes	Non-Impacted
Cigna HealthCare of California, Inc.	Yes	Yes	Non-Impacted
Health Net of California, Inc.	Yes	Yes	Impacted
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	Yes	Yes	Non-Impacted
Molina Healthcare of California	Yes	No	Impacted
Sharp Health Plan	Yes	No	Impacted
Sutter Health Plan (Sutter Health Plus)	No	Yes	Non-Impacted
UHC of California (UnitedHealthcare of California)	Yes	Yes	Non-Impacted
UnitedHealthcare Benefits Plan of California	Yes	Yes	Non-Impacted
Western Health Advantage, Inc.	No	Yes	Impacted

Table 2 shows information about the 10 most commonly dispensed prescription drugs impacted by the pilot project.

Table 2. Top 10 Impacted Drugs

Rank	Prescription Drug Name	Therapy Class	Drug Type	Number of Prescriptions	Average Cost Per Script
1	Atorvastatin	Cardiovascular Agents	Generic	85,090	$7.77
2	Lisinopril	Cardiovascular Agents; Central Nervous System Agents	Generic	67,978	$4.06
3	Metformin	Blood Glucose Regulators	Generic	61,982	$4.61
4	Losartan	Cardiovascular Agents	Generic	49,584	$7.20
5	Levothyroxine	Hormonal Agents - Thyroid	Generic	46,035	$7.50
6	Amlodipine	Cardiovascular Agents	Generic	41,652	$4.17
7	Metoprolol	Cardiovascular Agents	Generic	28,782	$7.05
8	Hydrochlorothiazide	Cardiovascular Agents	Generic	27,628	$2.37
9	Simvastatin	Cardiovascular Agents	Generic	17,954	$3.36
10	Glipizide	Blood Glucose Regulators	Generic	14,127	$4.90

Tables 3 shows summary findings for the total number of prescriptions, total cost, and member months for the six impacted health plans in Riverside and Sonoma counties.

Table 3. Summary of Data by County

Category	Riverside	Sonoma	Combined
All Prescription Drugs Dispensed for Impacted Plans	4,041,015	323,191	4,364,206
Impacted Drugs	821,729	63,900	885,629
Impacted Drugs as a Percentage of All Prescription Drugs for Impacted Plans	**20.3%**	**19.8%**	**20.3%**
Total Cost for All Prescription Drugs for Impacted Plans	$157,494,960	$13,252,047	$170,747,007
Total Costs for Impacted Drugs	$14,346,922	$1,236,973	$15,583,895
Impacted Drugs as a Percentage of All Prescription Drugs for Impacted Plans	**9.1%**	**9.3%**	**9.1%**
Member Months for Impacted Plans	7,719,276	553,268	8,272,544

Table 4 shows the total costs per member per month (PMPM) for all prescription drugs and impacted drugs for the six impacted health plans in Riverside and Sonoma counties.

Table 4. Total Cost PMPM for All Prescription Drugs and Impacted Drugs

Health Plan	Riverside			Sonoma		
	Total Cost	Total Member Months	PMPM Cost	Total Cost	Total Member Months	PMPM Cost
All Prescription Drugs	$157,494,960	7,719,276	$20.40	$13,252,047	553,268	$23.95
Impacted Drugs	$14,346,922	7,719,276	$1.86	$1,236,973	553,268	$2.24

Table 5 is a summary of the prescription drug costs by drug type for all prescription drugs and impacted drugs for the six impacted health plans.

Table 5. Prescription Drug Costs by Drug Type

Category	Costs	Costs as a Percentage of Total	Number of Prescriptions	Number of Prescriptions as a Percentage of Total
All Prescription Drugs				
Generic	$53,234,763	31.2%	3,748,515	85.9%
Brand	$84,393,515	49.4%	548,075	12.6%
Specialty	$33,118,729	19.4%	67,616	1.5%
Total	**$170,747,007**	**100.00%**	**4,364,206**	**100.00%**
Impacted Drugs				
Generic	$7,422,400	47.6%	828,393	93.5%
Brand	$7,938,195	51.0%	56,285	6.4%
Specialty	$223,300	1.4%	951	0.1%
Total	**$15,583,895**	**100.0%**	**885,629**	**100.0%**

Table 6 shows the estimated impact of the pilot project to enrollees' out-of-pocket costs for the six impacted health plans.

Table 6. Estimated Impact of Pilot Project to Enrollees' Out of Pocket Costs

Enrollee Impact	
Additional Enrollee Out of Pocket Cost for Impacted Drugs	$386,874
Total Enrollee Out of Pocket Cost for All Prescriptions Drugs	$38,867,376
Additional Enrollee Costs as Percentage of Total Enrollee Costs	1.0%

Table 7 shows the estimated costs savings achieved by the six impacted health plans resulting from the pilot project.

Table 7. Estimated Cost Savings for Health Plans Resulting from the Pilot Project

Health Plan Cost Savings	
Cost Savings for Health Plans for Impacted Drugs	$3,225,156
Total Costs for All Prescriptions Drugs	$170,747,007
Savings as a Percentage of Total Costs	1.9%

IV. Conclusions

There appear to be three primary results of the pilot project:

1. Health plan enrollees may exert greater choice over where they obtain their prescription drugs when given that option. For the six impacted plans, over 20% of prescription drugs were dispensed at pharmacies not owned or controlled by the health plan or PBM.
2. There may be a cost savings to health plans and/or PBMs. Outside of the pilot project, health plans can use quantity limits to direct members to fill prescriptions at health plan owned or controlled pharmacies. Given that total costs for impacted drugs were reduced during the pilot project, it appears that the average reimbursements to non-owned or non-controlled pharmacies were lower than those paid to their owned or controlled pharmacies.
3. Enrollee cost sharing may increase. While AB 315 required health plans to cover prescriptions at non-owned or non-controlled pharmacies, it does not require them to charge the same copays as they would at owned or controlled pharmacies. This may create incentives for enrollees to purchase their drugs from the owned or controlled pharmacies.

Because of the limitations of the pilot project and the data collected, it is not guaranteed that these results would be replicated if applied statewide. In particular, the COVID-19 pandemic likely impacted the number of enrollees who filled their prescriptions at network retail pharmacies, particularly in the first year. This should be considered when drawing any conclusions from the results of the pilot project. Further research and data collection would likely be necessary.

Appendix A: Relevant Assembly Bill 315 Text

Health and Safety Code § 1368.6

(a) Effective January 1, 2020, there is established a pilot project to assess the impact of health care service plan and pharmacy benefit manager prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies. The provisions of subdivision (b) shall apply to pharmacy providers located in the Counties of Riverside and Sonoma.

(b) Pursuant to the pilot project, a health care service plan shall not prohibit, or permit any delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the plan or pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the federal Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(c) This section shall not be construed to prohibit a health care service plan or pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy network provider as for a pharmacy owned or controlled by the health care service plan or pharmacy benefit manager.

(d) This section shall not be construed to prohibit differential cost sharing designed to encourage or discourage the use of mail-order pharmacy services or preferred pharmacies.

(e) On or before July 1, 2020, health care service plans subject to this section shall report annually to the Department of Managed Health Care information and data relating to changes, if any, to costs and utilization of prescription drugs attributable to the prohibition of certain contract terms in subdivision (b). The department shall solicit and receive any additional information relevant to changes in costs or utilization attributable to the pilot project from other interested stakeholders. The department shall summarize data received pursuant to this subdivision and provide the summary to the Governor and health policy committees of the Legislature on or before December 31, 2022.

(f) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

Appendix B: Glossary

Administrative Fee: A fee charged by the pharmacy benefit manager (PBM) to the plan sponsor under a pass-through pricing arrangement for PBM services.

Brand Name Drug: Medications protected by patents that grant their makers exclusive marketing rights for several years. When patents expire, other manufacturers can sell generic copies at lower prices.

Compounding: Often regarded as the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. Compounded drugs are not FDA-approved.

Dispensing Fees: Contracted amount in a traditional third-party prescription plan that is paid to the pharmacy in addition to the negotiated ingredient cost of the prescription.

Drug Name: Enter the prescription drug name by utilizing the field of PROPRIETARYNAME and not including the PROPRIETARYNAMESUFFIX in the NDC Database File from the FDA website.

Drug Price Benchmark: The value used to represent the ingredient cost of a prescription drug in reimbursement calculations. Reimbursement formulas vary by payer. Frequently used drug price benchmarks are Average Sales Price (ASP), Average Manufacturer Price (AMP), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC)."

Formulary: List of drugs used to treat patients in a drug benefit plan. Products listed on a formulary are covered for reimbursement at varying levels.

Generic Drug: A generic drug is a medication created to be the same as an already marketed brand name drug in dosage, form, safety, strength, route of administration, quality, performance characteristics, and intended use. These similarities help to demonstrate bioequivalence, which means that a generic medicine works in the same way and provides the same clinical benefit as its brand name version. In other words, you can take a generic medicine as an equal substitute for its brand name counterpart.

Ingredient Costs: The component of a prescription drug claim cost that represents the cost of the medication; usually negotiated at a discount based on a pricing benchmark.

In-Network/Out-of-Network: “In-Network” means Pharmacy who are contracted by a Health Care Service Plan (HCSP) or PBM; otherwise, Out-of-Network.

Mail Order: Licensed pharmacy established to dispense maintenance medications for chronic use in quantities greater than normally purchased at a retail pharmacy. The mail order pharmacy usually uses highly automated equipment so that non-pharmacists perform many routine tasks. As a result, mail order can typically dispense medication filled via mail order and delivered to an enrollee’s primary residence address.

Member Month: The number of months that members are covered under the prescription drug benefits.

National Drug Code (NDC): Numeric system to identify drug products in the United States. A drug’s NDC number is often expressed using a 3-segment-number where the first segment identifies the

manufacturer, the second identifies the product and strength, and the last identifies the package size and type.

If the NDC on the package label is less than 11 digits, then add a leading zero to the appropriate segment to create a 5-4-2 segment number. Example.
Label Configuration Add leading zero, Remove hyphens
4-4-2 (xxxx-xxxx-xx) 0xxxxxxxxx (5-4-2)
5-3-2 (xxxxx-xxx-xx) xxxxx0xxxxx (5-4-2)
5-4-1 (xxxxx-xxxx-x) xxxxxxxxx0x (5-4-2)

Number of Prescriptions (# of Prescriptions): "30-day supply is treated as a unit. The range is as follows:
- Between 1- to 30-day supply is 1 unit
- Between 31- to 60-day supply is 2 units
- More than 60-day supply will be 3 units."

Owned/Not Owned: “Owned” means a level of ownership the Health Care Service Plan (HCSP) or PBM holds in Pharmacy termed as an affiliate, associate, or subsidiary of it; otherwise, Not Owned.

Pharmacy Benefit Manager (PBM): 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.

PMPM: Per member per month. Costs are reported on a per member per month basis. In this report, it is the total cost divided by the number of member months.

Prescription Drug: “Prescription drug” or “drug” means a self-administered drug approved by the FDA for sale to the public through retail or mail order pharmacies that requires a prescription and is not provided for use on an inpatient basis or administered in a clinical setting or by a licensed health care provider. The term includes: (i) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (ii) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (iii) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002 and 1367.25 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (iv) at the option of the health care service plan, any vaccines or other health benefits covered under the prescription drug benefit of the product.

Retail: Medications are filled and picked up with a pharmacist's performance.

Specialty Drug: A drug with a plan- or insurer-negotiated monthly cost that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)). In 2018, the threshold amount is $670 for a one-month supply.

Total Cost: The total cost is a calculated value from the information provided in the by the health plans. It is ingredient costs plus dispensing fees plus administrative fees minus rebates.

Total Costs to Enrollees: The total cost-sharing amounts by members.


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