SENATE COMMITTEE ON HEALTH
Senator Dr. Susan Talamantes Eggman, Chair

BILL NO: SB 873
AUTHOR: Bradford
VERSION: February 17, 2023
HEARING DATE: April 19, 2023
CONSULTANT: Teri Boughton

SUBJECT: Prescription drugs: cost-sharing

SUMMARY: Requires, at the point-of-sale, the cost-sharing of an enrollee or insured of a health plan or health insurer to be reduced based on rebates received, or to be received, in connection with the dispensing or administration of the drug. Requires on or before March 1 each year, the Department of Managed Health Care and the Insurance Commissioner to provide a report on this bill's impact on drug prices and health care premium rates to the appropriate policy committees of the Legislature. Makes this bill's provisions inoperative on January 1, 2027.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers. [HSC §1340, et seq., and INS §106, et seq.]

2) Requires a health plan or health insurer that reports rate information, as specified, to report information no later than October 1 of each year that demonstrates the overall impact of drug costs on health care premiums. [HSC §1356.243 and INS §10123.205]

3) Requires health plans and insurers, for all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, to report:

   a) The 25 most frequently prescribed drugs;
   b) The 25 most costly drugs by total annual plan spending; and,
   c) The 25 drugs with the highest year-over-year increase in total annual plan spending. [HSC §1356.243 and INS §10123.205]

4) Requires DMHC and CDI to compile the information from 3) above into a report for the public and Legislators where the data is aggregated and does not reveal information specific to individual plans. Requires the report to be published on DMHC's and CDI's websites. [HSC §1356.243 and INS §10123.205]

5) Defines a "Pharmacy Benefit Manager or PBM" as a person, business, or other entity that, pursuant to a contract with a health plan, manages the prescription drug coverage provided by the health 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. Specifies that a licensed health plan or any individual employee of a

health plan or its contracted provider is not a PBM. [HSC §1385.001]

6) Requires a health plan that contracts with a PBM to require the PBM to comply with specified requirements including register with DMHC and exercise good faith and fair dealing in the performance of its duties, and comply with existing law that prohibits a contract from barring a pharmacy provider from informing a patient of a less costly alternative to a prescribed medication. [HSC §1385.004 and §1385.005]

7) Requires the failure by a health plan to comply with specified contractual requirements to constitute grounds for disciplinary action. Requires the DMHC director, as appropriate, to investigate and take enforcement action against a health plan that fails to comply with these requirements and to periodically evaluate contracts between health plans and PBMs to determine if any audit, evaluation, or enforcement actions should be undertaken by DMHC. [HSC §1385.006]

8) Establishes, as California's essential health benefits (EHBs) benchmark, the Kaiser Small Group Health Maintenance Organization, existing California mandates, and ten Affordable Care Act (ACA) mandated benefits, including prescription drugs. [HSC §1367.005 and INS §10112.27]

9) Prohibits, with respect to an individual or group health plan contract or health insurance policy that covers EHBs, the copayment, coinsurance, or any other form of cost-sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days from exceeding $250; for a product with an actuarial value at or equivalent to a Bronze level, limits cost-sharing to not more than $500 for a supply of up to 30 days; and for a high deductible health plan the $250 or $500 limits apply only after an enrollee's deductible is met. [HSC §1342.73 and INS §10123.1932]

10) Prohibits a non-grandfathered individual or small group health plan contract or insurance policy from having an annual deductible for outpatient drugs, if any, from exceeding twice the amount specified in 9) above. [HSC §1342.73 and INS §10123.1932]

This bill:

1) Requires, no later than January 1, 2025, an enrollee's or insured's defined cost-sharing for each prescription drug to be calculated at the point-of-sale based on a price that is reduced by an amount equal to at least 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug.

2) Requires the health plan or insurer to pass through at the point-of-sale a good faith estimate of the enrollee's or insurer's decrease in cost-sharing.

3) Requires a health plan or insurer to provide the enrollee or insured with an end-of-calendar-year reconciliation for any cost-sharing reductions owed to the enrollee or insured that were not passed on through the estimated amount at the point-of-sale. Prohibits this from authorizing a health plan or insurer to recover from an enrollee or insured any inaccurate estimate of cost-sharing reductions.

4) Requires each health plan or insurer, either directly or indirectly through its agents, to calculate the enrollee's or insured's defined cost-sharing and provide the dispensing pharmacy with the enrollee's or insured's defined cost-sharing for each prescription drug.

Indicates a health plan or insurer is not prohibited from decreasing an enrollee's or insured's defined cost-sharing by a greater amount.

5) Prohibits this bill from being interpreted or implemented in a manner inconsistent with federal law. Makes the provisions of this bill severable, so that if a provision or its application is held invalid or incapable of being enforced against a health plan or insurer due to a conflict with federal requirements, prohibits that invalidity from affecting other provisions or applications that can be given effect without the invalid provision or application.

6) Requires cost-sharing, including copayments, coinsurance, deductibles, and any other form of cost-sharing to be consistent with cost-sharing copayment caps, as specified, and other provisions of the law.

7) Establishes the following definitions:

   a) "Defined cost-sharing" means a deductible payment or coinsurance amount imposed for a covered prescription drug under the health plan contract or health insurance policy.
   b) "Price protection rebate" means a negotiated price concession that accrues directly or indirectly to a health plan, health insurer or other party on behalf of the health plan or insurer, in the event of an increase in the wholesale acquisition cost of a drug above a specified threshold.
   c) "Rebate" means both of the following:
      i) Negotiated price concessions, including base price concessions, whether or not described as a "rebate," and reasonable, good faith estimates of price protection rebates and performance-based price concessions from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug that may accrue directly or indirectly to the health plan, health insurer or other party on behalf of the health plan or insurer, including, but not limited to, health plan or insurer-owned PBMs, during a calendar year; and,
      ii) Reasonable, good faith estimates of negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the health plan or insurer and serve to reduce the health plan's or insurer's liabilities for a prescription drug.

8) Requires, on or before March 1 of each year, DMHC and the Insurance Commissioner to provide a report on this bill's impact on drug prices and health care premium rates to the appropriate policy committees of the Legislature.

9) Requires health plans and insurers to report the following as part of an existing requirement to report on prescription drugs and their costs:

   a) The 25 most frequently prescribed drugs with a point-of-sale rebate; and,
   b) The 25 most costly drugs by total annual plan/insurer spending with a point-of-sale rebate.

10) Requires for each health plan/insurer with a prescription drug benefit that the health plan/insurer issued for delivery, renewed, amended, or continued during the immediately preceding calendar year, all of the following:

a) The aggregate dollar amount of all rebates that the plan/insurer or a designee collected directly or indirectly from all pharmaceutical manufacturers in connection with the design and administration of the plan/insurer, which are attributable to enrollee or insured drug utilization during that calendar year;
b) The percentage of those rebates made available to enrollees/insureds to reduce cost-sharing for prescription drugs at the point-of-sale;
c) The percentage of those rebates that the health plan/insurer utilized to reduce the portion of premiums allocated to each of prescription drug expenditures, hospital expenditures, medical expenditures, administrative costs, and other expenditures; and,
d) The aggregate dollar amount of all administrative service fees that the plan/insurer or a designee paid to a PBM or its designee in connection with the PBM's managing or administering the pharmacy benefit and administering, invoicing, allocating, and collecting rebates.

11) Prohibits the drug cost and rebates report compiled by DMHC or CDI from identifying a specific manufacturer, the prices charged for specific drugs, or classes of drugs, or the amount of any rebates provided for specific drugs or classes of drugs, or otherwise have the potential to compromise the financial, competitive, or proprietary nature of that information.

12) Defines "health plan/insurer administrative service fees" as fees or payments from a health plan/insurer to, or otherwise retained by, a PBM or its designee pursuant to a contract between a PBM or affiliate and the health plan/insurer in connection with the PBM's managing or administering the pharmacy benefit and administering, invoicing, allocating and collecting rebates.

13) Sunsets the provisions of this bill on January 1, 2027.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, this bill will ensure patients are better able to afford their medications by reforming the state's prescription drug rebate system to ensure it benefits patients, not health care corporations. By including transparency provisions and requiring 90% of manufacturer rebates to be passed on at the pharmacy counter, patients will not only be able to better afford their medicines, they will also better adhere to their doctors' decisions by not rationing or skipping doses due to cost. Since 2020, more than 100 similar measures have been introduced across the nation, and in 2021 West Virginia passed a law (HB 2263) that requires 100% of rebates to first benefit the patient at the point-of-sale and then be used to lower premiums more broadly.

2) *Kaiser Family Foundation Survey, 2021.* From an individual perspective, prescription drug affordability is a bigger issue for those who are currently taking four or more prescription medicines. Three in ten of those taking four or more prescription drugs say they have difficulty affording their prescriptions, compared to one in five adults who currently take three or fewer prescription medications. Those who take four or more prescription drugs, those with chronic conditions in their households, and those with an annual household income of less than $40,000 report having much more difficulty affording prescriptions.

3) *Prescription drug costs.* According to the 2021 U.S. National Health Expenditures (NHE) report, NHE grew 2.7% to $4.3 trillion in 2021, or $12,914 per person, and accounted for

18.3% of Gross Domestic Product (GDP). Private health insurance spending grew 5.8% to $1,211.4 billion in 2021, or 28% of total NHE. Out-of-pocket spending grew 10.4% to $433.2 billion in 2021, or 10% of total NHE. Hospital expenditures grew 4.4% to $1,323.9 billion in 2021, slower than the 6.2% growth in 2020. Physician and clinical services expenditures grew 5.6% to $864.6 billion in 2021, slower growth than the 6.6% in 2020. Prescription drug spending increased 7.8% to $378.0 billion in 2021, faster than the 3.7% growth in 2020. The largest shares of total health spending were sponsored by the federal government (34%) and households (27%). The private business share of health spending accounted for 17% of total health care spending, state and local governments accounted for 15%, and other private revenues accounted for 7%.

A February 11, 2020 white paper issued by the USC Schaeffer Center for Health Policy & Economics on "The Association between Drug Rebates and List Prices," finds that drug rebates and list prices are positively correlated, on average, a $1 increase in rebates is associated with a $1.17 increase in list price. Single-source drugs have higher average list prices and rebates than multi-source drugs, and show a stronger relationship between changes in rebates and list prices. Rebates play a role in increasing drug prices, and reducing or eliminating rebates could result in lower list prices and reduced out-of-pocket expenditures for some patients.

4) *California data.* Health plans regulated by DMHC paid more than $10.8 billion for prescription drugs in 2021, an increase of almost $700 million or 6.6% from 2020. Total medical expenses increased by 9.2%. Enrollees spent nearly $1 billion for prescription drugs in 2021. Manufacturer drug rebates totaled approximately $1.674 billion, up from $1.437 billion in 2020 and $1.205 billion in 2019. This represents about 15.5% of the $10.8 billion spent on prescription drugs in 2021. While specialty drugs accounted for only 1.6% of all prescription drugs dispensed, they accounted for 62.9% of total annual spending on prescription drugs. Generic drugs accounted for 88.2% of all prescribed drugs but only 16.3% of the total annual spending on prescription drugs. Brand name drugs accounted for 10.2% of prescriptions and constituted 20.8% of the total annual spending on prescription drugs. According to a March 16, 2022, DMHC public meeting on rates and drug costs, for 2021, average health plan premium rate increases in the large group market were just over 4% (4.1-4.2%). Average health plan rate increases in the small group market ranged from 1.7% to 3.7% with total weighted average of 1.8%, and in the individual market health plan total weighted average premium rate decreased 4%.

   For CDI insurers, prescription drugs accounted for 14.1% of total health care premiums in 2021 once rebates are considered, this is up from 13.4% in 2020. Prescription drugs accounted for 16.3% of all medical costs in 2021 once rebates are considered, and 16.6% for 2020. Drug costs per prescription decreased by 1.5% overall. But decreased costs per prescription were not found across all drug categories: generic drugs decreased by 3.7% in cost per prescription, while specialty drugs increased in cost per prescription by 6.1%. A portion of the increased drug costs per prescription for brand and specialty drugs was offset by the increased use of rebates in 2021.

5) *PBMs.* PBMs help health plans manage their drug benefits through negotiating or contracting with manufacturers and/or pharmacies on behalf of their contracted health plans. The DMHC PBM report required by AB 315 (Wood, Chapter 905, Statutes of 2018), indicates that PBMs receive rebates from manufactures for certain prescription drugs. The "retained rebate" is the amount of rebate the PBM receives but does not pass along to the

plan. Even health plans are often unaware of the amount of the PBM's retained rebate. Additionally, rebates may offer perverse incentives, as higher cost drugs could mean higher rebates for the PBM. PBMs pay pharmacies on behalf of health plans. "Spread pricing" is the difference between the payment the PBM negotiates with the health plan and the amount the PBM pays the pharmacy. When a PBM pays the pharmacy less than the health plan pays the PBM, the PBM makes money on the difference (the "spread"). As with retained rebate amounts, the "spread" is often known only to the PBM and may contribute to rising prescription drug costs. PBMs receive negotiated payments (or fees) from manufacturers to reimburse pharmacies and cover the PBM's administrative expenses. The amount of these fees is unknown. PBMs may also receive per member per month payments from the health plans with which they contract.

6) *DMHC PBM Task Force recommendations.* AB 315, among other provisions, requires DMHC to convene a Task Force on PBM Reporting to determine what information related to pharmaceutical costs, if any, DMHC should require to be reported by health plans or their contracted PBMs. The Legislature recognized that any recommendation would be in addition to information already reported pursuant to SB 17 (Hernandez, Chapter 603, Statutes of 2017) reporting requirements. The Task Force met from July 2019 to December 2019 and developed a recommendation requiring PBMs to report data related to the services PBMs provide for commercial health plans directly to the DMHC. PBMs would be required to report drug-specific data as well as aggregated information on PBMs, including revenue and expense information. At the drug level, the Task Force recommends requiring PBMs to report the following:

   a) A list of the 100 most costly drugs, the 100 most frequently prescribed drugs, and the 100 highest revenue-producing drugs, grouped by generic, brand, specialty, and other; and,
   b) For each drug that falls into the above categories:
      i) The pharmacy type used to fill the drug prescription, such as integrated, chain, independent, specialty, and mail order pharmacies; and,
      ii) Pricing and rebate information, including the amount of rebate the PBM receives from the manufacturer, the amount of rebate the PBM passes to the health plan, the amount the health plan pays the PBM, and the amount the PBM pays the pharmacy.

   At an aggregated level, the Task Force recommends gathering information on PBMs, including revenue and expense information, to determine PBM market impact and the value PBMs provide to consumers. This information would include reporting on the following:

   a) The health plans with which the PBM contracts, the scope of services provided to the health plan, and the number of enrollees served by the PBM;
   b) PBM revenue, including revenue from manufacturers, health plans, pharmacies, and other revenue; and,
   c) PBM expenses, including payments to pharmacies, claims processing, special programs, administration, and other expenses.

7) *Attorney General action.* In January 2023, California Attorney General Rob Bonta announced a lawsuit against the nation's largest insulin makers (Eli Lilly, Novo Nordisk, and Sanofi) and three PBMs (CVS Caremark, Express Scripts, and Optum Rx) for driving up the cost of insulin through unlawful, unfair, and deceptive business practices in violation of California's Unfair Competition Law. The lawsuit alleges these manufacturers and PBMs have leveraged their market power to overcharge patients. The complaint alleges the

defendants separately conspired to artificially inflate prices while agreeing to provide secret rebates in an attempt to obtain preferred positions on drug formularies.

8) *California Health Benefits Review Program (CHBRP) analysis*. AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed AB 933 (Daly of 2020), which has some overlapping provisions with this bill with regard to the drug rebate provisions. Key findings include:

   a) *Rebates.* Drug rebates are used by pharmaceutical manufacturers to incentivize coverage and use for their products. Drug rebates are generally paid by a pharmaceutical manufacturer to a PBM, who then shares a portion with the health insurer. Rebates are mostly used for higher cost brand-name prescription drugs in competitive therapeutic classes where there are interchangeable products and aim to incentivize PBMs and health insurers to include the pharmaceutical manufacturer's products on their formularies and to obtain preferred "tier" placement.

   b) *Coverage impacts and enrollees covered.* Among enrollees with potentially impacted cost sharing at baseline, there are 836,000 enrollees who use brand or specialty medications. Postmandate, the number of enrollees who use brand or specialty medications with potentially impacted cost sharing would increase to 840,000. Details on manufacturer rebate programs are proprietary, such as, for instance, which drugs may have manufacturer rebates available. As such, CHBRP is unable to estimate the number of impacted individuals for which cost-sharing might change if this bill were enacted.

   c) *Individual impacts.* The average retail allowed cost of brand and specialty drugs, prior to rebates, was estimated to be $992. CHBRP estimated that the net cost of brand and specialty drugs after rebates was $675 which is the average amount that would be subject to cost-sharing postmandate. However, the $318 difference between the $992 average retail allowed cost and $675 net cost of brand drugs after rebates would still be paid by insurance carriers to retail pharmacies:
      i) For example, consider an enrollee with a $1,400 overall (medical and pharmacy) deductible filling a one-time medication with a $1,000 retail allowed cost with 50% rebates at baseline. If this enrollee fills the medication prior to any other health care expenditure, at baseline, their cost-sharing would be $1,000. As total manufacturer rebates are $500, and 90% of this value is passed through to the enrollee, then the enrollee would see a reduction in the allowable retail cost subject to cost-sharing of $450 (90% of $500). Postmandate, the cost-sharing would drop by 45% to $550, the new retail allowed cost after rebates, which would be used to calculate cost-sharing.
      ii) As another example, consider an enrollee with a $5,000 maximum out-of-pocket who has met this amount for the year. This enrollee would have no cost-sharing at baseline. Similarly, regardless of the rebates available, the enrollee would have no cost-sharing postmandate. For any enrollee who meets their maximum out-of-pocket amount both at baseline and postmandate, the bill has no impact on out-of-pocket expenditure.

   d) *Utilization.* CHBRP assumed that the increase in enrollee utilization of prescription drugs due to decreased cost-sharing would be 3.5% of total prescriptions for enrollees in

medium or high cost-sharing plans. CHBRP assumed that the increase in utilization is driven by a 0.5% increase in the number of enrollees utilizing brand or specialty drugs and a 3.0% increase in the utilization for enrollees utilizing brand or specialty drugs. This induced demand estimate is based upon evidence from the RAND Health Insurance Experiment, which allows for the estimation of increased use of outpatient services based on a price elasticity of −0.2.

e) *Impact on expenditures.* This bill would increase total health insurance premiums (paid by employers, employees, and individuals/families, including individuals who receive cost-sharing reductions because of this bill) by $200,558,000. For enrollees on brand name or specialty drugs with rebates, CHBRP estimates a total $70,833,000 decrease in enrollee share of cost for the brand name or specialty drug rebates passed through because of this bill. CHBRP projects total premium expenditures for individually purchased plans in Covered California to increase by $33,045,000, or 0.30%.

f) *Long-term impacts.* The enrollees most likely to benefit from this bill in the long-term are those with conditions that require treatment with higher cost brand-name or specialty drugs, which are typically more expensive out-of-pocket. In the long-term, this bill would reduce out-of-pocket spending on those drugs subject to rebates for those enrollees. As brand-name drugs lose their patent protection or face more competition, the relative value of certain existing rebates will decrease while new drugs with rebates will enter the market. The net allowed retail cost used to calculate cost-sharing will shift as the use of rebates shift, such that consumers may also experience shifts in the out-of-pocket cost-sharing they pay for prescription drugs. It is unclear how manufacturers, insurance companies, and PBMs may respond to this bill in the long-term. Because this bill would only change the law in California and impacts less than 10% of the enrollees in the DMHC- and CDI-regulated insurance market, it is unlikely to impact the use of rebates by manufacturers in the long-term. However, insurers that do a substantial amount of business in California might be incentivized by this bill to renegotiate how rebates are passed through or used to compensate PBMs in future contracts.

9) *Medicare Part D.* According to a 2022 federal Office of Inspector General (OIG) report, following the introduction of authorized generic versions of two brand-name hepatitis C drugs-Epclusa and Harvoni-in 2019, use of the authorized generic versions increased in Medicaid at greater rates than in Medicare Part D. In 2020, some Part D plans did not cover the authorized generics, limiting beneficiary access to less costly options. Medicare beneficiaries also were less likely to use other lower-cost brand-name options in 2020 compared to Medicaid beneficiaries. Although rebates from manufacturers reduced overall Part D spending for higher-cost hepatitis C drugs (like Epclusa and Harvoni), they provided little relief to beneficiaries or the Medicare program. Part D beneficiaries without financial assistance paid, on average, $2,200 more out of pocket for higher-cost hepatitis C drugs in 2020. Further, Medicare's average catastrophic coverage payment for a beneficiary prescribed a higher-cost drug was over $8,000 more compared to a beneficiary prescribed a lower-cost drug. As a result, Medicare spent $155 million more in catastrophic coverage payments for higher-cost hepatitis C drugs, despite a similar number of beneficiaries in each cost group reaching catastrophic coverage. OIG's findings about utilization trends for higher-cost hepatitis C drugs in Medicare align with experts' suggestions that certain programmatic factors, such as manufacturer rebates, may be providing incentives for Part D plan sponsors to prefer their enrollees use higher-cost drugs. Federal rules have been issued to require PBM

and Medicare Part D plans to abandon the use of rebates unless they are passed on to the consumer at the point of sale. The rule is effective January 1, 2024.

10) *Prior legislation.* SB 1361 (Kamlager of 2022) would have required health plans and insurers to reduce enrollee and insured cost-sharing to reflect drug manufacturer rebates at the point-of-sale and reporting of point-of-sale rebates until 2025 and additional reporting on rebates and PBMs until 2025; terminated an existing annual report on prescription drug costs published by DMHC; established multiple definitions related to PBMs; and, required PBMs to owe a duty to enrollees, health plans, and providers. *SB 1361 was held in the Senate Appropriations Committee.*

AB 2942 (Daly of 2022) would have required a health plan or insurer to define cost-sharing for a prescription drug to be calculated at the point-of-sale based on a price that is reduced by an amount equal to 90% of all rebates received, or expected to be received, in connection with the dispensing or administration of the drug; and, to provide an enrollee or insured with an end-of-calendar-year reconciliation for any cost-sharing reductions owed to the enrollee or insured that were not passed on to the enrollee or insured at the point-of-sale. AB 2942 would have required DMHC and the Insurance Commissioner to annually report on the impact of those provisions on drug prices and health care premium rates, as specified. *AB 2942 was never scheduled for a hearing in the Assembly Health Committee.*

AB 933 (Daly of 2020) was substantially similar to AB 2942. *AB 933 was held in the Assembly Appropriations Committee.*

SB 17 (Hernandez, Chapter 603, Statutes of 2017) requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to DMHC and CDI. SB 17 requires DMHC and CDI to compile specified information into a consumer-friendly report that demonstrates the overall impact of drug costs on health care premiums. SB 17 requires drug manufacturers to notify specified purchasers, in writing at least 90 days prior to the planned effective date, if it is increasing the WAC of a prescription drug by specified amounts. SB 17 requires drug manufacturers to notify the Department of Health Care Access and Information (HCAI) when introducing a new drug to market at a WAC that exceeds the Medicare Part D specialty drug threshold, and to provide specified information to HCAI related to the drug's price.

AB 315 (Wood, Chapter 905, Statutes of 2018) requires PBMs to register with DMHC, to exercise good faith and fair dealing, and to disclose, upon a purchaser's request, information with respect to prescription product benefits, as specified. AB 315 requires DMHC to convene a Task Force on PBM Reporting to determine what information related to pharmaceutical costs, if any, it should require to be reported by health plan or their contracted PBMs. AB 315 establishes a pilot project in Riverside and Sonoma Counties to assess the impact of health plan and PBM prohibitions that prohibit the dispensing of certain amounts of prescription drugs by network retail pharmacies.

11) *Support.* The California Access Coalition writes health insurers and pharmacy middlemen, known as PBMs negotiate rebates from drug manufacturers in return for placement of the manufacturers' medications on health plan drug formularies. These rebates average 48% of the medicine's list price on average and create a perverse incentive for the PBMs to place the highest cost drug on the plan. In 2021, rebates totaled $1.7 billion in California alone, up

from $1.4 billion in 2020 and $1.2 billion in 2019. Unfortunately, these massive payments only benefit PBMs and insurers and nothing to benefit patients. In fact, patients often end up paying nearly double for their prescriptions than the PBM and insurer pays. Due to high costs at the pharmacy counter, thousands of Californians struggle to have their prescription medications filled to treat acute or chronic conditions. Lawmakers must stand with patients and shed light on the unfair practices that leave so many struggling to afford and maintain their medications. Sharing rebates with patients at the point-of-sale will not only reduce out-of-pocket costs for patients, but it will also improve medication adherence rates – as demonstrated by UnitedHealth's OptumRx practice of sharing rebates at the pharmacy counter, which enabled patients to save an average of $130 per eligible prescription and improved adherence rates between 4% and16%. This bill will require insurance companies pass on at least 90% of rebates to patients at the pharmacy counter, helping them afford their prescriptions in a meaningful way. The ALS Association will immediately lower out-of-pocket costs at the pharmacy counter, helping to reduce costs for families impacted by ALS. Applied Pharmacy Solutions writes that PBMs have an outsized role in the rebate system yet there are no accountability or transparency measures put in place to determine they are acting in good faith.

12) *Opposition.* The California Chamber of Commerce writes the attention this bill directs at high drug prices is commendable, unfortunately the implementation of this bill will have weighty ramifications on employer and employee health care costs. CHBRP did not have an opportunity to review this bill but it is nearly identical to AB 933 which was analyzed by CHBRP. It was determined that if AB 933 went into effect, it would increase employer health care premiums by nearly $109 million. Employee premiums would also increase over $41 million. Thus, the benefits of this bill would likely be concentrated among patients who use highly rebated drugs while this global cost increase would impact all insured and plan members in California. Specifically, patients who are prescribed lower cost or generic brand drugs will pay higher premiums but not reap point of service savings as the bill intends. When looking at health care cost increases in isolation they seem tolerable, however, this bill must be considered in context. Premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2022 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 20% over the last five years and 43% over the last 10 years. Additionally, annual premiums for employer-sponsored family health coverage reached $22,463 in 2022, with workers on average paying $6,106 toward the cost of their coverage. California must remain mindful when increasing the cost of health care coverage costs through legislation. The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) write point of service rebates won't help the majority of patients who take generic drugs, which account for more than 90% of the market. This bill will also not help patients who take brand name drugs that do not have competition in their therapeutic class, since rebates are generally not offered for those drugs. In fact, CHBRP estimated that a similar bill (AB 933, Daly of 2022) would only impact 3.48% of all prescriptions but it increases health insurance premiums by $200 million annually. Furthermore, this bill does nothing to help uninsured patients afford the drugs that they need. CAHP, ACLHIC and AHIP indicate that when the Trump administration adopted a similar mandate in the Medicare Part D program, federal actuaries estimated that it would increase premiums by 25%, costs taxpayers between $200 and $400 billion, and lead to a $137 billion windfall for pharmaceutical manufacturers. The Senate Appropriations Committee refused to advance that bill due to the increased premium cost; Congress has continually disallowed the federal

"rebate rule" to take effect. Furthermore, nothing in this bill addresses the root cause of high drug cost for consumers, which is high list prices set by manufacturers. This legislation would allow pharmaceutical manufacturers to continue to raise their prices year after year, which will increase the cost of this mandate even further.

SUPPORT AND OPPOSITION:

Support: California Access Coalition (sponsor)
Alliance for Patient Access
ALS Association
American Diabetes Association
American Legion-Department of California
AMVETS-Department of California
Applied Pharmacy Solutions
Bay Area Cancer Connections
Biocom California
California Academy of Family Physicians
California Black Health Network
California Chronic Care Coalition
California Health Collaborative
California Hepatitis C Task Force
California League of United Latin American Citizens
California Life Sciences
California Manufacturers and Technology Association
California Podiatric Medical Association
California Retired Teachers Association
California Rheumatology Alliance
California State Commanders Veterans Council
Community Health Action Network
Crohn's and Colitis Foundation
Depression and Bipolar Support Alliance California
Hemophilia Council of California
International Foundation for Autoimmune and Inflammatory Arthritis
International Bipolar Foundation
Liver Coalition of San Diego
Liver Health Foundation
Looms for Lupus
Los Angeles Wellness Station
Lupus Foundation of America, Southern California Region
Mexican American Opportunity Foundation
Military Officers Association of America-California Council of Chapters
National Multiple Sclerosis Society, MS-CAN
Neighborhood Wellness Foundation
Partners in Care Foundation
Pharmaceutical Research and Manufacturers of America
Sickle Cell Disease Foundation
Steinberg Institute
The Kennedy Forum
The Wall Las Memorias Project
Vietnam Veterans Association-California State Council

Several Individuals

Oppose: America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Pharmaceutical Care Management Association

-- END --