SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2023 - 2024 Regular Session

SB 873 (Bradford) - Prescription drugs: cost sharing

Version: February 17, 2023
Urgency: No
Hearing Date: May 1, 2023
Policy Vote: HEALTH 8 - 1
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: SB 873 would require, at the point-of-sale, the cost-sharing of an enrollee or insured of a health plan or health insurer for prescription drugs to be reduced based on rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require the Department of Managed Health Care and the Insurance Commissioner to provide a report on the impact of the bill's provisions on drug prices and health care premium rates to the appropriate policy committees of the Legislature.

Fiscal Impact:

- Unknown ongoing costs, likely hundreds of thousands (Managed Care Fund), for the Department of Managed Health Care to administer the provisions.

- The Department of Insurance estimates costs of $269,000 in 2023-24, $325,000 in 2024-25, and $12,000 in 2025-56 and ongoing thereafter (Insurance Fund) to administer the provisions.

Background: The Department of Managed Health Care (DMHC) regulates health plans under the Knox-Keene Act and the California Department of Insurance (CDI) regulates health insurance. Current law 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.

Current law defines a Pharmacy Benefit Manager (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.

PBMs help health plans manage their drug benefits through negotiating or contracting with manufacturers and/or pharmacies on behalf of their contracted health plans. A DMHC report 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. 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.

Proposed Law: Specific provisions of the bill would:

- Require 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 percent of all rebates received, or to be received, in connection with the dispensing or administration of the drug.

- Require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing.

- Require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- Require the DMHC and the Insurance Commissioner to submit an annual report on the impact of the above provisions on drug prices and health care premium rates to the appropriate policy committees of the Legislature, as specified.

- Require a health care service plan or health insurer that files certain rate information to report to the appropriate department additional specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, as provided.

- Sunset the provisions of this bill on January 1, 2027.

Related Legislation: SB 1361 (Kamlager, 2022) was similar to this bill. The bill was held on the suspense file in this committee. AB 2942 (Daly, 2022) and AB 933 (Daly, 2021) were similar to this bill. AB 2942 was never heard in the Assembly Health Committee and AB 933 was held in the Assembly Appropriations Committee.

Staff Comments: According to the California Health Benefits Review Program (CHBRP) analysis of AB 933 (Daly, 2021), AB 933 would have increased total net annual expenditures by $129,725,000 for enrollees with health insurance subject to state-level benefit mandates. This assumed a $200,588,000 increase in total health insurance premiums and a $70,833,000 decrease in enrollee share of cost for services. The analysis estimated no changes to CalPERS health plan expenditures.

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