Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 873
Author: Bradford (D)
Introduced: 2/17/23
Vote: 21

SENATE HEALTH COMMITTEE: 8-1, 4/19/23
AYES: Eggman, Gonzalez, Limón, Menjivar, Roth, Rubio, Wahab, Wiener
NOES: Glazer
NO VOTE RECORDED: Nguyen, Dahle, Hurtado

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/18/23
AYES: Portantino, Ashby, Bradford, Wahab, Wiener
NOES: Jones, Seyarto

SUBJECT: Prescription drugs: cost sharing

SOURCE: California Access Coalition

DIGEST: This bill 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. This bill 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, and makes this bill's provisions inoperative on January 1, 2027.

ANALYSIS:

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]

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) 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.

8) 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.

9) Requires for each health plan/insurer with a prescription drug benefit that the health plan/insurer to report rebate information, as specified.

10) 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.

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

Comments

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.

Prescription drug costs. 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.

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. 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.

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.

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.

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:

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.

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.

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.

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.

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%.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

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

- The CDI 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.

SUPPORT: (Verified 5/18/23)

California Access Coalition (source)
Alliance for Patient Access
Alliance for Transparent and Affordable Prescriptions
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 Pharmacists Association
California Podiatric Medical Association

California Retired Teachers Association
California Rheumatology Alliance
California State Commanders Veterans Council
Carrie's Touch
Chronic Disease Coalition
Community Health Action Network
Crohn's and Colitis Foundation
Depression and Bipolar Support Alliance California
Epilepsy Foundation of San Diego County
Hemophilia Council of California
Infusion Access Foundation
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 Infusion Center Association
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

OPPOSITION: (Verified 5/18/23)

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

ARGUMENTS IN 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.

ARGUMENTS IN 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. This bill could increase employer health care premiums by nearly $109 million. Employee premiums could 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. 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 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. 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.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
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