

Date of Hearing: August 23, 2023

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
SB 873 (Bradford) – As Introduced February 17, 2023

Policy Committee: Health Vote: 13 - 1

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health care service plan (health plan) or health insurer to calculate an enrollee's or insured's share of cost for a prescription drug based on a reduction equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of that drug. This bill requires the health plan or insurer to provide the dispensing pharmacy, at the point of sale, the calculated share of cost for each prescription drug for an enrollee or insured.

This bill also requires the Department of Managed Health Care (DMHC) and the Insurance Commissioner to submit an annual report on the impact of these provisions to the Legislature.

The provisions of this bill sunset on January 1, 2027.

FISCAL EFFECT:

- 1) The California Department of Insurance (CDI) estimates costs of \$269,000 in fiscal year (FY) 2023-24, \$325,000 in FY 2024-25, and \$12,000 per year, ongoing (Insurance Fund).
- 2) DMHC estimates costs as follows (Managed Care Fund (MCF)):
 - \$5 million for 26 positions and other costs in FY 2023-24.
 - \$84 million and 379 positions in FY 2024-25.
 - \$139 million and 732 positions in FY 2025-26.
 - \$120 million and 733 positions (some for half of the year) in FY 2026-27.
 - \$52 million and 581 positions for half of the year FY 2027-28.

DMHC notes that, depending on final enrollment data, a \$1 million dollar increase to the MCF could result in a 2-cent increase per enrollee on assessments to full-service health plans. To the extent this bill and others result in an additional assessment on health plans, consumers could face increased premiums.

COMMENTS:

- 1) **Purpose.** According to the author:

SB 873 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.

The author further contends this legislation will save the average diabetic patient \$630 in out-of-pocket costs per plan year, patients with asthma will see an average decrease in out-of-pocket costs of approximately \$270 annually. The author concludes the sickest patients in the healthcare system drive expenditures, so decreasing out-of-pocket costs and increasing adherence for those patients will benefit the system as a whole.

- 2) **California Health Benefit Review Program (CHBRP) Analysis.** In its analysis of AB 933 (Daly), of the 2021-22 Legislative Session, which was similar to this bill, CHBRP reported:
- a) **Utilization.** 836,000 enrollees use higher cost brand-name or specialty drugs and have plan designs for which cost sharing might change if this bill were enacted. However, the actual number of impacted enrollees will be lower as not all brand-name and specialty drugs may be eligible for manufacturer rebates. Postmandate, the number of enrollees who use brand-name or specialty medications with potentially impacted cost sharing would increase to 840,000 due to a reduction in cost barriers for some enrollees.
 - b) **Expenditures.** This bill would increase total net annual expenditures by \$129,725,000 (0.10%) for enrollees with health insurance subject to state-level benefit mandates. This is due to a \$200,558,000 increase in total health insurance premiums and a \$70,833,000 decrease in enrollee share of cost for services for newly covered members.
 - i) California Public Employees' Retirement System. CHBRP projects no measurable change to CalPERS.
 - ii) Covered California. Total premium expenditures for individually purchased coverage through Covered California would increase by \$33,045,000 (0.30%).

According to CHBRP, rebates will effectively lower the price for consumers of specific drugs, which will then result in additional demand or use of those drugs. However, the spending incurred by health plans is not only focused on rebates, but the cost of all drugs that would be dispensed if the price was reduced to the patient and more utilization occurred at that lower price to consumers. The rebates would still need to be paid by someone, in this case the carrier would absorb the cost. The increase in cost to the plan can be attributed to three sources:

- i) A \$95,880,000 increase in medical cost to the plan caused by shifting rebates from plan to patients.
- ii) A \$69,488,000 increase in medical cost to the plan caused by increase in utilization.
- iii) A \$34,632,000 increase in administrative cost to the plan caused by an increase in medical costs.

- c) **Incentive to Use Brand-name Drugs.** CHBRP reports this bill would affect enrollees who use brand-name or specialty medications, and would likely increase their number because rebates on brand-name drugs could make them less expensive to the enrollee. Additionally, a Commonwealth Fund report suggests incentives to use brand-name products may decrease the market share for generics or even discourage manufacturers from developing more of them.

3) **Prior Legislation.**

- a) AB 315 (Wood), Chapter 905, Statutes of 2018, required DMHC, in collaboration with other specified entities and stakeholders, to convene a Task Force on Pharmacy Benefit Manager (PBM) Reporting to determine what information related to pharmaceutical costs, if any, it should require to be reported by health plans or their contracted PBMs. AB 315 required the task force to consider inclusion of information including, but not limited to: wholesale acquisition cost (WAC) of pharmaceuticals; rebates; payments to network pharmacies; and, exclusivity arrangements between health plans or contracted PBMs with manufacturers.
- b) AB 265 (Wood), Chapter 611, Statutes of 2017, prohibited prescription drug manufacturers from offering discounts or other reductions in an individual's out of pocket expenses associated with their insurance coverage, if a lower cost therapeutically equivalent generic drug is available.
- c) SB 17 (Hernandez), Chapter 603, Statutes of 2017, required 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 required DMHC and CDI to compile specified information into a consumer-friendly report demonstrating the overall impact of drug costs on health care premiums, and required drug manufacturers to notify specified purchasers, at least 90 days prior to the planned effective date, if it is increasing the WAC of a prescription drug by specified amounts, among other provisions.
- d) AB 2942 (Daly), of the 2021-22 Legislative Session, would have required an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the POS based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill also would have required a health plan or health insurer to, among other things, pass through to each enrollee or insured at the POS a good faith estimate of their decrease in cost sharing. AB 2942 was not heard in Assembly Health Committee.
- e) SB 1361 (Kamlager), of the 2021-22 Legislative Session, would have required health plans and insurers to reduce enrollee and insured cost-sharing to reflect drug manufacturer rebates at the POS and reporting of POS 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 Senate Appropriations Committee.

- f) AB 933 (Daly), of the 2021-22 Legislative Session, was substantially similar to this bill and was held on this committee's suspense file.

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