

California Health Benefits Review Program

Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing

A Report to the 2021–2022 California State Legislature

January 4, 2022



Key Findings

Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing

Summary to the 2021–2022 California State Legislature, January 4, 2022



SUMMARY

California Assembly Bill (AB) 933 impacts the flow of drug manufacturer rebate dollars. AB 933 would require that the defined cost sharing an enrollee pays at the point of sale (generally, the pharmacy) be based on a price that is reduced by approximately 90% of the rebate amount. These rebates should be provided at the point of sale but reconciled at the end of each calendar year for any additional cost-sharing reductions owed to the insured not passed on to the insured through the estimated amount at the point of sale. The bill exempts Medi-Cal.

In 2022, of the 21.9 million Californians enrolled in state-regulated health insurance, 13.9 million of them would have insurance subject to AB 933.

Cost and Health Impacts¹: CHBRP estimates that in 2022:

- 836,000 enrollees use brand-name or specialty drugs and have plan designs which would have potentially impacted cost sharing under AB 933. However, the actual number of impacted enrollees will be lower as not all brand-name and specialty drugs may be eligible for manufacturer rebates. 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 AB 933 were enacted.
- AB 933 would increase total net annual expenditures by \$129,725,000, or 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.

CONTEXT

Pharmaceutical drug net spending in the United States reached \$324 billion in 2017 and was expected to increase 2% to 5% annually from 2017 to 2022. Retail prescription drug expenditures in 2018 accounted for approximately 10% of national health care expenditures, a percentage that has remained consistent over the past decade.² 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 pharmacy benefit manager (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.

BILL SUMMARY

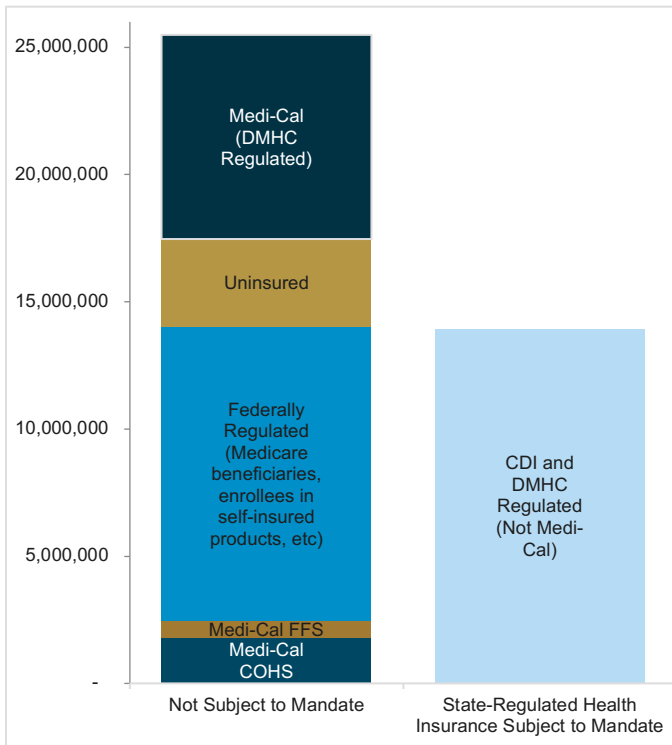
AB 933 would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. If enacted, AB 933 would apply to the health insurance of approximately 13.9 million enrollees. This represents 64% of the 21.9 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, exempting Medi-Cal. Figure A notes how many Californians have health insurance that would be subject to AB 933.

¹ Similar cost and health impacts could be expected for the following year, though possible changes in medical science

and other aspects of health make stability of impacts less certain as time goes by.

² Refer to CHBRP's full report for full citations and references.

Figure A. Health Insurance in CA and AB 933



Source: California Health Benefits Review Program, 2022.

IMPACTS

Benefit Coverage, Utilization, and Cost

CHBRP estimates that 836,000 enrollees use higher cost brand-name or specialty drugs and have plan designs for which cost sharing might change if AB 933 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. Details on manufacturer rebate programs are proprietary; for instance, manufacturers prohibit the disclosure of 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 AB 933 were enacted.

Utilization

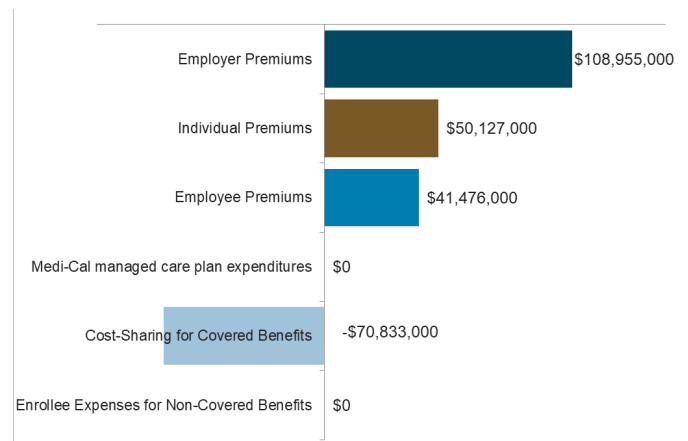
Among enrollees with potentially impacted cost sharing

at baseline, there are 836,000 enrollees who use brand-name or specialty medications. Postmandate, the number of enrollees who use brand-name or specialty medications with potentially impacted cost sharing would increase to 840,000 (Table 1 in the Full Report) due to a reduction in cost barriers for some enrollees.

Expenditures

AB 933 would increase total net annual expenditures by \$129,725,000, or 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.

Figure B. Expenditure Impacts of AB 933



Source: California Health Benefits Review Program, 2022.

CalPERS

CHBRP projects no measurable impact to CalPERS.

Covered California – Individually Purchased

CHBRP projects total premium expenditures for individually purchased plans in Covered California to increase by \$33,045,000, or 0.30%.

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January 4, 2022

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. AB 933 Impacts on Benefit Coverage, Utilization, and Cost, 2022

	Baseline (2022)	Postmandate Year 1 (2022)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,945,000	21,945,000	0	0.00%
Total enrollees with health insurance subject to AB 933	13,940,000	13,940,000	0	0.00%
Total percentage of enrollees with coverage	0%	0%	0%	0.00%
Utilization and Cost				
Number of enrollees using brand or specialty drugs with potentially impacted cost sharing	836,000	840,000	4,000	0.48%
Annual Number of brand or specialty scripts per member with potentially impacted cost sharing	4.78	4.92	0.14	3.00%
Number of potentially impacted scripts	3,995,000	4,134,000	139,000	3.48%
Average allowed retail cost per brand or specialty script subject to cost sharing	\$992	\$675	-\$318	-32.02%
Average cost sharing per brand or specialty script with potentially impacted cost sharing	\$198	\$175	-\$24	-11.98%
Expenditures				
<i>Premium (expenditures) by payer</i>				
Private employers for group insurance	\$55,032,803,000	\$55,141,758,000	\$108,955,000	0.20%
CalPERS HMO employer expenditures (b) (c)	\$5,765,017,000	\$5,765,017,000	\$0	0.00%
Medi-Cal Managed Care Plan expenditures	\$24,150,529,000	\$24,150,529,000	\$0	0.00%
<i>Enrollee premiums (expenditures)</i>				
Enrollees for individually purchased insurance	\$15,847,507,000	\$15,897,634,000	\$50,127,000	0.32%
Individually purchased – outside Exchange	\$4,890,852,000	\$4,907,934,000	\$17,082,000	0.35%
Individually purchased – Covered California	\$10,956,655,000	\$10,989,700,000	\$33,045,000	0.30%
Enrollees with group insurance HMOs, and Covered California (c)	\$20,753,446,000	\$20,794,922,000	\$41,476,000	0.20%
<i>Enrollee out-of-pocket expenses</i>				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	\$13,168,032,000	\$13,097,199,000	-\$70,833,000	-0.54%
Expenses for noncovered benefits (d) (e)	\$0	\$0	\$0	0.00%
Total Expenditures	\$134,717,334,000	\$134,847,059,000	\$129,725,000	0.10%

Source: California Health Benefits Review Program, 2021.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Of the increase in CalPERS employer expenditures, about 54.1% would be state expenditures for CalPERS members who are state employees or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not regulated by DMHC or CDI. CHBRP has projected no impact for those enrollees.

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance and health insurance purchased through Covered California.

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems, OPD = Outpatient Prescription Drug.

BACKGROUND ON PHARMACY BENEFIT MANAGERS AND OUTPATIENT PRESCRIPTION DRUG REBATES

AB 933 addresses the flow of outpatient prescription drug rebates between manufacturers and pharmacy benefit managers (PBMs) and plan sponsors. Drug rebates are used by pharmaceutical manufacturers to incentivize coverage and use for their products. These 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. This section gives an overview of prescription drug spending, the evolution of PBMs and their business/revenue models, and the flow of rebate.

Prescription Drug Spending

Spending on pharmaceuticals was \$324 billion in 2017 after removing rebates and was expected to increase 2% to 5% annually from 2017-2022 (Wineinger et al., 2019). Per capita pharmaceutical spending is higher in the United States than other high-income countries (Papanicolas et al., 2018). In addition, utilization is higher on an average per capita basis in the United States, as well (although California's per capita average is lower than the U.S. average). The number of prescriptions filled per capita at retail pharmacies averages 11.6 nationally, and 8.5 in California in 2019 (KFF State Health Facts, 2019). Retail prescription drug expenditures in 2018 accounted for approximately 10% of national health care expenditures, a percentage that has remained consistent over the past decade (Tichy et al., 2020).³

The Role of Pharmacy Benefit Managers in Prescription Drug Benefit Administration

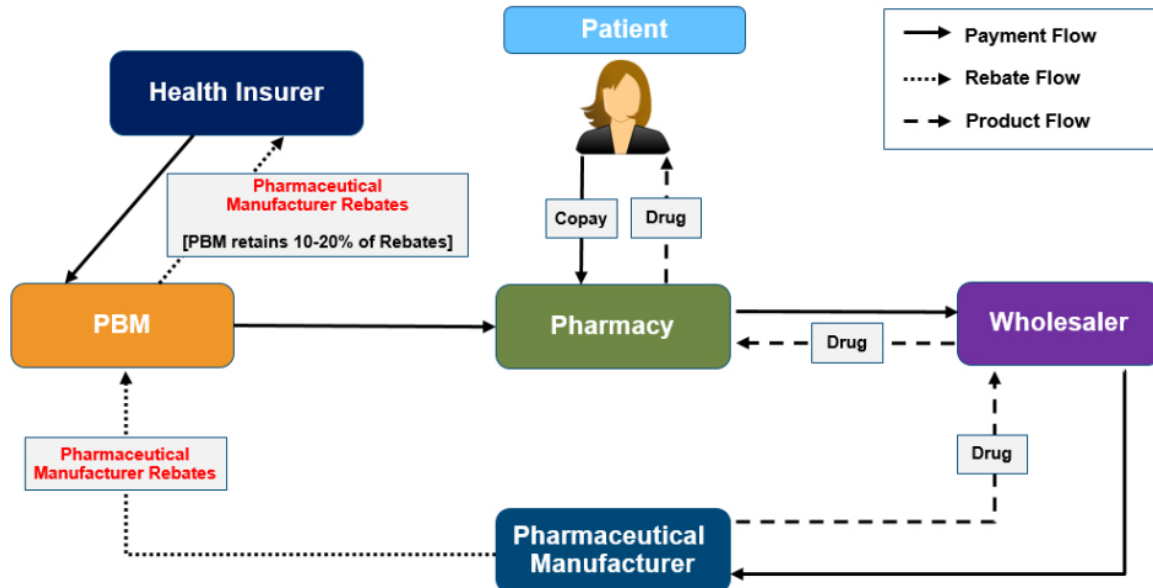
Pharmacy benefit management generally applies to self-administered drugs prescribed by a health care professional (i.e. outpatient prescription drugs).⁴ An outpatient pharmacy benefit is generally independent from a medical benefit (which, for example, covers office visits,⁵ hospitalizations, and physician-administered drugs). For the purposes of analyzing AB 933 and its related impacts and implementation, drugs administered by a health care professional are not, in CHBRP's interpretation of AB 933, addressed in this legislation. Pharmacy benefits are often administered through a third-party, PBMs, which on behalf of payers or plan sponsors provide coverage for outpatient prescription drugs for enrollees. PBMs manage the drug benefits for over 90% of Americans with prescription drug coverage. (Shepherd, 2020)

The role of PBMs in the U.S. pharmacy distribution and reimbursement system is depicted in Figure 1. As depicted, PBMs handle pharmacy reimbursement, rebates, and general contracts with pharmacies and manufacturers on behalf of third-party payers, who may be a public entity such as Medicare, an employer, or a health plan.

³ Total U.S. health care spending in 2019 totaled \$3.81 trillion (CMS, Actuary).

⁴ Pharmacy benefits in some cases may also cover vaccines administered by a pharmacist.

⁵ This includes in-person or virtual office visits.

Figure 1. The U.S. Pharmacy Distribution and Reimbursement System

Source: Dieguez et al., 2018.

PBMs have evolved significantly over recent decades. They went from primarily processing prescription claims (which was largely an administrative function) in the late 1960s to serving as gatekeeper to outpatient prescriptions through active management of formularies and pharmacy networks. The first-generation PBMs were heavily focused on developing innovations that allowed them to keep costs down for employers/health plans and for patients. PBMs pioneered electronic claims processing in health care in 1987 (Fox et al., 1999), and started in the 1970s with the plastic drug benefits “credit card” that patients used at the local pharmacy to buy their prescription drugs (Schulman and Dabora, 2018).

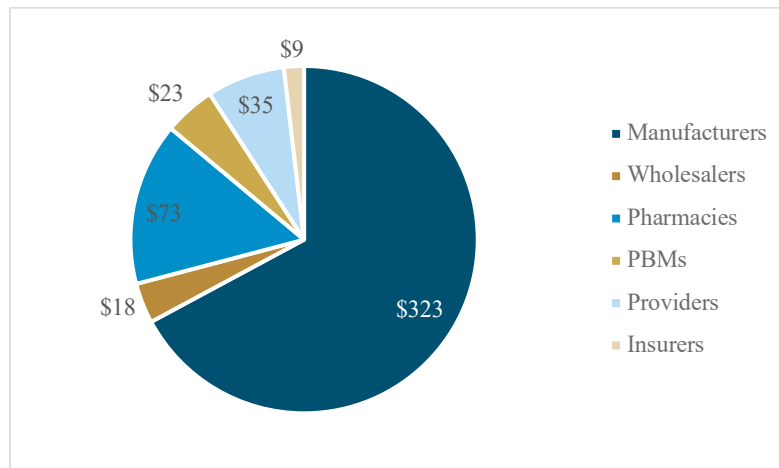
PBMs also play a role in pricing as they negotiate directly with drug manufacturers⁶ but reveal little about how those savings are passed onto consumers. The current formulary-for-rebate arrangement between PBMs and manufacturers is a form of selective contracting that has been employed in the provision of health care since the 1980s (Shepherd, 2020). Predominantly serving the private sector during the 1970s and 1980s, PBMs expanded services to Medicaid programs in the 1990s and to Medicare Part D under the Medicare Modernization Act. In addition, during the 1990s, the focus of PBMs shifted from pharmaceutical claims management to more complex business models with a diversified portfolio of services, including the use of incentives to modify consumer behavior, and disease management programs (Schulman and Dabora, 2018).

Today, PBMs use their buying power, combined with utilization management strategies, to lower the total cost of pharmaceuticals. Werble (2017) estimates that PBMs provide prescription drug coverage for 266 million Americans. PBMs have consolidated significantly in recent years. There are now three large PBMs — CVS, Express Scripts, and Optum — that account for more than 70% of prescription drug claim volume. A white paper (Sood et al., 2020) sheds light on an important aspect of the issue: it shows that rising rebates demanded by PBMs are associated with rising list prices for prescription drugs.

⁶ Some PBMs outsource this function to rebate aggregators, which are often owned by the PBMs. More information on this can be found at: <https://www.benefitspro.com/2021/04/15/cautionary-tale-plan-sponsors-losing-manufacturer-rebate-dollars-to-pbms-through-rebate-aggregators/?slreturn=20211117180559>.

As depicted in Figure 2, drug manufacturers' net revenues comprised two-thirds of total retained revenue across pharmaceutical sectors in 2016 (Yu et al., 2018). Yu et al. (2018) estimates that pharmacy benefit managers' net revenues represent about \$23 billion, or 4.8% of this spending.

Figure 2. Retained Revenue across All U.S. Pharmaceutical Sectors in 2016 (\$ Billions)



Source: Yu et al., 2018, modified by the California Health Benefits Review Program, 2021.

Operation of PBMs

The prescription drug distribution chain is complex and involves several interested parties and stakeholders, as Figures 1 and 2 illustrate. These stakeholders' contracts determine how much a patient's health insurance pays for prescription drugs and the patient's out-of-pocket (OOP) costs. While there are many factors that influence how health insurers provide prescription drugs, pharmaceutical manufacturer rebates are one of the key drivers (Dieguez et al., 2018).

Rebates

A rebate is the return of part of the purchase price by the seller to the buyer. Rebates are used by a wide array of manufacturers, such as automakers, electronics companies, and pharmaceutical manufacturers to drive demand for their products. Prescription drug rebates are generally paid by a pharmaceutical manufacturer to a PBM, who then shares a majority with the health insurer (or in some cases, the plan sponsor). 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. Rebates are rarely paid by manufacturers for generic prescription drugs.

Rebates are a key negotiating tool for payers and help produce lower net prices for drugs that can help reduce the overall costs of drug spending. But for many years, the PBM business model has included a revenue stream by retaining a percent of the absolute rebate amount they return to plan sponsors. Higher list prices⁷ impact those patients with ongoing drug treatments, because increased use of coinsurance and of high deductible plans has resulted in rising numbers of patients that are required to pay their out-of-pocket share for drug coverage in relation to the list price, not the negotiated (and generally confidential) post-rebate price (Pearson et al., 2019).

To offset high list prices of prescription drugs, manufacturers often offer rebates to payers. PBMs frequently collect these rebates on behalf of payers (Werble, 2017). Critics of PBMs argue that the

⁷ Drug List Price is the price of a drug that is shown by a pharmacist's computer.

opaque system through which rebates are collected and distributed does not allow payers to adequately discern the proportion of rebates that they are receiving, and thus whether a PBM's administration of those rebates serves the best interest of the payer. This controversy is one reason that PBMs are under scrutiny in discussions about drug prices (Yu et al., 2018).

Rebates are typically negotiated when drugs are first introduced to market. They are then renegotiated on a regular or ad hoc basis.

PBMs make their revenue through several mechanisms, the most relevant for this analysis are revenues generated through retained manufacturer rebates.⁸

PBMs typically negotiate contracts with payers based on, among other things, percentage off of average wholesale price (AWP) — commonly referred to “list price” — of given categories of drugs. However, a high rebate on a given drug does not necessarily result in a lower net cost to payers. Although PBMs claim to pass large amounts of rebates onto payers, there is generally little open disclosure of rebates. Thus, payers are generally unable to verify the complete accuracy.

Point-of-Sale Rebates

The pharmacy point of sale (POS) is a system that allows pharmacies to enter outpatient, self-administered prescription claims in “real time” into the payment system. Within seconds, providers receive confirmation that a claim has been processed. A POS system is commonly used in a retail pharmacy setting. A recent white paper found that almost half of individuals with Medicare Part D coverage would see a reduction in out-of-pocket spending if patient cost-sharing were based on the price negotiated after the rebate (or net price), rather than the pre-rebate list price (Lakdawalla and Li, 2021). The most important potential benefit of POS rebates is that patients who require extended use of expensive medications for chronic conditions could have their financial burden lessened. Although evidence is limited, POS rebates could improve adherence and consequently clinical outcomes. Notably, aligning patient cost sharing with allowed retail price after rebates can enhance the effectiveness of value-based formularies if patient cost sharing is lowest, because of the POS rebates, for the most cost-effective treatment. Finally, PBMs may react to POS rebates by adjusting formularies to achieve desired business outcomes. For instance, PBMs may reconsider the formulary tier of drugs, especially in instances where there is an opportunity to retain comparably higher rebates postmandate or achieve more appealing discounts or rebates when evaluated by plan sponsors.

POS rebates give individual patients some of the money that would otherwise flow back to the plan sponsor. The payer no longer has the option to apply those funds to reduce health insurance premiums. In addition, POS rebates to the patient, by themselves do not address much of the financial burden faced by many patients who need high-cost medicines. Patients requiring expensive, chronic treatment may still reach their annual out-of-pocket maximum. Furthermore, while applying POS rebates can reduce out-of-pocket cost for specific patients, that is dependent on the drug and rebate amount. Finally, for those patients who have reached their out-of-pocket maximum in their respective plans, rebate savings will continue to flow directly to the payer.

Pharmacy Benefits in California

In 2017, health plans in California paid almost \$8.7 billion for prescription drugs, accounting for 13.1% of total health plan premiums. During the same year, prescription drug costs increased by 5%, as medical expenses increased by 5.9%. Manufacturer rebates totaled about \$915 million (10.5% of the total amount that health plans spent on prescription drugs) (California Department of Managed Health Care, 2018).

⁸ PBMs generate revenues via fees from the supply chain, administrative fees, and spread pricing. PBMS also generate profits through group purchasing organizations, research grants, and the sale of claims data, prior authorizations, and valued-added programs.

Almost all Californians enrolled in plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) have coverage for outpatient prescription drugs through a pharmacy benefit that is part of the plan or policy.⁹ In this arrangement, the health insurer may use an in-house PBM of their own or subcontract with a PBM. A small percentage of enrollees in state-regulated health insurance (about 1.9% in 2021) access pharmacy benefits directly through a PBM.¹⁰ In this latter arrangement, PBM contracts are not subject to state health insurance benefit mandates.¹¹ However, other types of regulation exist in California that do impact these PBM contracts, as is outlined in the *State Legislation Regarding PBMs* below.

⁹ A small number of enrollees either do not have a pharmacy benefit in their plan/policy or have a pharmacy benefit that is separate from their plan/policy that is not subject to regulation by DMHC or CDI. See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage in California*, available at: https://chbrp.org/other_publications/index.php.

¹⁰ See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage in California*, available at: https://chbrp.org/other_publications/index.php.

¹¹ See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage in California*, available at: https://chbrp.org/other_publications/index.php.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)¹² conduct an abbreviated evidence-based assessment of the financial impacts of AB 933, Prescription Drug Cost Sharing.

Bill-Specific Analysis of AB 933, Prescription Drug Cost Sharing

Bill Language

AB 933 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 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would prohibit a health care service plan, health insurer, or a plan's or insurer's agents from publishing or otherwise revealing information regarding the actual amount of rebates the health care service plan or health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. The bill would also require a health care service plan or health insurer to disclose information sufficient to show compliance with these provisions to the director or commissioner.

AB 933 does not prohibit a health care service plan from sharing more than 90% of all rebates received. In addition, AB 933 prohibits revealing information regarding the actual amount of rebates the health care service plan receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. That information, per AB 933, shall be protected as a trade secret and is not considered a public record as defined in the California Public Records Act.

The full text of AB 933 is included in Appendix A.

Relevant Populations

If enacted, AB 933 would apply to the health insurance of approximately 13.9 million enrollees. This represents 64% of the 21.9 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, exempting Medi-Cal.

Interaction with Existing State and Federal Requirements

AB 933 may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

In 2018, California passed AB 315, Pharmacy Benefit Management, which amended the California Business and Professions and Health and Safety codes. AB 315 requires pharmacists to inform customers about purchase options (i.e., whether the retail price of a drug is lower than the applicable cost-sharing amount for that drug) and ensures that outright purchasing of a drug applies to the patient's deductible and maximum out-of-pocket limit as applicable.

¹² CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

The bill places additional requirements on PBMs, including a requirement for PBMs to register with the DMHC. Other requirements include disclosing (to the third-party purchaser) aggregate wholesale acquisition costs and rebates for certain categories of drugs, utilization data, and exclusivity arrangements with pharmaceutical manufacturers.

AB 315 applies to purchasers and third-party payers (e.g., large employers who contract directly with PBMs), but not to health care plans that are regulated by DMHC.

California also passed SB 17 Health Care: Prescription Drug Costs in 2018, which amended the Health and Safety Code and Insurance Code to increase prescription drug cost transparency. In addition to requirements placed on manufacturers, the legislation requires health care service plans that were already required under state law to report rate information to DMHC and the California Department of Insurance (CDI) to also report prescription drug-specific information to the departments, including:

- The 25 most frequently prescribed drugs;
- The 25 most costly drugs by total annual spending; and
- The 25 drugs with the highest year-over-year increase in total annual plan spending.

Large-group plans that report rates to DMHC are also required to disclose, for nonspecialty generic and brand-name drugs, and for drugs dispensed at a plan, network, or mail order pharmacy for outpatient use:

- The percentage of premium attributable to prescription drug costs for certain categories of drugs;
- The year-over-year increase, as a percentage, in per-member, per-month total health plan spending;
- The year-over-year increase in per-member, per-month costs for drug prices compared to other parts of the health care premium; and
- The specialty tier formulary list.¹³

Similar requirements in other states

Other State Laws

State Legislation related to Drug Rebates

In 2020 and 2021, seven states introduced legislation related to AB 933, with one state (West Virginia) enacting legislation in 2021.¹⁴ Proposals vary in diverting 51% to 100% of rebate dollars to the enrollee or plan sponsor, with calculation occurring at the point of sale.

In West Virginia, HB 2263 was enacted in 2021, requiring enrollee cost sharing to be calculated at the point of sale based on a price reduced by at least 100% of all rebates received. Any rebate exceeding this must be passed on to the health plan to reduce premiums. Also in the 2021 legislative session, Oklahoma introduced SB 721, requiring discounts, rebates, price concessions, and fees related to medication claims to be passed to enrollees at the point of sale and proposing that enrollee cost sharing be the lesser of the copayment, maximum allowable cost, maximum allowable claim, adjusted out-of-pocket maximum, the

¹³ Some prescription drug plans have a specialty tier, which is a fourth category of medications that requires a patient to pay co-insurance, or a percentage of the entire drug price.

¹⁴ Search of state legislation was conducted via Politico Pro and state-specific databases.

amount the enrollee would pay without insurance, and the amount the pharmacy would be reimbursed by the PBM.

In the 2020 legislative session, Georgia introduced HB 1027, requiring enrollee cost sharing be calculated at the point of sale based on a price reduced by at least 80% of all rebates received. Indiana introduced HB 1219 and SB 160, requiring enrollee cost sharing be calculated at the point of sale (based on a price reduced by at least 75% and 85% of all rebates received, respectively). Iowa introduced HF 2465, diverting 51% of rebate dollars to enrollee cost sharing, and Missouri introduced HB 2527, diverting 100% of rebate dollars to enrollee cost sharing.

Drug Pricing

There has been considerable activity in other states in introducing and passing a range of laws aimed at drug prices, from price transparency requirements to drug affordability boards (NASHP, 2021). One example is legislation regulating excessive or unsupported price increases (UPIs) of prescription drugs. Laws addressing UPIs impose a tax or penalty when a drug's price increases by more than a specified percentage (such as the rate of general inflation) over a defined period (Mello and Riley, 2021).

The UPI concept has found expression in both federal and state bills, as well as in then-candidate Biden's health care proposals.¹ Bills in both the House and the Senate in 2019-2020 proposed to penalize drug manufacturers when the average manufacturer's price for a Medicare-covered drug increased by more than the rate of inflation, requiring them to pay rebates to Medicare equal to the excessive portion of the increase.

In Massachusetts, the Governor has introduced legislation to limit annual price increases for drugs with average annual costs of \$50,000 or more to inflation plus 2%. Increases above the limit are subject to a tax penalty of 80% on the excess portion. Originally introduced in 2019, the proposal is included in the Governor's fiscal year 2022 budget proposal, which awaits legislative action. The National Academy for State Health Policy has created model legislation. Washington, Hawaii, Maine, and Connecticut introduced UPI legislation in the opening weeks of 2021 and more states are likely to follow (Mello and Riley, 2021).

In the 2021 legislative session, the Colorado legislature approved SB 21-175, establishing a Prescription Drug Affordability Board (PDAB). The legislation requires health insurance payers to provide more detailed drug rebate information to the Center for Improving Value in Health Care (CIVHC),¹⁵ which will enable further evaluation of the impact of drug rebates.

Federal Policy Landscape

Unlike a number of other industrialized countries, the United States has no federal process in which prices charged by drug makers are evaluated with consideration of the quality and evidence of clinical benefit. Rather, drug makers must negotiate with a myriad of payers, including both insurers and PBMs (Pearson et al., 2019).

Gag Clauses

On October 10, 2018, the Patient Right to Know Drug Prices Act became Public Law.¹⁶ The law prohibits what is commonly called the "gag clause," a PBM contract requirement that prohibited pharmacists from disclosing to a patient when the out-of-pocket cost for a drug is lower than their cost sharing, and applies to the private insurance market. Advocates argue that the removal of the gag clause could have large impacts on prescription drug prices, but critics point to a report from the Congressional Budget Office that

¹⁵ CIVHC is a public-private entity created to identify and advance initiatives that enhance consumers' health care experiences, contain costs, and improve the health of Coloradans.

¹⁶ 42 US Code 300gg-11.

predicted little impact (Sachs, 2019). On the same day, the Know the Lowest Price Act of 2018 established a similar provision for Medicare.¹⁷ According to the National Council of State Legislatures, 33 states had enacted similar laws as of June of 2018¹⁸ (NCSL, 2018).

Rebates

In January of 2019, the Trump Administration proposed a rule that would have fundamentally changed how drug manufacturer rebates work by removing safe harbor protection for prescription drugs paid by manufacturers to PBMs working with plans under federal programs, Medicare Part D plans, and Medicaid managed care organizations (U.S. Department of Health and Human Services, 2019). The rule also would have created a new safe harbor for rebates paid directly to patients, and fixed fee service agreements between manufacturers and PBMs.

Ultimately, the Administration retracted (but did not withdraw) the rule in July of 2019, amidst criticism and uncertainty about its potential outcomes. While supporters argued that rebate reform would have made the pricing system more transparent and begun transformation of a broader system by beginning with federal programs, critics pointed to added complexity, limited scope, a high price tag, and ambiguity about potential outcomes (Fein, 2019).

However, on November 20, 2020, as part of a release of several drug pricing rules, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (“OIG”) adopted a Final Rule modifying the Anti-Kickback Statute (AKS) discount safe harbor and adding two new safe harbors to reform drug pricing in the Medicare Prescription Drug Benefit (Part D). The Rule requires pharmacy benefit managers (PBMs) and Part D Plans (PDPs) to abandon the use of rebates unless they are passed on to the consumer at the point of sale. The Final Rule, if it survives inevitable judicial scrutiny, may significantly change Part D drug pricing between manufacturers and Part D plan sponsors.

The Final Rule creates a new AKS point-of-sale prescription drug price reduction safe harbor that would exempt manufacturer rebates paid to Part D plan sponsors and Medicaid managed care organizations for prescription drugs if those rebates are passed through to the enrollee at the point of sale. The Final Rule also creates a second safe harbor for certain “legitimate” service fees paid by manufacturers to PBMs. These new safe harbors will be available starting 60 days after publication of the Final Rule in the Federal Register.

In addition, notably, the Final Rule explicitly carves out from discount safe harbor protection rebates and other remuneration in connection with the sale or purchase of prescription drugs from a manufacturer to a Part D plan sponsor (including indirectly through a PBM acting under contract with a plan sponsor). The Final Rule does not explicitly carve out of the discount safe harbor price reductions provided to Medicaid Managed Care Organizations, in contrast to the Proposed Rule in 2019. The changes to the discount safe harbor — including loss of discount safe harbor protection for rebates to Part D plan sponsors — will go into effect on January 1, 2022. Presumably, the purpose of the delayed effective date of the discount safe harbor changes is to allow manufacturers and plan sponsors time to enter into agreements that satisfy the new point-of-sale prescription drug price reduction safe harbor and PBM services fees safe harbor to help avoid scrutiny under the AKS.¹⁹

Build Back Better Act

On November 19, 2021, the House of Representatives passed H.R. 5376, the [Build Back Better Act \(BBBA\)](#), which includes a broad package of health, social, and environmental proposals. The BBBA includes several provisions that are intended to lower prescription drug costs for people with Medicare

¹⁷ Public Law No: 115-262.

¹⁸ California AB 315 was enacted on September 29, 2018 (Chaptered 905, Statutes of 2018).

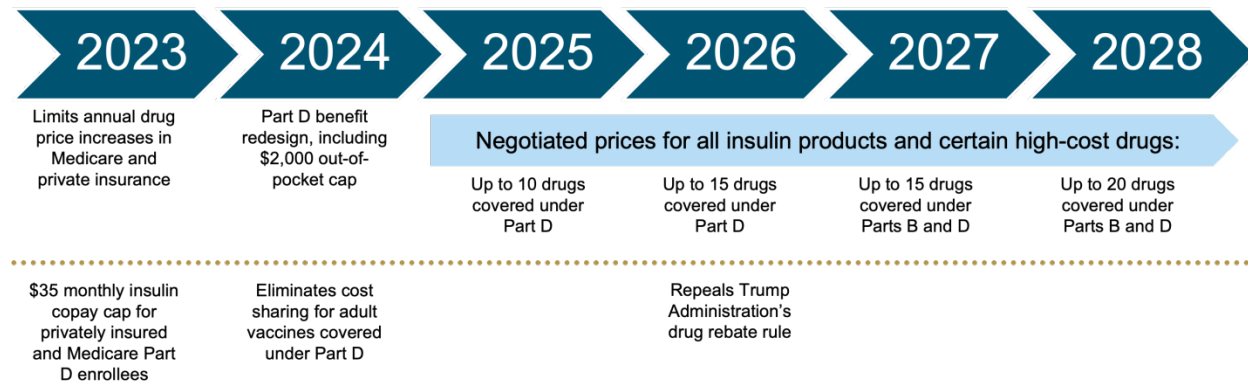
¹⁹ Similar, but less stringent requirements were passed as part of the Consolidated Appropriations Act. Enforcement has been deferred. Information may be accessed at: <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f>.

and private insurance and reduce drug spending by the federal government and private payers. Some of these provisions would impact private health insurance policies (and eventually interact with AB 933), and some elements of the legislation (were enacted) relate to Medicare and may indirectly interact with AB 933. As of the date of this report submission, the ultimate outcome of the BBB is uncertain.

The key prescription drug proposals included in the BBBA (KFF, 2021) would:

- [Allow the federal government to negotiate prices for some high-cost drugs covered under Medicare Part B and Part D.](#)²⁰ The CBO estimates that the drug pricing provisions in the BBBA would reduce the federal deficit by \$297 billion over 10 years (2022-2031).
- [Require inflation rebates to limit annual increases in drug prices in Medicare and private insurance](#)
- [Cap out-of-pocket spending for Medicare Part D enrollees and other Part D benefit design changes](#)
- [Limit cost sharing for insulin for people with Medicare and private insurance](#)
- [Eliminate cost sharing for adult vaccines covered under Part D](#)
- [Repeal the Trump Administration's drug rebate rule](#)

Figure 3. Implementation Timeline of the Key Prescription Drug Provisions in the Build Back Better Act



Source: Kaiser Family Foundation, 2021. Adapted by California Health Benefits Review Program, 2022.

²⁰ The BBBA would amend the noninterference clause by adding an exception that would allow the federal government to negotiate prices with drug companies for a small number of high-cost drugs covered under Medicare Part D (starting in 2025) and Part B (starting in 2027). The negotiation process would apply to no more than 10 (in 2025), 15 (in 2026 and 2027), and 20 (in 2028 and later years) single-source brand-name drugs or biologics that lack generic or biosimilar competitors. These drugs would be selected from among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending. The negotiation process would also apply to all insulin products.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 933 would require that the defined cost sharing for prescription drugs paid by an enrollee at the point of sale be based on a price that is reduced by rebates received or to be received by the payer. Approximately ninety percent of the value of rebates would be provided at the point of sale, and the health insurer would provide the enrollee with an additional end-of-calendar-year payment for any cost sharing reductions owed to the insured that were not correctly passed on to the insured through the estimated rebates provided at the point of sale so that the consumer would receive 90% of the value of the rebate each calendar year.

AB 933 would apply to the health insurance of Californians enrolled in a plan or policy regulated by the California Department of Insurance (CDI) or the California Department of Managed Care (DMHC), except Medi-Cal beneficiaries enrolled in DMHC-regulated plans (which is excluded in the bill language) (see Figure A).

In addition to commercial enrollees, more than 50% of enrollees associated with the California Public Enrollees' Retirement System (CalPERS) and more than 70% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.²¹ As noted in the *Policy Context* section, AB 933 would impact these CalPERS enrollees'; however, CHBRP is not estimating an impact to CalPERS plans (due to low cost sharing plan design of CalPERS plans).

This section reports the potential incremental impacts of AB 933 on estimated baseline benefit coverage, utilization, and overall cost for 2022. Because the analysis of AB 933 was requested prior to finalization of the annual CHBRP cost model update and carrier survey, a 2023 projection is not available.

Analytic Approach and Key Assumptions

Assumptions for Baseline Benefit Coverage

- CHBRP assumed that potential rebates under AB 933 apply to only brand-name and specialty pharmacy claims handled by a pharmacy benefit manager (PBM) under an outpatient prescription drug benefit — typically, claims for prescription drugs filled at retail pharmacies, mail order pharmacies, and specialty pharmacies associated with the PBM.
- CHBRP assumed that potential rebates associated with physician-office administered drugs and other drugs paid for through medical benefits were outside the scope of AB 933 and did not consider these services.
- The population subject to the mandate includes enrollees covered by DMHC-regulated commercial insurance plans and CDI-regulated policies.
- CHBRP assumed 0% of the plans and policies subject to AB 933 currently offer coverage for point-of-sale rebates to reduce cost sharing. CHBRP recognizes that some PBMs and plan sponsors may offer this benefit, however, adoption appears to be very low.²²
- CHBRP did not conduct carrier surveys to determine the percentage of enrollees that currently have coverage for point-of-sale rebates to reduce cost sharing.

²¹ For more detail, see CHBRP's *Estimates of Sources of Health Insurance in California for 2023*, a resource available at http://chbrp.org/other_publications/index.php.

²² <https://www.drugchannels.net/2019/09/employers-slowly-warm-to-point-of-sale.html>.

Assumptions for Baseline Utilization and Cost

- Baseline utilization and cost was modeled using Milliman's Prescription Drug Managed Care Rating Manual which provides utilization and unit cost for preferred brand drugs,²³ nonpreferred brand-name drugs,²⁴ and specialty drugs.
- Baseline utilization and cost was modeled separately for ages 17 and under, 18 to 64, and 65 and older. CHBRP modeled utilization and cost for each market segment using a blended age approach that reflected the segment's demographic distribution.

Assumptions for Baseline Cost Sharing

- CHBRP utilized its annual carrier survey, not specific to AB 933, to determine the percentage of enrollees that are enrolled in plans by regulator, line of business, and deductible or metal tier.
- CHBRP used the same baseline carrier survey to determine the percentage of plans with coverage for brand or specialty drugs by line of business. Note that California law requires plans without drug coverage to cover insulin. To address the impact of AB 933 on these utilizers, CHBRP assumed the mandate would have no impact on enrollees without brand or specialty coverage, except for 0.85% of this population who have mandated coverage for insulin. The proportion of the population using insulin is based upon CHBRP's 2021 analysis of SB 473, Insulin Cost Sharing.
- CHBRP made simplifying assumptions about the current benefit designs of individuals subject to AB 933. CHBRP mapped the level of cost sharing to one of three typical plan designs that reflect the plan types available in the DMHC- and CDI-regulated insurance market and would be impacted differently by AB 933:
 - Low cost sharing: CHBRP assumed these plans have a fixed copayment for brand and specialty drugs, and that cost sharing would not be impacted under AB 933. Cost sharing would not be impacted, because these plans would typically have a copayment-based cost structure for the drug benefit (e.g., \$40 copays for brand drugs), as well as deductibles and maximum-out-of-pocket amounts that would be met regardless of point-of-sale rebates. For example, CHBRP assumed that pharmacy deductibles under \$100 also had low cost sharing and would not be impacted by this change.
 - Medium cost sharing: CHBRP assumed these plans had a \$750 deductible, 20% coinsurance, and a \$3,250 maximum-out-of-pocket for all services, including pharmacy.
 - High cost sharing: CHBRP assumed these plans had a \$2,200 deductible, 20% coinsurance, and a \$5,000 maximum-out-of-pocket for all services, including pharmacy.
- The following logic was used to classify plans based on their pharmacy benefit designs:

²³ Preferred brand drugs are brand-name drugs that may not be available in generic form but are chosen for their cost effectiveness compared to alternatives.

²⁴ Non-preferred brand drugs often have a generic or preferred brand drug option in which the cost sharing for the enrollee is generally lower.

COST SHARING CLASSIFICATION	PLAN DESIGN
LOW COST SHARING	Zero Deductible Plans, Silver 70 Plans, Silver 73 Plans, Silver 87 Plans, Silver 94 Plans, Platinum Plans
MEDIUM COST SHARING	Low Deductible Plans, Gold Plans
HIGH COST SHARING	High Deductible Plans, Bronze Plans, Catastrophic Plans

Assumptions for Postmandate 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 (Keeler and Rolph, 1988).
- CHBRP did not model changes in utilization due to discount card programs or other programs where individuals use a self-pay, discounted cash price to purchase brand-name or specialty drugs without using their pharmacy benefit. It is possible that lower cost sharing would cause enrollees currently using discount card programs to shift their utilization to their insured pharmacy benefit.

Assumptions for Postmandate Cost

- CHBRP assumed no change to the postmandate unit cost paid by health plans or health insurers to pharmacies. That is, the allowable charges for prescription drugs prior to rebates applied is assumed to be unchanged. Similarly, the total available funds available from manufacturer rebates is assumed to be unchanged. Due to AB 933, an impacted enrollee would receive the benefit of 90% of these funds which would have otherwise been retained by the plan sponsor at baseline.
- The impact of point-of-sale rebates to reduce cost-sharing was assumed to directly increase plan sponsor responsibility by reducing the total rebate dollars received by the plan sponsor with an offset for the reduction in cost sharing.
- CHBRP assumed varying rebates for preferred brand, nonpreferred brand, and specialty medications and modeled each of these drug classifications separately to arrive at the blended unit costs weighted based on utilization.

Approach and Assumptions for Postmandate Cost Sharing

- The Milliman Prescription Drug Managed Care Rating Manual was used to determine the level of cost-sharing postmandate when point-of-sale rebates impact the applicable cost sharing.
- The industry has not yet determined the standard way of reflecting point-of-sale rebates. One approximation commonly used for modeling is the concept that the rebates would be applied as a flat percentage reduction. This is the modeling approach CHBRP has taken.
- At baseline, point-of-sale rebates were assumed to be as follows:

DRUG CLASSIFICATION	REBATES AS PERCENTAGE OFF ALLOWED RETAIL COST
PREFERRED GENERIC	0%
NON-PREFERRED GENERIC	0%
PREFERRED BRAND	40%
NON-PREFERRED BRAND	40%
SPECIALTY	20%
ACA-DEFINED PREVENTIVE DRUGS	0%

- Since AB 933 requires that 90% of the value of rebates be applied to reduce cost sharing, we have adjusted the values in the table above, by multiplying each value by a factor of 90%. For instance, 90% of 40% is 36%. Postmandate, point-of-sale rebates impacting allowed retail cost sharing were assumed to be as follows:

DRUG CLASSIFICATION	REBATES AS PERCENTAGE OFF ALLOWED RETAIL COST IMPACTING COST SHARING
PREFERRED GENERIC	0%
NON-PREFERRED GENERIC	0%
PREFERRED BRAND	36%
NON-PREFERRED BRAND	36%
SPECIALTY	18%
ACA-DEFINED PREVENTIVE DRUGS	0%

- The calculations performed on postmandate cost sharing isolated the impact of reduced unit costs on cost sharing; for instance, no induced utilization was modeled during this step of the analysis.
- The impact in cost sharing was determined to be the difference in aggregate cost sharing for each plan design and age-band after the application of the deductible and maximum out-of-pocket.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

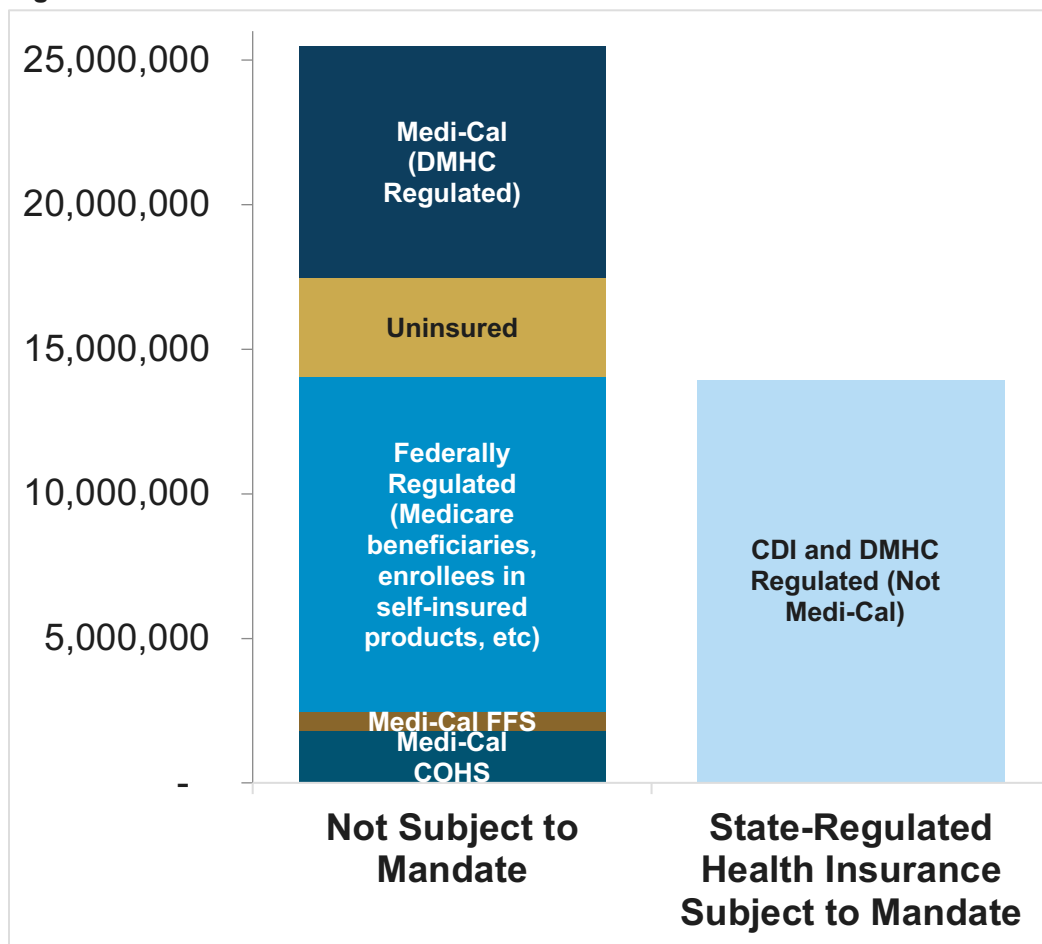
Baseline and Postmandate Benefit Coverage

Currently, there are 13,940,000 enrollees with health insurance that would be subject to AB 933. If enacted, the law would affect the health insurance of 100% of enrollees in DMHC-regulated plans and CDI-regulated policies that have an outpatient prescription drug benefit.

Over 93% of enrollees in commercial and CalPERS plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications. Approximately 3.1% do not have a pharmacy benefit and 3.6% have a pharmacy benefit that is not regulated by DMHC or CDI. Because AB 933 does not require creation of a pharmacy benefit — only compliant benefit coverage when a pharmacy benefit is present — baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is compliant.

CHBRP estimates that 836,000 enrollees use brand or specialty drugs and have plan designs which would have potentially impacted cost sharing under AB 933. However, the actual number of impacted enrollees will be lower as not all brand and specialty drugs may be eligible for manufacturer rebates. Details on manufacturer rebate programs are considered proprietary, including information on which drugs have manufacturer rebates and the amount of those rebates. As such, CHBRP is unable to directly estimate the number of impacted individuals who will see cost sharing reductions resulting from AB 933.

Figure A. Health Insurance in CA and AB 933



Source: California Health Benefits Review Program, 2021.

Baseline and Postmandate Utilization

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 (Table 1).

Baseline and Postmandate Per-Unit Cost

Baseline and postmandate costs for covered benefits were modeled using the Milliman Managed Care Rating Manual, as discussed in more detail below. 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 allow cost and \$675 net cost of brand drugs after rebates would still be paid by insurance carriers to retail pharmacies.

Baseline and Postmandate Expenditures

AB 933 would increase total net annual expenditures by \$129,725,000, or 0.10%, for enrollees with health insurance subject to state-level benefit mandates. This is due to a \$200,588,000 increase in total health insurance premiums and a \$70,833,000 decrease in enrollee share of cost for services.

Table 2 and Table 3 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Premiums

Changes in premiums as a result of AB 933 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 2, and Table 3), with health insurance that would be subject to AB 933.

Total premiums for private employers purchasing group health insurance would increase by \$108,955,000, or 0.20%. Total premiums for purchasers of individual market health insurance would increase by \$50,127,000, or 0.32%. The greatest change in premiums as a result of AB 933 is for the individual policies (0.53% increase) and small-group policies (0.48% increase) in the CDI-regulated market.

Among publicly funded plans, DMHC-regulated Medi-Cal Managed Care is not subject to AB 933. For CalPERS HMO enrollees, the impact on premiums is \$0 because these plans have copayments for prescription drugs and do not have pharmacy deductibles.

Enrollee Expenses

AB 933 related changes in cost-sharing for covered benefits (deductibles, coinsurance, copayments, etc.) would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 2, and Table 3) with health insurance that would be subject to AB 933 expected to use brand or specialty drugs during the year after enactment.

CHBRP also projects an increase in total enrollee cost sharing due to an increase in utilization.

Across various market segments, the reduction in cost sharing, on average, will be most pronounced in segments where current average cost sharing is highest. The largest reduction in enrollee cost sharing due to AB 933 would be for individual policies in the CDI-regulated market, with reductions of approximately \$1.09 per member per month, on average.

Average enrollee expenses per user

CHBRP projects that for potentially impacted members, on average, cost sharing per prescription would reduce from \$198 to \$175 or 12% (Table 1). These numbers reflect population averages over the course

of an entire year and will vary significantly for individual members. As a result of AB 933, the cost-sharing impact for each individual prescription would vary depending on the rebates available for the specific medication dispensed, the individual's unique cost sharing for covered benefits, the amount already applied to the deductible and maximum out-of-pocket for the individual. Therefore, an enrollee may experience a mandate impact significantly higher or lower than those included in Table 1.

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.

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.

At baseline CHBRP estimates that 836,000 enrollees utilize brand or specialty drugs and are in plans with cost sharing that may be impacted by AB 933. However, as noted above, the actual number of impacted enrollees will be lower as not all brand-name and specialty drugs may be eligible for manufacturer rebates and not all enrollees will use brand-name or specialty drugs each year.

Potential Cost Offsets or Savings in the First 12 Months After Enactment

For mandates analyzed by CHBRP, we often consider offsets or reductions in cost which may arise from a mandate. For instance, there is a body of research that suggests that greater compliance with medication adherence can reduce avoidable outcomes and complications. CHBRP anticipates that changes in compliance patterns would be modest with respect to AB 933, as members will still be subject to identical plan designs and cost sharing. For instance, the impact on enrollee behavior may be modest as enrollees will still experience their deductibles and coinsurance across all medical and pharmacy benefits covered, albeit at reduced allowable retail costs subject to cost sharing. In the long run, we may anticipate some modest reduction in medical expenditure driven by improved medication adherence. CHBRP is unable to quantify this reduction given the range of chronic conditions impacted by AB 933.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Due to the existence of pharmacy software that allows for point-of-sale variation in prices, cost-sharing amounts, benefit coverage, and formulary information, it is clearly possible for pharmacy software to be updated to calculate new cost-sharing amounts and net allowed retail costs after rebates to allow for compliance with AB 933. Administrative costs will be incurred by insurance carriers, pharmacy benefit managers, manufacturers, and pharmacies to implement or update systems to deliver at least 90% of point-of-sale net allowed cost sharing discounts to consumers. In addition, the reconciliation process used to calculate the value of any additional cost sharing owed to consumers will likely be an administrative expense for insurance carriers or their contracted pharmacy benefit managers.

Changes in Public Program Enrollment

AB 933 would not apply to Medi-Cal, and AB 933 would not impact CalPERS HMO Plans (due to plan design). Thus, CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 933.

Table 2. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to AB 933	8,405,000	2,086,000	1,989,000	889,000	0	0	384,000	43,000	144,000	13,940,000
Premium Costs										
Average portion of premium paid by employer	\$426.28	\$374.49	\$0.00	\$540.40	\$226.61	\$478.87	\$530.80	\$421.81	\$0.00	\$84,948,349,000
Average portion of premium paid by enrollee	\$141.02	\$180.89	\$624.47	\$96.86	\$0.00	\$0.00	\$186.55	\$212.07	\$545.57	\$36,600,954,000
Total Premium	\$567.30	\$555.38	\$624.47	\$637.27	\$226.61	\$478.87	\$717.35	\$633.88	\$545.57	\$121,549,303,000
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	\$43.61	\$121.70	\$173.51	\$50.75	\$0.00	\$0.00	\$134.75	\$197.13	\$184.11	\$13,168,032,000
Expenses for noncovered benefits (e)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Total Expenditures	\$610.91	\$677.07	\$797.97	\$688.02	\$226.61	\$478.87	\$852.10	\$831.01	\$729.68	\$134,717,335,000

Source: California Health Benefits Review Program, 2022.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state’s health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 3. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to AB 933	8,405,000	2,086,000	1,989,000	889,000	0	0	384,000	43,000	144,000	13,940,000
Premium Costs										
Average portion of premium paid by employer	\$0.6428	\$1.3247	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$2.1509	\$2.0376	\$0.0000	\$108,955,000
Average portion of premium paid by enrollee	\$0.2126	\$0.6399	\$1.8890	\$0.0000	\$0.0000	\$0.0000	\$0.7559	\$1.0244	\$2.9167	\$91,603,000
Total Premium	\$0.8554	\$1.9646	\$1.8890	\$0.0000	\$0.0000	\$0.0000	\$2.9068	\$3.0620	\$2.9167	\$200,559,000
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	-\$0.3038	-\$0.6489	-\$0.6914	\$0.0000	\$0.0000	\$0.0000	-\$1.0843	-\$1.0781	-\$1.0928	-\$70,832,000
Expenses for noncovered benefits (e)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Total Expenditures	\$0.5516	\$1.3157	\$1.1975	\$0.0000	\$0.0000	\$0.0000	\$1.8225	\$1.9839	\$1.8239	\$129,726,000
Postmandate Percent Change										
Percent change insured premiums	0.1508%	0.3537%	0.3025%	0.0000%	0.0000%	0.0000%	0.4052%	0.4831%	0.5346%	0.1650%
Percent Change total expenditures	0.0903%	0.1943%	0.1501%	0.0000%	0.0000%	0.0000%	0.2139%	0.2387%	0.2500%	0.0963%

Source: California Health Benefits Review Program, 2022.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Other Considerations for Policymakers

Considerations for Federal Actuarial Value Calculation Requirements

Under the ACA, annual actuarial value (AV) calculations are a means of ensuring consistent and comparable plan designs. The goal of the calculations is to standardize plan designs into “metal levels” which describe the benefit richness. The AV calculator is used, for instance, to classify “gold” plans. Every plan sold through Covered CA must fall into one of the metal levels.

Under the ACA, annual AV calculations are a means of ensuring consistent and comparable plan designs. For example, the AV calculator is used to classify “gold” plans. The calculation of the federal AV for the individual and small group markets has a nationwide scope and is not calibrated to each state to reflect state-specific spending levels. In the short term, changes to the average cost for brand and specialty drugs in California will not have an impact on the AV. Even in the medium term, changes to spending in California are unlikely to have a material impact on the federal AV. This is due to a lag in the claims experience used in the AV calculator. For example, the 2021 AV calculator used 2017 claims data.

Medical Loss Ratio Requirements and AB 933

The plan sponsor is required to payout a minimum level of benefits as a percentage of premiums as required by Medical Loss Ratio (MLR) requirements. Under the ACA, MLR requirements ensure that policyholders, in aggregate, receive value for the premiums as the plan sponsor is required to payout a minimum level of benefits as a percentage of premiums. Effective for the 2021 plan year, CMS changed the MLR formula to capture rebates as an offset to claims expenses in the MLR formula (CMS, 2021). Because of this recent change, the proposed bill should not have any impact on MLRs (Keith, 2021).

MLR is the percentage of premium dollars that a plan spends on paid claims and quality improvement activities less rebates received by the plan sponsor. AB 933 would cause a reduction in the rebate received by the plan sponsor and an increase in corresponding premiums, providing an offset which would result in a substantially similar MLR postmandate.

Other Cost Considerations with Respect to AB 933

For mandates analyzed by CHBRP with cost-sharing impacts, the typical approach is to assume an increase in premiums to offset reduced cost sharing, which is the approach CHBRP has taken with AB 933. Given the uncertainty of implementation of AB 933, CHBRP recognizes that plan sponsors may consider several approaches:

- Plan sponsors may increase cost sharing for other benefits to offset the impact of AB 933.
- Plan sponsors may offer modified plan designs, for instance copayment plans with \$0 deductibles which would have no change in prescription drug cost sharing under AB 933.

Second Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 933 would have a substantially different impact on utilization of either the brand or specialty drugs for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP consulted content experts about the possibility of varied second year impacts and determined the second year’s impacts of SB 933 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures may occur due to population changes between the first year postmandate and the second year postmandate.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of AB 933, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

Due to lower out-of-pocket cost sharing faced by consumers when filling prescriptions, a portion of the population in plans subject to reduced cost sharing due to rebates may be more likely to fill their prescriptions and take prescribed drugs. The enrollees most likely to benefit from AB 933 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, AB 933 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 in the long-term, 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.

Cost Impacts

It is unclear how manufacturers, insurance companies, and pharmacy benefit managers may respond to AB 933 in the long-term. Because AB 933 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 AB 933 to renegotiate how rebates are passed through or used to compensate pharmacy benefit managers in future contracts.

APPENDIX A TEXT OF BILL ANALYZED

On November 1, 2021, the California Assembly Committee on Health requested that CHBRP analyze AB 933.

ASSEMBLY BILL

NO. 933

**Introduced by Assembly Member Daly
(Coauthors: Assembly Members Carrillo, Gipson, Medina, O'Donnell, and Rodriguez)
(Coauthor: Senator Wiener)**

February 17, 2021

An act to add Section 1367.52 to the Health and Safety Code, and to add Section 10123.66 to the Insurance Code, relating to prescription drugs.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, as introduced, Daly. Prescription drug cost sharing.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price.

This 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 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would prohibit a health care service plan, health insurer, or a plan's or insurer's agents from publishing or otherwise revealing information regarding the actual amount of rebates the health care service plan or health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.52 is added to the Health and Safety Code, to read:

1367.52. (a) An enrollee's defined cost sharing for each prescription drug shall 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.

(b) This section does not prohibit a health care service plan from decreasing an enrollee's defined cost sharing by an amount greater than that required pursuant to subdivision (a).

(c) To comply with this section, a health care service plan or its agents shall not publish or otherwise reveal information regarding the actual amount of rebates the health care service plan receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. That information is protected as a trade secret, is not a public record as defined in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and shall not be disclosed directly or indirectly. A health care service plan shall impose the confidentiality protections of this section on a vendor or downstream third party that performs health care or administrative services on behalf of the health care service plan and that may receive or have access to rebate information.

(d) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties to the full extent permissible under this chapter if the director determines that a health care service plan has violated this section.

(e) This section shall not be interpreted or implemented in a manner inconsistent with federal law. The provisions of this section are severable. If a provision of this section or its application is held invalid or incapable of being enforced against a health care service plan due to a conflict with federal requirements, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(f) For purposes of this section:

(1) "Defined cost sharing" means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health care service plan contract.

(2) "Health care service plan" shall have the meaning set forth in Section 1345 and includes a specialized health care service plan.

(3) “Price protection rebate” means a negotiated price concession that accrues directly or indirectly to a health care service plan, or other party on behalf of the health care service plan, in the event of an increase in the wholesale acquisition cost of a drug above a specified threshold.

(4) “Rebate” means both of the following:

(A) Negotiated price concessions, including base price concessions, whether or not described as a “rebate,” and reasonable 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 care service plan during the coverage year.

(B) Reasonable 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 care service plan and serve to reduce the health care service plan’s liabilities for a prescription drug.

SEC. 2. Section 10123.66 is added to the Insurance Code, to read:

10123.66. (a) An insured’s defined cost sharing for each prescription drug shall 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.

(b) This section does not prohibit a health insurer from decreasing an insured’s defined cost sharing by an amount greater than that required pursuant to subdivision (a).

(c) To comply with this section, a health insurer or its agents shall not publish or otherwise reveal information regarding the actual amount of rebates the health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. That information is protected as a trade secret, is not a public record as defined in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and shall not be disclosed directly or indirectly. A health insurer shall impose the confidentiality protections of this section on a vendor or downstream third party that performs health care or administrative services on behalf of the health insurer and that may receive or have access to rebate information.

(d) The commissioner may, after appropriate notice and opportunity for hearing in accordance with Section 704, by order, suspend an insurer’s certificate of authority if the commissioner determines that a health insurer has violated this section. Section 704.7 shall apply to a proceeding conducted pursuant to this section.

(e) This section shall not be interpreted or implemented in a manner inconsistent with federal law. The provisions of this section are severable. If a provision of this section or its application is held invalid or incapable of being enforced against a health insurer due to a conflict with federal

requirements, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(f) For purposes of this section:

(1) “Defined cost sharing” means a deductible payment or coinsurance amount imposed on an insured for a covered prescription drug under the insured’s health insurance policy.

(2) “Health insurer” includes any health insurer holding a certificate of authority pursuant to Article 3 (commencing with Section 699) of Chapter 1 of Part 2 of Division 1.

(3) “Price protection rebate” means a negotiated price concession that accrues directly or indirectly to a health insurer, or other party on behalf of the health insurer, in the event of an increase in the wholesale acquisition cost of a drug above a specified threshold.

(4) “Rebate” means both of the following:

(A) Negotiated price concessions, including base price concessions, whether or not described as a “rebate,” and reasonable 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 insurer during the coverage year.

(B) Reasonable 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 insurer and serve to reduce the health insurer’s liabilities for a prescription drug.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.²⁵ Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.²⁶

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Illustrative Example of AB 933 on Cost Sharing

Table 4 provides an illustration of how AB 933 might affect cost sharing for a \$1,000 brand drug with \$300 rebates and 20% coinsurance. The purpose of this table is to show that there is no change in what is paid to the pharmacy. Rather, the change is to shift a portion of the cost from the consumer to the health plan.

Table 4: Illustrative Example of AB 933 Impact on Cost Sharing

	Baseline	Postmandate	Increase/ Decrease
Illustrative Assumptions for a Brand Drug			
Retail Allowed Cost (A)	\$1,000	\$1,000	\$0
Rebates (B)	\$300	\$300	\$0
Enrollee Coinsurance (C)	20%	20%	0%
AB 933 Assumptions			
Percentage of Rebates Impacting Cost Sharing (D)	0%	90%	90%
Calculations			
Retail Allowed Cost Subject to Cost Sharing (E) = (A) - (B) x (D)	\$1,000	\$730	-\$270
Summary			
Enrollee Cost sharing (F) = (E) x (C)	\$200	\$146	-\$54
Plan responsibility to Retail Pharmacy (A) - (F)	\$800	\$854	\$54
Plan responsibility after Rebates	\$500	\$554	\$54

Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

²⁵ CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

²⁶ See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2023 Cost Analyses: Data Sources, Caveats, and Assumptions*.

Second Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 933 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second year impacts and determined the second year's impacts of AB 933 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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