Key Findings

Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing

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

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

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 Impacts[1]: 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.

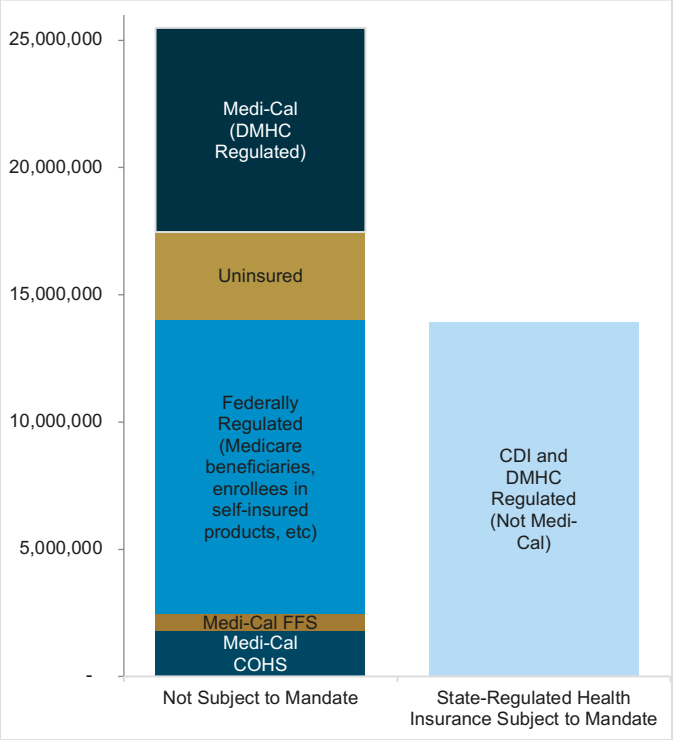
BILL SUMMARY

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.

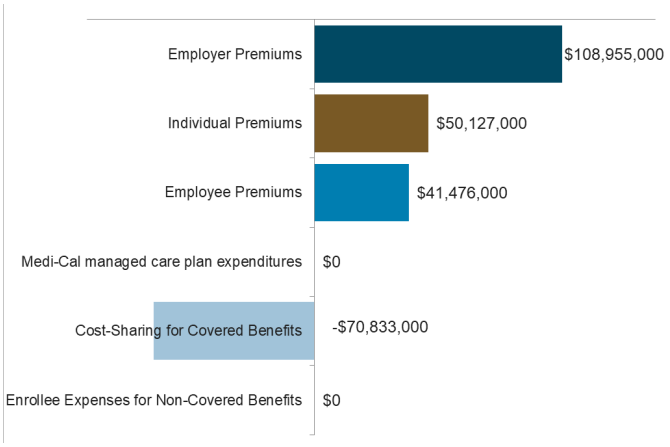
Utilization

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%.