CALIFORNIA ACCESS COALITION
ADVOCATING FOR ACCESS TO BEHAVIORAL HEALTH TREATMENT

AB 933: Prescription Drug Affordability

Frequently Asked Questions

Q: What is the current rebate system?

Health care insurers and pharmacy middlemen, also known as Pharmacy Benefit Managers (PBMs), utilize the prescription drug rebate system to lower the price they pay drug manufacturers for medications.

PBMs are hired by insurance companies to negotiate rebates and create a health plan's list of approved medications for their patients, known as a drug formulary. PBMs then negotiate drug manufacturer rebates by agreeing to place the manufacturers' medications on health plan drug formularies in exchange for a lower purchase price.

The average amount of these drug rebates is 40% off the list price of the medication. For example, if the list price of a drug is $100, a PBM may negotiate a rebate of $40 on the medication. The PBM and their insurer client then only pay $60 for the medication.

Q: How does this rebate system help patients?

It does not. The current rebate system only benefits pharmacy middlemen and health insurance plans, and does nothing to lower the price patients pay for medications at the pharmacy counter. In fact, patients often end up paying more for the prescription than the PBM and insurer paid for it.

Studies have shown that patients facing high costs are less likely to take medicines as prescribed, more likely to abandon therapy, and more likely to delay or forgo treatment, putting them at higher risk for expensive emergency room visits, avoidable hospitalizations, and poorer health outcomes.

Q: Why don't patients benefit from the rebate system?

Instead of giving the rebates back to patients, the PBMs keep part of the rebates and give the rest to their insurance company client.

To make matters worse, patients who have not met their deductible (in 2018, 2 million Californians were enrolled in state regulated high-deductible plans) and have to pay out-of-pocket at the pharmacy counter are often forced to pay the full list price of the medication – not the rebated price. So, the PBMs and insurers only pay $60 for a prescription, but the patient pays $100.

Patients with co-insurance and copays are also negatively affected. With co-insurance – where, for example, the insurer covers 80% for patient care and the patient pays 20% – patients are required to pay 20% of the ***list price*** of the drug rather than the ***discounted price***. And, for those with copays, they pay a fixed amount for each prescription.

It's important to note that in other areas, such as care at an in-network hospital or a physician's office, patients ***do*** benefit from negotiated rates. And, a decade ago, out-of-pocket spending for prescriptions consisted almost entirely of copays, but the use of deductibles and coinsurance has increased rapidly in recent years. Between 2012 and 2016 alone, the share of commercial health plans requiring patients to meet a deductible for prescription medicines increased from 23% to 49%.

For more information, contact Le Ondra Clark Harvey, Ph.D,
California Access Coalition – lclarkharvey@cccbha.org

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Q: How much money is involved in the current rebate system?

In 2019 alone, PBMs in the U.S. negotiated $89.5 billion dollars in rebates overall – with not a dime of that money going to offset the high cost of medications for patients at the pharmacy counter.

In California, a report from the Department of Managed Healthcare showed that health plans in the state received over $1.2 billion in rebates from manufacturers in 2019, up 27% from 2017. That is $1.2 billion that could and *should* go to patients but is not.

That same report found that prescription drugs only accounted for 12.8% of total health plan premiums in 2019, while the amount of California premium dollar that went to health plan profits increased 27.5%.

Q: Do health insurers use their rebate money to help patients in any way?

Because there is no transparency in the current rebate system, patients have no idea how much, if any, rebate money goes to lowering insurance premiums.

Health insurance companies have claimed that sharing rebates with patients would require them to increase the price of premiums, but a 2019 Milliman study titled "Can Voluntary POS Rebates Work for Medicare Part D?" found that even if health insurance companies were required to share *all* the negotiated rebates with patients, premiums would increase at most 1%, while patients could save up to $800 each year on their medication costs.

Q: How can the rebate system be reformed to benefit patients?

Assembly Bill 933 authored by Assemblymember Tom Daly (D-Anaheim) requires that insurance companies pass on at least 90% of rebates to patients. This bill should be approved immediately by the Legislature and signed by Governor Newsom to help ensure *all* patients can afford their medications, especially now as Californians are continuing to experience economic hardships due to the COVID-19 pandemic.

Q: Opposition claims that this bill will create winners vs. losers by helping some patients with out-of-pocket Rx costs but will raise premiums for all and will eliminate a tool/cost savings used to keep premiums low. Is this true?

This bill certainly will create winners – the patients.

Health insurance plans and their middleman will argue this bill is just cost-shifting and ends up taking away a tool to lower premium costs. They also may argue that the health care industry in general is going through too many changes right now because of COVID-19 (i.e. waiving copays and coinsurance for COVID-related issues, boosting telehealth, etc.) Health insurance has always been a dynamic marketplace, and health insurers are making substantial profits, and many are sitting on billions of dollars of reserves.

With this legislation, the average diabetic patient will experience an average of a $630 decrease in out-of-pocket costs per plan year. The sickest patients in the healthcare system drive expenditures so decreasing out-of-pocket costs and increasing adherence for those patients will benefit the system as

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a whole. This bill will provide immediate relief for Californians by lowering the costs they pay for the medicines they need. In virtually every other scenario, consumers receive the rebate. Take buying a toaster for example. Once purchased, a consumer receives a rebate in the mail from the company. Why isn't this the case for prescriptions? Rather than health plans providing patients with rebates or lowering health care costs, they take the savings to line their own pockets.

Q: What happens if rebate amounts change after a health plan or PBM purchases the drug from the manufacturer?

The convoluted prescription drug rebate system lacks structure and transparency. Currently, rebates are often triggered annually, meaning they don't happen at the point of sale. Therefore, health plans claim it would be too hard to calculate at the pharmacy counter.

While this is true with certain types of rebates, we took this into account when drafting the bill language. You will note that the definition of rebate allows for reasonable estimates of negotiated price concessions, price protection rebates, and performance-based price concessions. Ultimately, the legislation does not contemplate health plans providing "sure up" payments to consumers where the estimated rebate amount was ultimately higher than predicted.

Plans and PBMs saying they can't do this is false. Some national PBMs have even started incorporating this process as of late to provide better care to patients, meaning health plans in California have the ability to change their process, they just don't want to take the time.

Starting in 2019, OptumRx began sharing discounts as part of a broader effort to improve and simplify pharmacy benefits by delivering lower out-of-pocket costs directly to members and helping make prescriptions more affordable at the pharmacy counter.

Express Scripts has a program called SmartShare Rx that allows for rebates to be shared at the pharmacy counter. In their own report, Express Scripts says:

> *"This estimated rebate value reduces the patient's out-of-pocket cost at the point of sale, further alleviating their exposure to high costs in the deductible phase."*

The reason Express Scripts started offering the plan? According to them:

> *"To keep the benefit more affordable, plans are shifting to plan designs, such as high-deductible plans, that increase cost sharing for members. Unfortunately, this confluence of factors has had an unintended consequence for some patients, who may find themselves paying more at the pharmacy counter. As a result, some patients are abandoning prescriptions or skipping doses, neither of which is a positive outcome for the patient or the plan."*