Pharmacy Benefits

HEALTH CARE NUTS AND BOLTS with CHBRP

PHARMACY VS. MEDICAL BENEFITS

When a patient receives a prescription, the claim is filed under one of two benefits. Which applies depends on how and where the drug is administered — **and it determines what patients pay**.[1]

PHARMACY BENEFIT: Covers **self-administered** drugs (oral pills, patches, inhalers) and those given by a pharmacist (e.g., vaccines).

Dispensed by a retail, mail-order, or specialty pharmacy and processed by a pharmacy benefit manager (PBM) using National Drug Codes (NDCs).

MEDICAL BENEFIT: Covers drugs administered **under physician or clinician supervision** given in a doctor's office, hospital, or infusion center (e.g., infusions, chemotherapy).

Billed by the prescriber using medical procedure or Health Common Procedure Coding System (HCPCS) codes.

WHAT PHARMACY BENEFIT COSTS LOOK LIKE TO THE PATIENT

Patients may face **cost sharing** regardless of benefit type, but the amount differs by benefit and plan design. For **drugs billed through the pharmacy benefit,** California law[2] caps out-of-pocket costs by formulary tier.[3]

Tier placement is governed by California law.[4] Drugs administered billed through the medical benefit **are not subject to these limits**.

TIER	DRUG TYPES INCLUDED	PER-RX CAP (30-DAY)[5]	APPLIES TO
Tier 1	• Most generic drugs • Low-cost preferred brand-name drugs	$250 max	Most DMHC- and CDI regulated policies*
Tier 2	• Non-preferred generics • Preferred brand-name drugs	$250 max	Most DMHC- and CDI regulated policies*
Tier 3	• Non-preferred brand-name drugs • Drugs with a lower-cost therapeutic alternative	$250 max ($500 for bronze plans and HDHPs)	Most plans; bronze plans have a higher cap
Tier 4 (specialty/ highest cost)	• Biologics • Specialty pharmacy-only drugs • Drugs needing special training • Drugs costing plans over $600 per month	$250 max ($500 for bronze plans and HDHPs)	Most plans; HDHP enrollees must first meet an annual deductible

**Caps under HSC §1342.73 and INS §10123.1932 apply to non-grandfathered plans and policies regulated by the Department of Managed Health Care or the California Department of Insurance. Self-insured employer plans (governed by federal ERISA law), grandfathered health plans, and Medicare Part D plans are not subject to these limits. **Bronze plans in CoveredCA, California's state health insurance marketplace.*

IMPACT ON CALIFORNIA ENROLLEES

Cost-sharing caps cover millions of Californians, but for most, they're rarely met.

WHO'S COVERED

13.2 million Californians are enrolled in state-regulated health plans and policies subject to the cost-sharing cap.[6]

WHO RELIES ON THE CAP

Only ~3% (342,300 people) hit the $250 cap in a given year (as of 2018).[7]

WHY IT MATTERS

Enrollees taking **high-cost prescription drugs** (ones costing at least $1,250 per prescription) have average annual medical and prescription costs of **$42,700.**[7]

Enrollees **not taking high-cost prescription drugs** have average annual medical and prescription costs of **$3,700.**[8]

These costs are even more concentrated among **specialty drugs.**

SMALL SHARE, BIG COST

Specialty drugs make up just **1.8%** of prescriptions dispensed in California,[8] but **63%** of total drug spending, with an average of **$8,001** spent per prescription.[6]

A GROWING TREND

Health plan drug spending reached **$14.9 billion** in 2024 — up 72% since 2017 — and prescription drugs account for **15.4%** of total premiums.[8]

"BAGGING" MODELS

Health plans and insurers often route specialty drugs through the pharmacy benefit, rather than the traditional "buy-and-bill" medical benefit process, using distribution practices known as "bagging" models. This shift can change what the patient owes, since the two benefits often carry separate deductibles and cost-sharing rules.[9]

WHITE-BAGGING: A specialty pharmacy **ships the drug directly** to the provider's office, which stores and administers it; the pharmacy bills the drug to the pharmacy benefit while the provider bills for administration.

BROWN-BAGGING: The **patient picks up the drug** from a specialty pharmacy and brings it to the provider's office for administration, with billing likewise shifted to the pharmacy benefit.

CLEAR-BAGGING: A hospital or health system's **internal pharmacy dispenses** and delivers the patient's specialty drug directly to the provider for administration, rather than using an outside pharmacy.

Want to learn more? Check out our **pharmacy benefits** explainer!

1. National Association of Medication Access & Patient Advocacy. (2022). Medical vs. pharmacy benefit. 2. HSC §1342.73; INS §10123.1932 3. Health and Safety Code HSC §1342.73; California Insurance Code § 10123.1932. 4. California Department of Managed Health Care. (2025, December 16). Prescription Drug Cost Transparency Report for measurement year 2024. 5. HSC §1342.71; INS §10123.1932. 6. CHBRP. (2024). Abbreviated analysis of California Assembly Bill 2180 (as amended April 10, 2024). 7. California Health Benefits Review Program. (2018). Analysis of California Senate Bill 1021 (updated). 8. California Department of Managed Health Care. (2025, December 16). Prescription Drug Cost Transparency Report for measurement year 2024. 9. Pearson, C., Schapiro, L., & Pearson, S. D. (2023). White bagging, brown bagging and site of service policies.