Assembly Bill 874 (2023)

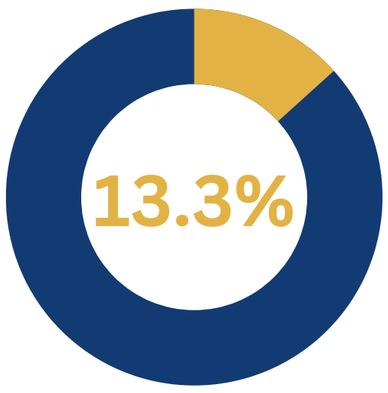
Analysis at a Glance

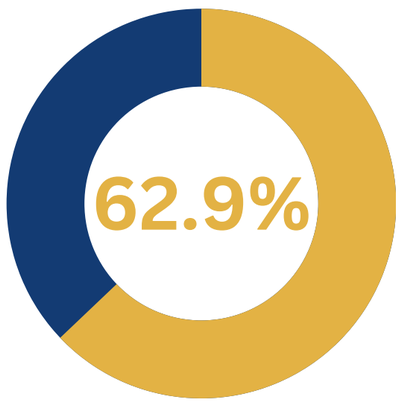
CHBRP

Out-of-pocket Expenses
as introduced on 2/14/2023

Background Context

In 2021, DMHC-regulated health plans in California paid approximately **$10.8 billion** for prescription drugs, accounting for **13.3%** of their total premiums.





Specialty drugs accounted for only **1.6%** of all prescription drugs dispensed yet accounted for **62.9%** of total annual spending on prescription drugs.

Bill Summary

The version of California **Assembly Bill (AB) 874** analyzed by CHBRP would require DMHC-regulated health plans, CDI-regulated health policies, other health coverage carriers, and PBMs that administer pharmacy benefits to take any amounts paid for an enrollee/insured's OOP expenses using a discount, repayment, product voucher, or other reduction and count them towards their health plan or policy's cost-sharing requirement.

In essence, AB 874 would impact pharmacy benefit designs regarding use of **copayment adjustment programs** and how payments made for prescription drugs using drug manufacturer coupons are accounted for.

Definitions

Copayment adjustment programs include:

- **Copayment accumulator programs**: prohibit any amounts collected at the point-of-sale when using drug manufacturer coupons from counting towards enrollee/insured's deductible or annual OOP maximum.
- **Copayment maximizer programs**: amounts collected at the point-of-sale when using drug manufacturer coupons for prescription drugs do not count towards enrollee/insured's deductible or annual OOP maximum. The cost share is adjusted to maximum value of the coupon and applied throughout the benefit year.

Drug manufacturer coupons: prescription discounts offered to patients by a drug manufacturer to reduce enrollee cost at point-of-sale. Drug manufacturer coupons may result in higher unit cost of drugs, and higher premiums as a way to offset the cost of the coupon.

California Health Benefits Review Program (**CHBRP**), California Department of Insurance (**CDI**), California Department of Managed Health Care (**DMHC**), Out-of-pocket (**OOP**), Pharmacy Benefit Manager (**PBM**)

Policy Context and Additional Background

Federal law restricts drug manufacturer coupon use in federal health programs, including Medicare and Medicaid.

California law prohibits drug manufacturer coupon use if a lower-cost, therapeutically equivalent generic is available.

Drug discounts from patient assistance programs (e.g. from independent charities) and cash card programs (e.g. GoodRx, ScriptSave WellRx) operate outside of insurance coverage and **are not applicable** to AB 874.

Federal law allows **copayment adjustment programs** to be regulated (or prohibited) by states; 16 states and Puerto Rico have banned them.

Insurance Impacted by Mandate

AB 874 would impact **pharmacy benefit coverage** for the following types of insurance:

- ☑ CDI and DMHC Regulated (Commercial & CalPERS)
- ☒ Medi-Cal

Medication Impacted by Mandate

AB 874 would impact **copayment adjustment programs**, which are typically only used for the following:

- ☑ Specialty drugs
- ☒ Generic drugs
- ☒ Brand name drugs

Utilization and Cost

284,000

estimated **number of prescriptions** filled that would be impacted by AB 874

$6,339

Average **unit cost** of impacted prescriptions filled (at baseline and postmandate)

Average amount of drug manufacturer coupons applied to prescriptions would decrease from **$1,772** at baseline to **$863** postmandate due to increased likelihood enrollees hit OOP maximum earlier and would not use coupons

Benefit Coverage and Expenditures

At baseline, approximately **6 million** enrollees have health insurance where drug manufacturer **coupons do not apply** to their deductible or OOP maximum. Postmandate, enrollee expenses for prescription drugs paid for with drug manufacturer coupons would **count toward their deductible** and OOP maximum.

AB 874 would increase total net annual expenditures by **$177,593,000** or **0.12%** for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase in health insurance premiums (**$213,312,000**) for newly covered benefits, adjusted by a decrease in enrollee expenses for covered and/or noncovered benefits (**$35,719,000**).

Additional details are in the full analysis at www.chbrp.org. Questions? Email CHBRP at info@chbrp.org.