



Abbreviated Analysis

California Assembly Bill 874: Out-of-pocket Expenses

Report to the 2023–2024
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)¹ conduct an evidence-based assessment of California Assembly Bill (AB) 874. AB 874 would require health plans regulated by the Department of Managed Health Care (DMHC), health policies regulated by the California Department of Insurance (CDI), other health coverage carriers, and pharmacy benefit managers (PBMs) that administer pharmacy benefits to take any amounts paid for an enrollee/insured's out-of-pocket (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 the use of systems known as "copayment adjustment programs." These programs maximize the dollar amount that a health plan or insurer can receive directly from a drug manufacturer from the use of a drug manufacturer coupon, by prohibiting any amount paid with the coupon from counting toward an enrollee's cost sharing responsibility. AB 874 would instead require health plans and insurers to credit the full value of the discounted out-of-pocket payments that are borne by the insurance company toward the enrollee's cost-sharing responsibility.

Background

In 2021, DMHC-regulated health plans in California, including those regulating plans for Medi-Cal beneficiaries, paid approximately \$10.8 billion for prescription drugs, accounting for 13.3% of total DMHC-regulated health plan premiums. During the same year, prescription drug costs increased by 6.6%, as medical expenses increased by 9.2%. Specialty drugs (which typically include high-cost brand name drugs delivered by specialty pharmacies) accounted for only 1.6% of all prescription drugs dispensed yet accounted for 62.9% of total annual spending on prescription drugs.

Pharmaceutical manufacturers, state programs, nonprofit organizations, and digital companies have established the following strategies and programs to reduce some of the high costs patients face when purchasing prescription drugs:

- **Drug manufacturer coupon:** prescription discounts offered to patients by a drug manufacturer to reduce enrollee cost at point-of-sale.
- **Patient assistance programs:** provide financial support for prescription drugs – particularly specialty drugs – to uninsured and underinsured populations. May be operated by pharmaceutical manufacturers, state governments, or independent charities.

- **Cash card programs:** prescription discounts offered typically by digital companies; not offered by a drug manufacturer.

Note that of these programs, only drug manufacturer coupons are applicable to AB 874, as patient assistance programs and cash programs typically operate outside of insurance coverage.

Drug manufacturer coupons were introduced, in part, in response to tougher negotiations with health plans and insurers, tighter drug formularies, price-elastic patient demand (i.e., there is a large change in demand due to change in price), and efforts to make consumers more sensitive to out-of-pocket costs within a therapeutic drug class. These coupons are used to promote sales of high-cost, later entrants of the same drug class, and compete against new entrants that share the same mechanisms of drug action. Although drug manufacturer coupons reduce the cost to the enrollee at the point-of-sale and lessen the impact of cost sharing – which is intended by health plans/insurers to limit utilization of drugs, especially those that are higher priced – they also run counter to health plan and insurers' attempts to require patients to directly share in and consider the increased costs of certain medications. As a result, drug manufacturer coupons may result in higher premiums.

To help offset the impact of drug manufacturer coupons – and to encourage use of lower cost

¹ Refer to CHBRP's full report for citations and references.

prescription drugs, help drive down drug prices, and reintroduce price sensitivity to those enrollees who use drug manufacturer coupons – pharmacy benefit managers (PBMs), which generally contract with health plans and insurers to manage their pharmacy benefit, may impose what are known as copayment adjustment programs. Copayment adjustment programs restrict the contributions made by the enrollee using a drug manufacturer coupon from counting towards the enrollee’s annual OOP maximum. There are two types of programs: copayment accumulator programs, and copayment maximizer programs.

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

It should be noted that copayment maximizer programs are, in standard practice, always combined with an accumulator program, and not implemented alone. Because of this, throughout this report, when CHBRP refers to maximizer programs, the reference is to a combined maximizer and accumulator program.

While copayment adjustment programs may result in lower premiums, they may also preserve the affordability challenges that enrollees originally faced in their plan design. Other unintended consequences may include increased nonadherence or discontinuation of therapies and confusion by enrollees due to insufficient transparency on implementation of the copayment adjustment programs.

PBMs rely on specialty pharmacies to handle pricing adjustments at point-of-sale to administer copayment adjustment programs. It is standard practice that for generic and brand drugs, coupon payments are accepted and treated as

member-funded dollars at baseline. Thus, CHBRP assumed that compliance with AB 874 will impact only specialty medications.

Relevant Populations

If enacted, AB 874 would apply to the health insurance of approximately 22.8 million enrollees (58.6% of all Californians). This represents all 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 DMHC or the CDI. If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, including DMHC-regulated Medi-Cal.

Medi-Cal beneficiaries, including those in DMHC-regulated plans, with full-scope coverage do not have cost sharing for their pharmacy benefit, therefore CHBRP estimates Medi-Cal beneficiaries will not be impacted by the bill. Furthermore, the pharmacy benefit for Medi-Cal beneficiaries in DMHC-regulated is “carved out” and administered by the Department of Health Care Services through a program called Medi-Cal Rx. Thus, although AB 874 applies to DMHC-regulated Medi-Cal plans, it would not impact them.

Benefit Coverage

At baseline, 35% of enrollees with state-regulated health insurance that would be subject to AB 874 have coverage that allows payments using drug manufacturer coupons to count toward deductibles and OOP maximums.

Postmandate, AB 874 would result in approximately 6.04 million enrollees gaining coverage for drug manufacturer coupons counting toward their deductibles and OOP maximum out of approximately 14.025 million enrollees with outpatient prescription drug benefits in commercial plans.

This represents a 75.64% increase from baseline. While AB 874 does apply to Medi-Cal, it would not have an impact due to the carveout of the pharmacy benefit.

Utilization and Expenditures

The number of specialty prescriptions filled that have drug manufacturer coupons (284,000) will not change due to AB 874. Similarly, the average unit cost of \$6,339 will not change from baseline to postmandate.

Additional utilization of other services would be covered by health plans or insurers due to enrollees reaching their OOP maximum earlier in the year.

Overall, 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 a \$213,312,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a \$35,719,000 decrease in enrollee expenses for covered and/or noncovered benefits.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 874.

Long-Term Impacts

There is an existing workaround that could be applied more broadly to avoid implementation/enforcement of AB 874. Currently, health plans and insurers remove specific high-cost specialty drugs that have

therapeutic equivalent drugs from their formulary. This happens frequently in self-insured plans, but the approach could be used in the fully-insured DMHC/CDI-regulated market if designed within the bounds of current state law. The insurer will still provide the drug through a specialty pharmacy based on medical necessity (which requires prior authorization). When a patient obtains the drug through that pharmacy, the accumulator or maximizer-related discounts will be applied to make their copayment zero dollars, but it will not be counted toward their deductible or out-of-pocket maximum because it is off-formulary and is not considered a covered benefit. The use of this approach could increase to avoid AB 874 oversight for drugs that can be provided off-formulary (they have a substitute in a class of medication, etc.).

It is also possible that PBMs, drug manufacturers, and health plans/insurers may make strategic changes related to benefit design and drug manufacturer coupons. In addition, relationships between businesses are constantly shifting. CHBRP is unable to predict such changes and therefore did not include them in this analysis, nor can predictions be made about related long-term impacts.

Essential Health Benefits and the Affordable Care Act

AB 874 does not appear to exceed the definition of essential health benefits, as all health plans and insurance carriers in California are already required to cover outpatient prescription drugs, and the reforms to counting OOP spending do not represent a new benefit.

BACKGROUND ON PRESCRIPTION DRUG COSTS AND COST CONTROL METHODS

AB 874 would require health plans regulated by the Department of Managed Health Care (DMHC), health policies regulated by the California Department of Insurance (CDI), other health coverage carriers, and pharmacy benefit managers (PBMs) that administer pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket (OOP) expenses toward the enrollee's or insured's overall contribution to any OOP maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's plan, policy, or other health care coverage.

In essence, AB 874 would impact pharmacy benefit designs regarding the use of systems known as "copayment adjustment programs." These programs maximize the dollar amount that a health plan or insurer can receive directly from a drug manufacturer from the use of a coupon, by prohibiting any amount paid with a coupon from counting toward an enrollee's cost sharing responsibility. AB 874 would instead require health plans and insurers to credit the full value of the discounted OOP payments that are borne by the insurance company toward the enrollee's cost sharing responsibility. See the *Policy Context* section for more details.

This background section provides an overview of pharmacy benefits in California, how PBMs manage pharmacy benefits, cost-sharing mechanisms, several existing programs used to help consumers contend with some of the high costs of prescription drugs, and copayment adjustment programs.

Pharmacy Benefits in California

Pharmacy benefits generally cover outpatient prescription drugs that are available at a retail, mail-order, or specialty pharmacies. Prescription drugs that are administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility) are typically covered through a medical benefit. For the purposes of analyzing AB 874 and its related impacts and implementation, drugs billed through the medical benefit, in CHBRP's interpretation of AB 874, are not addressed in this legislation.

Over half of Californians enrolled in plans regulated by the DMHC and policies regulated by the CDI have coverage for outpatient prescription drugs through a pharmacy benefit. In this arrangement, the health insurer may use an in-house PBM or

AB 874 Terminology

Drug manufacturer coupon: prescription discount offered by a drug manufacturer.

Patient assistance programs: provide financial support for prescription drugs – particularly specialty drugs – to uninsured and underinsured populations. May be operated by pharmaceutical manufacturers, state governments, or independent charities. Typically operate outside of insurance coverage.

Cash card programs: prescription discount offered typically by companies; not offered by a drug manufacturer. Typically operate outside of insurance coverage.

Copayment accumulator program: prohibit any amounts collected at the point-of-sale when using drug manufacturer coupons for a prescription drug from counting towards the enrollee/insured's deductible or annual OOP maximum.

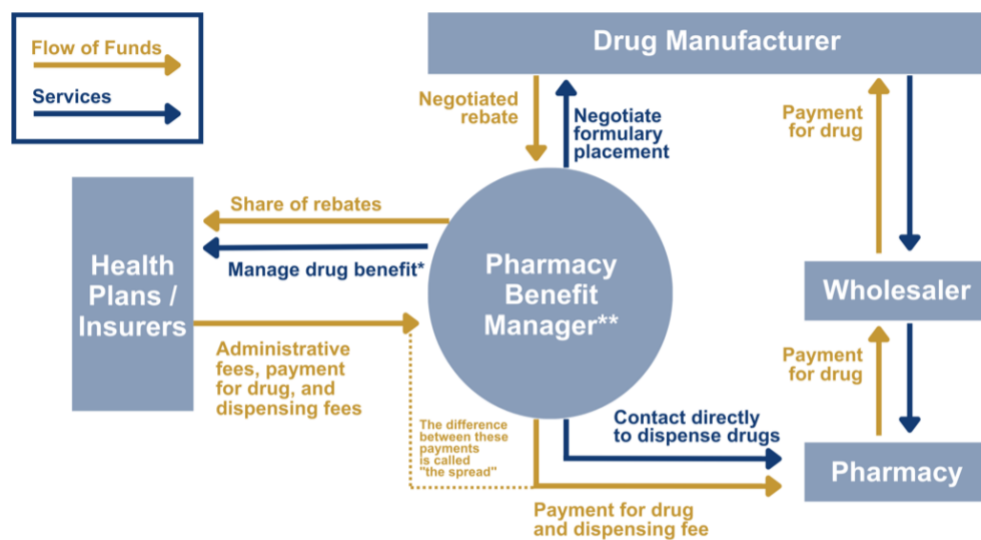
Copayment maximizer program: amounts collected at the point-of-sale when using drug manufacturer coupons for a prescription drug do not count towards the enrollee/insured's deductible or annual OOP maximum, however the maximum value of the manufacturer's coupon is realized throughout the benefit year. These are generally used in combination with accumulator programs. Throughout this report, references to maximizer programs are to combined copayment accumulator and maximizer programs.

subcontract with a PBM to manage the pharmacy benefit. PBMs manage the pharmacy benefits for over 90% of Americans with prescription drug coverage (Shepherd, 2020). Approximately 40.6% enrollees in state-regulated health insurance will access pharmacy benefits directly through a PBM, including Medi-Cal Rx, in 2024.² In this latter arrangement, PBM contracts are not subject to state health insurance benefit mandates, such as that proposed under AB 874.

Pharmacy Benefit Managers and Prescription Drug Benefit Administration

PBMs handle several aspects of prescription drug administration, including: pharmacy reimbursement; pharmacy benefit design; rebates; network development and maintenance; claims adjudication; member services; 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. Figure 1 provides an overview of the role of PBMs in the U.S. pharmacy distribution and reimbursement system.

Figure 1. The Role of Pharmacy Benefit Managers in U.S. Pharmacies



*Includes establishing formulary and patient adherence programs and implementing utilization management tools -- such as prior authorization, step therapy, and tiering - to steer patients toward certain drugs on formulary.

**Pharmacy Benefit Managers also handle network development, maintenance, claims, adjudication and member services.

Source: California Health Benefits Review Program (adapted from The Commonwealth Fund, 2019).

PBMs and Prescription Drug Pricing

PBMs play a significant role in prescription drug pricing. They may impose several cost control methods and strategies that are intended to affect, or target, pharmacies or pharmacists, drug manufacturers, prescribers, and/or patients. Competitiveness within the PBM industry limits disclosure of their methods and outcomes as they are often considered proprietary (Kreling, 2000). In general, PBMs obtain price discounts from manufacturers and pharmacies based on bulk purchasing of prescription drugs, and also engage in utilization review and cost-based coverage decisions to manage drug spending for payers (Kreling, 2000). An example of the latter is designing a pharmacy benefit that assigns higher copayments to brand name drugs to encourage the use of generics. They also develop exclusionary formularies and cost-sharing differentials to obtain higher rebates from manufacturers. Table 1 shows the range of cost control methods, strategies, and approaches used by PBMs, a brief definition of each method, and which parties they are intended to impact.

² See CHBRP's resource, *Estimates of Pharmacy Benefit Coverage in California*, available at: www.chbrp.org/other-publications/resources.

Table 1. Cost Control Methods Used by PBMs

Cost Control Method	Description	Party Intended to Impact
Negotiated price	Negotiation with pharmacy on pharmacy payments/reimbursement	Pharmacies
Generic substitution	Increased in dispensing fees for generic drugs, programs on maximum allowable cost, and/or dispensing rate incentives	Pharmacies
	Applying different copayments for generics vs. brand drugs	Patients
Rebates	Negotiation with manufacturers on their price concessions; charging fee/percent of rebate for administering rebates	Drug manufacturers
Cost sharing: copayments and coinsurance	Tiering generic vs. brand and formulary vs. nonformulary copayments; application of coinsurance to shift cost burden on patients	Patients
Restricted Formularies	Controlling which drugs are available on the formulary	Patients, prescribers, pharmacies, and drug manufacturers
Disease management programs		Patients, prescribers, and pharmacies
Mail service prescriptions	Incentivizing increased use of mail-order pharmacy, minimizing pharmacist-patient interactions, while increasing convenience and potentially decreasing costs for patient	Patients and pharmacies
Drug utilization management	Prior authorization, step therapy, and other protocols to ensure medical necessity for high-cost drugs; medication therapy management to optimize therapeutic outcomes through improved medication use	Patients, prescribers, and pharmacies

Source: California Health Benefits Review Program, 2023 (adapted from Kreling, 2000).

Key: PBM = pharmacy benefit manager.

Werble (2017) estimates that PBMs provide prescription drug coverage for 266 million Americans across the country. PBMs have consolidated significantly in recent years. Nationally, there are now three large PBMs – CVS, Express Scripts, and Optum – that account for 79% of prescription drug claim volume in 2020 (The Commonwealth Fund, 2022). In California, as of January 1, 2020, Kaiser Pharmacy and IngenioRx were the PBMs with the greatest market share, controlling 48% and 16%, respectively (Guardado, 2022).

Prescription Drug Spending

National Trends

In the United States, prescription drug prices are more than 2.5 times higher than those in similar high-income nations (Mulcahy et al., 2021). According to an issue brief from the U.S. Office of the Assistance Secretary for Planning and Evaluation, in 2021, \$603 billion was spent on prescription drugs across the U.S. health care system, before accounting for rebates; retail drugs accounted for approximately 70% (or approximately \$421 billion). Between 2016 and 2021, spending on retail prescription drugs increased 13%, however there was only a 5.7% increase in the number of retail prescriptions. Spending per prescription increased by an average of 7%, indicating that higher utilization was not the primary driver of retail drug spending (Parasrampur and Murphy, 2022). The number of prescriptions filled per person in 2019 at retail pharmacies averages 11.6 nationally, and 8.5 in California (KFF, 2019).

California

In 2021, DMHC-regulated health plans in California, including those regulating plans for Medi-Cal beneficiaries,³ paid approximately \$10.8 billion for prescription drugs, accounting for 13.3% of total DMHC-regulated health plan premiums. During the same year, prescription drug costs increased by 6.6%, as medical expenses increased by 9.2%. Specialty drugs (which typically include high-cost brand name drugs delivered by specialty pharmacies) accounted for only 1.6% of all prescription drugs dispensed yet accounted for 62.9% of total annual spending on prescription drugs. Generic drugs accounted for 88.2% of all prescribed drugs but only 16.3% of total annual spending. Brand name drugs accounted for 10.2% of prescriptions and constituted 20.8% of the total annual spending on prescription drugs (DMHC, 2022).

Cost Sharing

This section provides an overview of the cost-sharing structures used for health insurance benefits, including prescription drugs.

Cost Sharing

Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, deductibles, and OOP maximums (but do not include premium expenses⁴). Definitions of each are as follows:

- **Deductible:** The enrollee is responsible for paying the full cost of covered benefits subject to the deductible until the full value of the deductible is paid by the enrollee. The enrollee's payments towards the deductible accumulate over the course of the plan/policy year. For example, if an enrollee has a \$750 deductible, and uses four \$250 services that are subject to the deductible throughout the course of the year, the enrollee would pay for the first three services ($\$250 \times 3 = \750) in full. At that point, the deductible would be met and a different form of cost sharing such as a copayment or coinsurance may be applied to the fourth visit, depending on the plan/policy.
- **Copayment:** A copayment is a flat dollar amount paid by the enrollee per service for services subject to a copayment. Copayments may be applied on their own or to services subject to a

³ In 2021, the pharmacy benefit for Medi-Cal beneficiaries in DMHC-regulated plans was not yet carved out. California's Medi-Cal Rx program, which now handles the pharmacy benefit for all Medi-Cal beneficiaries, including those in DMHC-regulated plans, was not implemented until January 1, 2022.

⁴ Premiums are paid by most enrollees, regardless of their use any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through Covered California, or they receive benefits through Medi-Cal.

deductible after the deductible is met. Copayments are often higher for brand drugs, particularly when a lower-cost bioequivalent generic is available, to discourage their use.

- **Coinsurance:** Coinsurance is the percentage of the total cost of a service that will be paid by the enrollee. For example, on a \$250 service subject to a 10% coinsurance, the enrollee cost sharing would be \$25. Coinsurance may be applied on its own or to services subject to deductible after the deductible is met.
- **Out-of-pocket (OOP) maximum:** The annual OOP maximum is the maximum an enrollee will spend on cost sharing for covered services in the form of deductibles, copayments, and coinsurance during the plan/policy year.⁵ For plans and policies available through Covered California, OOP maximums for in-network essential health benefits are applicable. In 2023, the OOP maximum limit for self-only coverage is \$9,100 (CMS, 2022). If an enrollee has a high-cost hospital stay in the first month of their plan/policy year (whether or not that plan or policy includes a deductible) and reaches their OOP maximum, the enrollee will not have any other cost sharing for covered services for the remaining 11 months of the plan/policy year.

There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (Figure2). Some health insurance benefit designs incorporate higher enrollee cost sharing to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.⁶

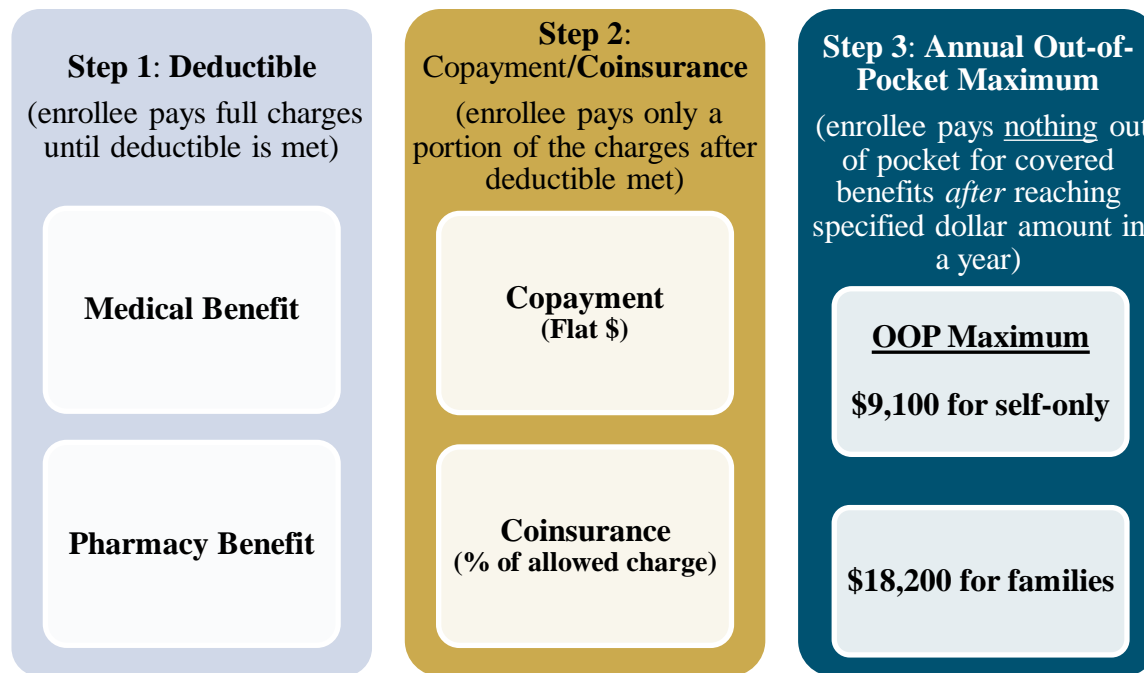
Annual out-of-pocket maximums for covered benefits limit annual enrollee cost sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits.

Under current law, some health plans and insurers may design their pharmacy benefit to not allow payments made in association with pharmaceutical drug discount cards or by pharmaceutical assistance programs from counting towards an enrollee's copayment, coinsurance, or OOP maximum. AB 874 would prohibit this practice from occurring, and instead mandate that all such payments would count towards the enrollee's cost-sharing responsibility.

⁵ This limit doesn't apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies – note on “table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2020” available at www.irs.gov/publications/p969.

⁶ Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percentage of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost-sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.

Figure 2. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2023; CMS, 2022.

Notes: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2).

The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2022).

Key: OOP = out-of-pocket.

High deductible health plans

Both DMHC-regulated plans and CDI-regulated policies may be designated high deductible health plans (HDHPs).⁷ HDHPs are a type of health plan with requirements set by federal regulation.⁸ As the name implies, these plans include a deductible – but they are not allowed to have separate medical and pharmacy deductibles. For the 2023 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least \$1,500 for an individual and \$3,000 for a family.⁹ Annual OOP expenses for coverage of in-network tests, treatments, and services, which would result from cost sharing¹⁰ applicable after the deductible is met, are not allowed to be more than \$7,500 for an individual and \$15,000 for a family.¹¹

⁷ For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*, available at https://chbrp.org/other_publications/index.php.

⁸ HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Available at www.healthcare.gov/glossary/high-deductible-health-plan/#:~:text=For%202019%2C%20the%20IRS%20defines,or%20%2413%2C500%20for%20a%20family. Accessed March 5, 2021.

⁹ IRS Revenue Procedure 2022-24, available at www.irs.gov/pub/irs-drop/rp-22-24.pdf.

¹⁰ Such as copays and coinsurance applicable to the covered test, treatment, or service.

¹¹ There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.

Allowed Cost Amounts for Medical Services

Insurers usually negotiate how much they will pay for the costs of covered health care services with health care providers and suppliers (Center on Budget and Policy Priorities, 2022). These negotiated amounts are known as the “allowed cost amount.” Health care providers, including hospitals and physicians, participating in a plan’s network agree to accept these payment amounts when an enrollee covered by the plan uses covered services. The cost-sharing charges the enrollee owes (for example, a 20% coinsurance rate) are based on this allowed cost amount. If an enrollee uses a service that is not covered or sees a provider that is not within the insurer’s network, the overall charge, including an enrollee’s cost sharing, could be higher than the allowed amount.

Drug Discounts: Drug Manufacturer Coupons, Cash Cards, and Patient Assistance Programs

Pharmaceutical manufacturers, state programs, nonprofit organizations, and online companies have established different strategies and programs to reduce some of the high costs patients face when purchasing prescription drugs.

Drug manufacturer coupons

Drug manufacturer coupons – also referred to as copayment cards, copayment coupons, and prescription drug discount cards – are offered by pharmaceutical manufacturers, which help reduce enrollee OOP costs, including copayments, coinsurance, and deductibles. Kang et al (2021) showed there is no difference in coupon offerings based on how high or low the mean patient copayment is. These coupons run counter to health plan and insurer attempts to require patients to directly share in and consider the increased costs of certain medications. As a result, overall medication expenses to health plans/insurers and patients may increase (Ramachandran et al, 2021).

Drug manufacturer coupons were introduced, in part, in response to tougher negotiations with health plans and insurers, tighter drug formularies, price-elastic patient demand (i.e., there is a large change in demand due to change in price), and efforts to make consumers more sensitive to out-of-pocket costs within a therapeutic drug class (Dafny et al, 2017; Kang et al, 2021). Coupons are used to promote sales of high-cost, later entrants of the same drug class, and compete against new entrants that share the same mechanisms of drug action (Kang et al, 2021).

There are no comprehensive public data on drug manufacturer coupon distribution and use (Kirchhoff, 2022). Drug manufacturers each make independent decisions on whether to offer a coupon and how patient eligibility is determined; patients can use coupons based on their availability (Kang et al, 2021). Retail pharmacy data from IQVIA shows that manufacturer coupons offset \$12 billion in consumer prescription drug spending in 2019, up from \$8 billion in 2013 (IQVIA, 2020). The majority of drug manufacturer coupons are for drugs that have lower-cost, and potentially therapeutically equivalent, alternatives (Ross and Kesselheim, 2013). On average, drugs with available coupons experience lower increases in the utilization of generic medications when direct generic substitutes are available than those without (Dafny et al, 2017). Coupons for branded drugs can increase sales of those drugs by over 60%, completely by reducing sales of bioequivalent generic alternatives (Dafny et al, 2017).

The proportion of prescriptions adjudicated with a drug manufacturer coupon nearly doubled between 2017 and 2021, increasing from 3.3% of all prescription adjudications to 5.4% (IQVIA, 2022). A study by Munigala et al. (2019) looked at a drug discount program over 8 years and found an approximate savings of \$18 per prescription, for a total of nearly \$200 million. The most common drug class for which discount cards were used were opiates (Munigala et al, 2019).

See Table 2 for an example of how an enrollee’s monthly prescription costs may be impacted using a drug manufacturer coupon. The federal government has restricted the use of drug manufacturer coupons

in federal health programs, including Medicare and Medicaid. See the *Policy Context* for more information.

Table 2. Example of Drug Manufacturer Coupon Use

Enrollee Cost Sharing for Single Prescribed Drug	Without Drug Manufacturer Coupon	With Drug Manufacturer Coupon
Monthly prescription cost	\$1,000	\$1,000
Enrollee coinsurance	25%	25%
Coupon value	N/A	Limits out-of-pocket cost of drug to \$100 for a 30-day supply
Monthly cost to enrollee	\$250	\$100
Amount of enrollee's monthly cost paid to pharmacy by drug manufacturer	N/A	\$150

Source: California Health Benefits Review Program, 2023.

Drug manufacturer coupons are typically processed electronically when a person fills a prescription at a pharmacy. When an enrollee presents a prescription for a covered pharmacy benefit, the pharmacist will send a claim to the PBM or health plan/insurer. The PBM or health plan/policy will then submit a claim to any secondary payers for the remaining cost of the drug, including manufacturers for the value of the coupon. Once all payments are processed, the enrollee covers the outstanding balance on the copayment, if any (Kirchhoff, 2022). Some discounts may be in the form of a manufacturer's rebate or discount after the point-of-sale, in which case, the enrollee is required to send proof-of-payment and the rebate offer to the manufacturer directly for reimbursement if the payer will accept the request (Kirchhoff, 2022).

Cash Card Programs

Several companies (e.g., GoodRx, ScriptSave WellRx, etc.) offer cash card programs that are not sponsored by drug manufacturers. These programs allow consumers to access lower-cost prescription drugs through a free "cash card" – sometimes known as prescription discount cards or prescription savings cards – or a mobile application from the company. Companies will partner with PBMs to negotiate price discounts from pharmacies based on bulk purchasing of prescription drugs and then consumers access the discounts through the card or mobile application at the pharmacy. Pharmacies then pay a fee for each time a consumer uses the company's card or mobile application in a prescription drug purchase. Importantly, these cash programs operate outside of health insurance benefits and do not alter the contracted price or consumer's share of cost from the health plan or carrier perspective but do provide an out-of-pocket spending discount at the point-of-service.

For prescription drug purchases made with cash cards, the claim is adjudicated through the company with the cash card; it is not also adjudicated through the health plan/insurer or PBM. Therefore, the use of the cash card is not tracked by the health plan or insurer and the PBM or health plan/insurer applies the total amount paid in cost sharing of the prescription towards the enrollee's out-of-pocket maximum, even if the enrollee did not pay the full price.

Patient Assistance Programs

Patient assistance programs (PAPs) provide financial support for prescription drugs – particularly specialty drugs – to uninsured and underinsured populations. They may be operated by pharmaceutical

manufacturers, state governments, or independent charities. California's only state PAP is the AIDS Drug Assistance Program (NCSL, 2022). Nongovernment PAPs are often established as 501(c)(3) nonprofit organizations and receive tax-deductible contributions and are exempt from federal income taxes (Kirchhoff, 2022). Some independent charity PAPs are supported, in part, by pharmaceutical manufacturers through donations for a condition treated by drugs they produce. Eligibility for PAPs varies between programs, however eligibility is generally based on annual income, insurance status, physician endorsement, prescription information, and proof of U.S. citizenship or legal residence (Kirchhoff, 2022).

Because the populations served by PAPs are underinsured or uninsured, PAPs generally operate outside of insurance coverage and pay for the full cost of the drug; none of the payments from the PAP are considered cost sharing made on behalf of the patient. Some PBM formularies cover drugs available through PAPs, however others opt to exclude them to access PAP funding. AB 874 would only impact payments that occur within the context of a patient's insurance coverage, therefore the bill would have no impact on PAPs, and amounts provided by PAPs would not be applied to patient cost-sharing requirements in a private health plan or health insurance program.

Copayment Adjustment Programs

To help offset the impact of drug manufacturer coupons – and to encourage use of lower cost prescription drugs, help drive down drug prices, and reintroduce price sensitivity for those enrollees who use drug manufacturer coupons – PBMs may impose what are known as copayment adjustment programs (Linehan, 2019). Copayment adjustment programs allow for the use of coupons to reduce cost sharing for a given prescription, but restrict the payments made by the enrollee using a drug manufacturer coupon from counting towards the enrollee's deductible and annual OOP maximum. As a result, these programs shift costs from the health plan/insurer to the enrollee and the drug manufacturer.

There are two types of programs: copayment accumulator programs, and copayment maximizer combination programs.

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

While these programs may result in lower premiums due to actual or projected savings in drug spending, they may also maintain the affordability challenges that enrollees originally faced in their plan design. (MHPC, 2020). Other unintended consequences may include increased nonadherence or discontinuation of therapies and confusion by enrollees due to insufficient transparency on implementation of the copayment adjustment programs (Fein, 2018).

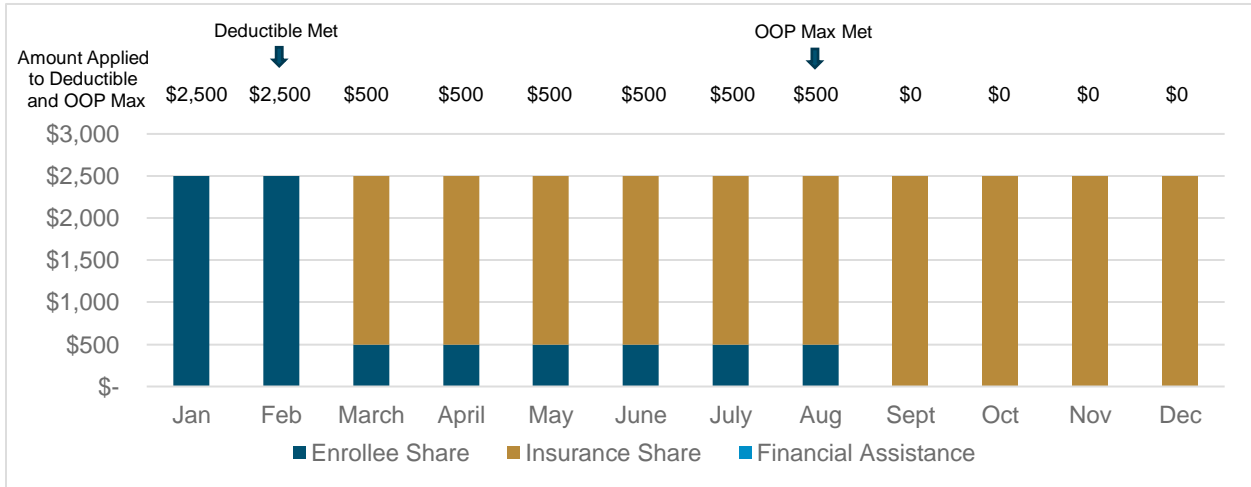
To better understand how copayment adjustments work, consider the following four examples demonstrating monthly copayments with no financial assistance, financial assistance via a drug manufacturer coupon (with no copayment adjustment programs), implementation of a copayment accumulator program, and implementation of a copayment maximizer program.

First consider the example of an enrollee with a 20% coinsurance, a deductible of \$5,000, and an annual OOP maximum of \$8,000. They are prescribed a drug costing \$2,500 a month¹² and do not participate in

¹² For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copayments and coinsurance is limited to \$250, or \$500 for enrollees in the "bronze plans" available from Covered California, the state's ACA

a PAP and do not use drug manufacturer coupons. Typically, an enrollee would pay the full \$2,500 until they met their deductible, after month 2. In the following months, the patient would be responsible for covering \$500 of the total, and their health plan or policy would contribute the remaining \$2,000, until they met their annual OOP maximum. The health plan or policy would then pay the full monthly cost of the drug for the remainder of the year (Figure 3).

Figure 3. Example of Monthly Copayments With No Financial Assistance

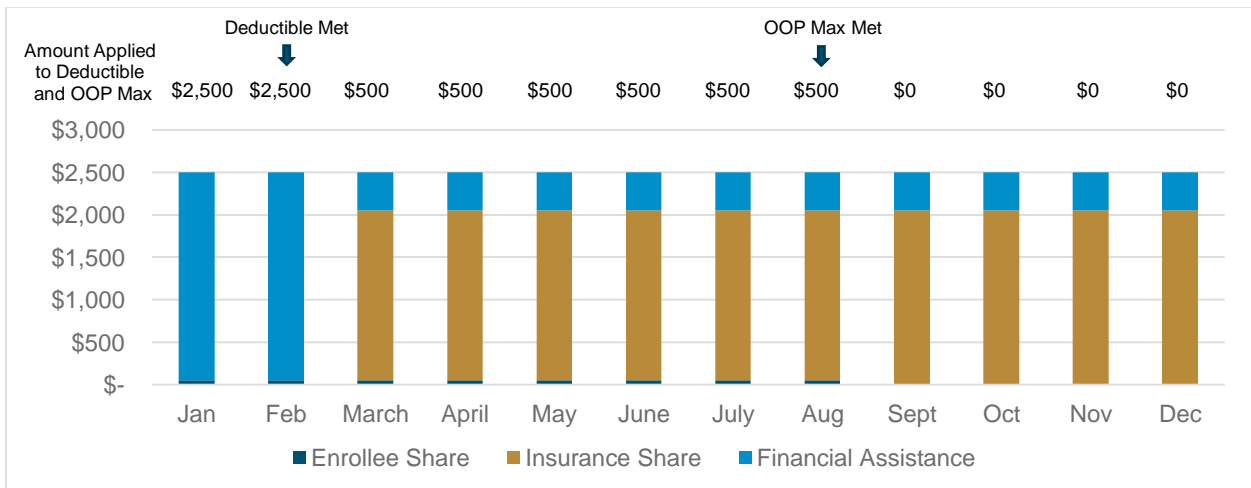


Source: California Health Benefits Review Program, 2023.

Key: OOP max = out-of-pocket maximum.

If the enrollee instead had a drug manufacturer coupon to assist with their coinsurance and limited their monthly OOP expense to \$50, and the contributions of both the enrollee and the drug manufacturer coupon counted towards the enrollee’s OOP maximum, the enrollee would still meet their deductible after month 2 and their OOP maximum a few months later. However, their monthly costs would be significantly reduced (Figure 4).

Figure 4. Example of Monthly Copayments With a Drug Manufacturer Coupon (No Copayment Adjustment Program)



Source: California Health Benefits Review Program, 2023.

Key: OOP max = out-of-pocket maximum.

marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible. The examples in this section are for illustrative purposes only.

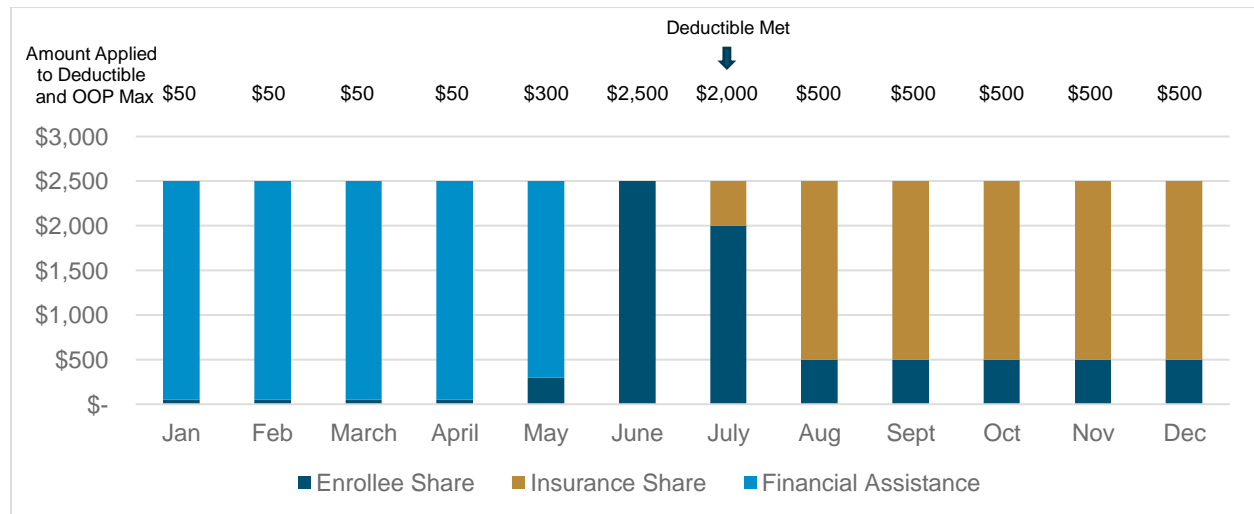
Copayment adjustment programs come in the form of either a copayment accumulator, or a copayment maximizer program. As mentioned previously, throughout this report, references to a copayment maximizer program are always in reference to a copayment maximizer program combined with a copayment accumulator program. The following sections use this example to provide explanations of how a simple accumulator and maximizer program would work.

Copayment Accumulator Programs

In copayment accumulator programs, any amounts collected at the point-of-sale when using drug manufacturer coupons do not count towards their deductible or annual OOP maximum. In 2021, 80% of commercially insured beneficiaries were enrolled in plans with copayment accumulators available in the plan design; 43% of covered lives were under plans or policies that had implemented copayment accumulator programs (Fein, 2022).

Using the same example as above, assume the enrollee is now eligible for a drug manufacturer coupon that provides \$12,000 a year with a required enrollee contribution of \$50 per fill. Under the copayment accumulator program, the enrollee would use the financial assistance very quickly at the beginning of the year and would initially only pay what was required by the drug manufacturer to obtain the financial assistance. Once the funding was exhausted, the enrollee would be responsible for contributing up to their annual deductible¹³ prior to their health plan or policy needing to pay any amount. After the deductible was met, although their health plan or policy would become responsible for some of the monthly cost, the enrollee would still be responsible for their 20% coinsurance, as they had not met the annual OOP maximum (Figure 5).

Figure 5. Example of Monthly Copayments Under a Copayment Accumulator Program



Source: California Health Benefits Review Program, 2023.

Key: OOP max = out-of-pocket maximum.

Copayment Maximizer Programs

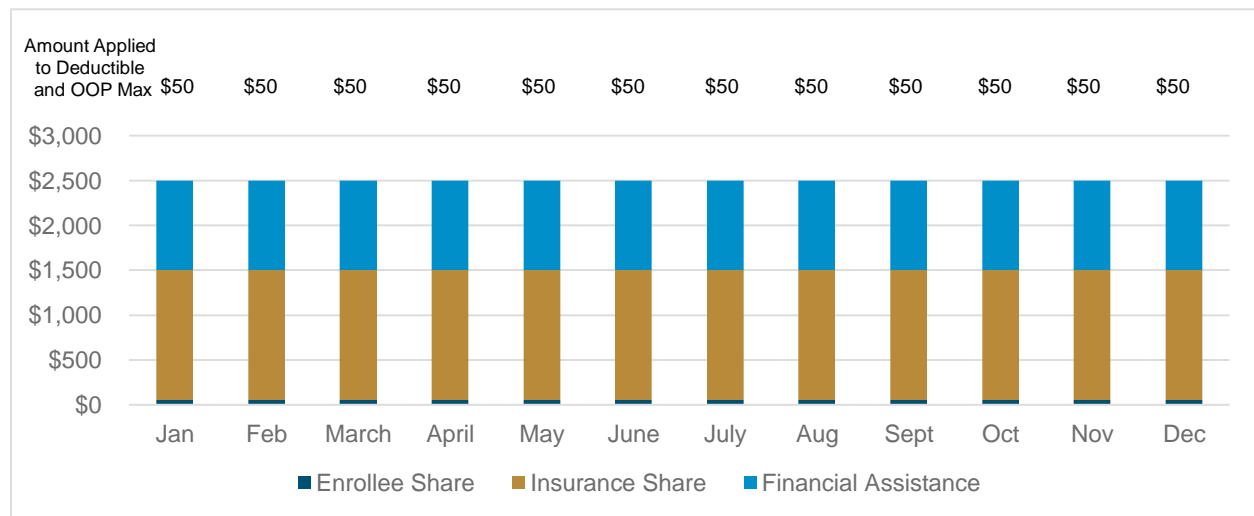
Copayment maximizer programs are designed to use the total amount of financial assistance provided to an enrollee for a specific drug. Under these programs, the enrollee’s typical monthly cost-sharing maximums are inflated to equal the total amount of financial assistance, plus any required copayment for such assistance, divided into a monthly amount. Copayment maximizer programs are generally

¹³ In this example, assume the enrollee has contributed \$0 towards their deductible from other medical or pharmacy expenses.

implemented in conjunction with a copayment accumulator program; therefore, the value of the financial assistance usually does not count toward the enrollee’s deductible or annual OOP maximum.¹⁴

Consider, once again, the example from above where the enrollee is eligible for a drug manufacturer coupon that provides \$12,000 a year with an enrollee contribution of \$600 (i.e., \$1,000 per month for the drug with an enrollee contribution of \$50). In a copayment maximizer program, the enrollee’s monthly cost sharing for the drug would now be \$1,050, with the enrollee responsible for \$50, \$1,000 contributed from the drug manufacturer coupon each month, and the health plan or policy covering a monthly total of \$1,450; the addition of the accumulator makes it such that none of the contributions paid via the drug manufacturer coupon count towards the enrollee’s OOP maximum or deductible (Figure 6).

Figure 6. Example of Monthly Copayments Under a Copayment Accumulator and Maximizer Program



Source: California Health Benefits Review Program, 2023.

Key: OOP = out-of-pocket.

Implementation of Copayment Adjustment Programs

Implementation of copayment adjustment programs involves complex claim processing that has requirements at the pharmacy. In addition, if a PBM, health plan, and/or insurer intends to impose a copayment adjustment program for a specific drug, the drug must be treated in the same manner for all pharmacies where the drug could be filled. These requirements make implementation of copayment adjustment programs through specialty pharmacies more attractive to PBMs. In general, PBMs either own or have exclusive contracts with specialty pharmacies to employ them.¹⁵ In order to facilitate provision of these drugs through specialty pharmacies with the ability to process copayment adjustment program-related claims, PBMs and health plans/insurers might use plan and network design to keep prescriptions for that drug within their specialty pharmacy network.

As discussed in the *Policy Context* section, the Centers for Medicare & Medicaid Services (CMS) recently finalized a rule that authorizes states to regulate (or prohibit) copayment adjustment programs as they deem appropriate. In states that allow copayment adjustment programs, health plans and insurers must use them in a uniform, nondiscriminatory manner. CMS further encourages, but does not require, transparency regarding the use of copayment adjustment programs by prominently providing information about their policies through their websites, brochures, plan summary documents, and other plan materials.

¹⁴ Communication with T. Sloan, March 2023.

¹⁵ Communication with T. Sloan, March 2023.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)¹⁶ conduct an evidence-based assessment of the financial impacts of AB 874, health care coverage: out-of-pocket expenses.

Bill-Specific Analysis of AB 874, Out-of-Pocket Expenses

Bill Language

As stated in the *Background on Prescription Drug Costs and Cost Control Methods* section, AB 874 would require health plans regulated by the Department of Managed Health Care (DMHC), health policies regulated by the California Department of Insurance (CDI), other health coverage carriers, and pharmacy benefit managers (PBMs) that administer pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket (OOP) expenses toward the enrollee's or insured's overall contribution to any OOP maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's plan, policy, or other health care coverage.

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

The full text of AB 874 can be found in Appendix A.

Relevant Populations

If enacted, AB 874 would apply to the health insurance of approximately 22.8 million enrollees (58.6% of all Californians). This represents all 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 DMHC or the CDI. If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, including DMHC-regulated Medi-Cal.

Medi-Cal beneficiaries, including those in DMHC-regulated plans, with full-scope coverage do not have cost sharing for their pharmacy benefit, therefore CHBRP estimates Medi-Cal beneficiaries will not be impacted by the bill. Furthermore, the pharmacy benefit for Medi-Cal beneficiaries in DMHC-regulated is "carved out" and administered by the Department of Health Care Services through a program called Medi-Cal Rx. Thus, AB 874, although it applies to DMHC-regulated Medi-Cal plans, would not impact them.

Analytic Approach and Key Assumptions

CHBRP previously analyzed similar bill language, AB 933 in 2022. Where applicable, this analysis builds off that analysis.

CHBRP assumes AB 874 does not apply to prescription drug purchases that occur outside of insurance coverage, which include those for which claims are not, legally or by the enrollee's choice, submitted as a claim to their health insurance. Payments for prescription drugs made by patient assistance programs (PAPs) are also conducted outside of an enrollee's insurance coverage, and therefore, CHBRP assumes they would not be impacted by AB 874.

¹⁶ CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

CHBRP also assumes that copayment maximizer programs are always implemented in conjunction with copayment accumulator programs, but that copayment accumulator programs may exist outside a copayment maximizer program. Therefore, CHBRP assumes AB 874 would impact all copayment adjustment programs.

As noted in the *Background on Prescription Drug Costs and Cost Control Methods* section, PBMs typically only work with specialty pharmacies on implementation of copayment adjustment programs; accordingly, CHBRP has assumed that AB 874 would only impact specialty drugs, which are typically high-cost brand name drugs.

Table 3. Relation of AB 874 to Prescription Drug Discounts and Subsidies

Impacted by AB 874 (Included in CHBRP Analysis)	Programs Not Impacted by AB 874 (Excluded From CHBRP Analysis)
Drug manufacturer coupons	Cash card programs (e.g., GoodRx, etc.)
	Patient assistance programs (i.e., charitable organizations, manufacturer-driven foundations, state-funded programs)

Source: California Health Benefits Review Program, 2023.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

Under existing law, pharmaceutical manufacturers are prohibited from offering discounts or other reductions to an enrollee’s out-of-pocket expenses associated with their health insurance coverage, if a lower cost, therapeutically equivalent generic drug available.¹⁷ This prohibition also applies to any prescription drugs for which the active ingredients are in Food and Drug Administration–regulated products that are available without prescription at a lower cost, and not otherwise contraindicated for treatment of the condition for which the drug is approved.¹⁸ There are limited exceptions to this law including, among other things, if the individual has completed any applicable step therapy or prior authorization for the prescription drug as mandated under their health coverage, or if a rebate is received by a state agency.¹⁹

California also 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.²⁰

The state also has laws intended to increase prescription drug cost transparency. For example, existing law requires health plans and insurers that were already required under state law to report rate information to DMHC and CDI to also report prescription drug-specific information to the departments,

¹⁷ Health and Safety Code (HSC) §132000.

¹⁸ HSC §132002.

¹⁹ HSC §132004.

²⁰ Business and Professions Code (BPC) §4079.

including the most frequently prescribed drugs, the costliest drugs by total annual spending, and the drugs with the highest year-over-year increase in total annual plan spending.²¹

Similar requirements in other states

Massachusetts has also banned the use of discounts or other reductions for prescription drugs when a generic equivalent is available.²²

Sixteen states, including Arizona, Arkansas, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New York, North Carolina, Oklahoma, Tennessee, Virginia, Washington, and West Virginia, and Puerto Rico, currently ban copayment adjustment programs (NCSL, 2023).

Federal Policy Landscape

Federal rules on coupon use

Federal laws limit the use of prescription drug coupons and other assistance in conjunction with programs such as the Medicare Part D prescription drug benefit, TRICARE military insurance, and Veterans Health Administration programs due to potential conflict with the federal anti-kickback statute (AKS). The federal AKS generally prohibits the knowing and willful offer or payment of remuneration to encourage a person to purchase an item or service that will be reimbursed by a federal health care program.²³ However, federal workers who purchase private health plans through the Federal Employees Health Benefit (FEHB) Program are allowed to use prescription drug coupons or other pharmacy incentive programs with their insurance benefits because the FEHB program is not considered a federal health care program for the purposes of the AKS. In addition, enrollees may choose to complete prescription drug purchases outside of their government benefit (i.e., a cash purchase for a drug at a retail pharmacy with the use of a coupon that does not count towards the enrollee's OOP expenses).

There is also guidance from the Internal Revenue Service from 2004²⁴ that states that high deductible health plans (HDHPs) must ignore discounts, including those from prescription drug coupons, in their determination of whether an enrollee has met their minimum deductible. PBMs work to dissuade HDHPs from using copayment adjustment programs because they could run afoul of IRS rules.²⁵

Rules on accumulator programs

Effective as of July 2021, the Centers for Medicare & Medicaid Services' (CMS) final rule on copayment adjustment programs defers to states regarding the regulation of copayment adjustment programs for health plans sold on the exchanges and in nongrandfathered individual and group health plans sold off exchanges (CMS, 2021). Health plans and insurers may count payments associated with drug manufacturer coupons towards an enrollee's cost-sharing limits but are not mandated to do so unless the state regulates them otherwise. The federal rule encourages, but does not require, health plans and policies to disclose the use of copayment accumulator programs on websites, brochures, plan documents, and other materials (CMS, 2021).

Legal and regulatory actions

As of the date this report was published, there is a lawsuit pending in federal district court related to the pieces of the final 2021 payment notice related to copayment adjustment programs. In the lawsuit, *HIV and Hepatitis Policy Institute v. United States Department of Health and Human Services*, the plaintiffs

²¹ HSC §1367.243.

²² Massachusetts General Laws Chapter 175H § 3(b)(2).

²³ Federal Social Security Act §1128B(b).

²⁴ IRS Notice 2004-50.

²⁵ Communication with T. Sloan, March 2023.

argue that the federal rules regarding these programs conflict with the Affordable Care Act's definition of "cost sharing," are inconsistent with other agency regulations, and are considered arbitrary and capricious under the federal Administrative Procedures Act.

Affordable Care Act

Several Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 874 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).^{26,27}

Essential Health Benefits

In California, nongrandfathered²⁸ individual and small-group health insurance is generally required to cover essential health benefits (EHBs).²⁹ In 2024, approximately 12.1% of all Californians will be enrolled in a plan or policy that must cover EHBs.³⁰

States may require state-regulated health insurance to offer benefits that exceed EHBs.^{31,32,33} Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.³⁴

AB 874 does not appear to exceed the definition of EHBs, as all health plans and insurance carriers in California are already required to cover outpatient prescription drugs and the reforms to counting OOP spending do not represent a new benefit.

²⁶ The ACA requires nongrandfathered small-group and individual market health insurance – including, but not limited to, qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website:

www.chbrp.org/other_publications/index.php.

²⁷ Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

²⁸ A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Available at: www.healthcare.gov/glossary/grandfathered-health-plan.

²⁹ For more detail, see CHBRP's issue brief, *California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits*, available at https://chbrp.org/other_publications/index.php.

³⁰ See CHBRP's resource, *Sources of Health Insurance in California* and CHBRP's issue brief *California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits*, both available at https://chbrp.org/other_publications/index.php.

³¹ ACA Section 1311(d)(3).

³² State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

³³ However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

³⁴ Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 874 would require health plans regulated by the Department of Managed Health Care (DMHC), health policies regulated by the California Department of Insurance (CDI), other health coverage carriers, and pharmacy benefit managers (PBMs) that administer pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket (OOP) expenses toward the enrollee's or insured's overall contribution to any OOP maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's plan, policy, or other health care coverage. The full text of AB 874 can be found in Appendix A.

In addition to commercial enrollees, more than 73% of enrollees associated with the California Public Enrollees' Retirement System (CalPERS) and more than 80% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.³⁵ As noted in the *Policy Context* section, AB 874 would not impact Medi-Cal beneficiaries' benefit coverage due to existing prohibitions on cost sharing for outpatient prescription drugs.

This section reports the potential incremental impacts of AB 874 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

- AB 874 would impact all copayment adjustment programs, including copayment accumulator programs and copayment maximizer programs. CHBRP also assumes that copayment maximizer programs are always implemented in conjunction with copayment accumulator programs.
- Cash card programs are not tracked at the point-of-sale by health plans or insurers when dispensed through an outpatient pharmacy and therefore are not part of any copayment adjustment program. Although pharmacies are tracking discount information and receiving payments directly from drug manufacturers, the health plan or insurer is not able to track discounts from cash cards. Any waived copayment or coinsurance amounts are not effectively tracked by any existing data system. Therefore, even if a health plan or insurance carrier does not technically apply the value of coupons/discounts to an enrollees' aggregate out-of-pocket costs as required by AB 874, the practice is incidental to obtaining the prescription.
 - For example, if a patient goes to a pharmacy to fill a prescription and their copayment amount is \$50 for any prescription drug through their health plan or insurance carrier, the pharmacy will enter that amount in the patient's OOP share. However, if a cash card is produced that makes the OOP cost of the drug \$5, the patient will pay \$5 OOP and the \$45 discount will be applied. The pharmacy will be paid the \$45 discount value by the manufacturer or drug discount program, but they will not be able to track the source of funds in their pharmacy billing system. This will result in patients getting "credit" for \$50 of spending toward their deductible or OOP maximum regardless of AB 874.
 - Thus, CHBRP assumes that AB 874 would not apply to cash card programs where an enrollee is able to obtain a lower retail price for a prescription drug, often by submitting the claim to a different processor control number (PCN) than their carrier or PBM. While such pricing concessions through cash card programs do result in lower costs for enrollees, these pricing concessions are not intended to reduce the cost sharing for an enrollee. These pricing concessions offer a means to obtain a prescription drug without using their insurance coverage.

³⁵ For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

- Unlike cash card programs, copayment adjustment program are implemented and tracked by pharmacy benefit managers (PBMs) and are typically used for specialty drugs that can only be filled by specialty pharmacies with a relationship with the PBM. These specialty pharmacies may be owned by the PBM or have an exclusive contractual relationship with the PBM.
- Due to lawsuits, regulations, entry of new brand and generic substitute drugs to market, and other factors, CHBRP projects that there will be a 20% reduction in the use of accumulator programs between 2021 (the baseline data used for this analysis) and 2024 that would occur without AB 874.
- There will be an increase in other medical utilization and plan expenses due to a portion of enrollees' who use these programs hitting their OOP maximum earlier in the year and receiving first dollar coverage for subsequent services (for every \$1 of cost sharing "saved," there will be \$0.91 in additional spending). The rate of increase was determined by market segment using induced utilization (IU) adjustment factors. For enrollees filling specialty drugs in plans where monthly cost sharing requirements for the specialty drugs alone are high enough to satisfy the OOP maximum in the year, the postmandate IU factor was a blend of the baseline IU factor and the IU factor reflecting a plan with zero cost-sharing requirements. IU factors were blended based on the month in the year when member OOP maximums would be satisfied based on coupon-eligible specialty drug fills alone. Postmandate, utilization was not adjusted for plans where specialty drug cost sharing requirements were not high enough to meet the OOP maximum. The baseline utilization was multiplied by a ratio of the postmandate IU factor divided by the baseline IU factor. For the full methodology see Appendix B.
- About 0.5% of all prescriptions, will have a copayment adjustment program available. They will be administered by PBMs in concert with specialty pharmacies.
- CHBRP assumed that compliance with this mandate will impact only specialty medications, as PBMs rely on specialty pharmacies to handle pricing adjustments at point-of-sale to administer these programs. It is standard practice that for generic and brand drugs, coupon payments are accepted and treated as member-funded dollars at baseline.³⁶ Likewise, patient assistance programs (i.e., state- or charity-funded payments for drugs) are not assumed to be subject to AB 874. Payments through these programs typically help offset the cost of noncovered services and take place outside of a member's insurance coverage.
- CHBRP assumed the drug manufacturer cost-sharing contribution for specialty drugs with a drug manufacturer coupon is limited to the lesser of the total cost-sharing requirement and 20% of the drug cost.
- The total cost-sharing requirements for specialty drugs with a manufacturer coupon were assumed to be the same as the average cost sharing for all services covered by the plan or policy. For enrollees in non-high deductible health plans (HDHPs) or enrollees in HDHPs after \$1,500 of deductible has been satisfied, cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost per service. For enrollees in HDHPs within the deductible phase of coverage, cost sharing is equal to 100% of drug expenses.
- At baseline, copayment maximizer programs are assumed to have a potential benefit to plans that exceeds the value of member cost sharing (i.e., plans may use these programs to realize the full value of drug manufacturer coupons, beyond the plan benefit cost-sharing requirements). This additional value to the plan is treated like a drug manufacturer rebate for these medications and has a benefit to the plan premiums that is not evident to the member filling medications. It is not currently clear how this bill would be interpreted related to these payment amounts. For the

³⁶ Communication with T. Sloan, March 2023.

purposes of AB 874, CHBRP assumed all coupon amounts are tracked toward the enrollee deductible and OOP maximum (including those that exceed plan benefit–required cost sharing).

- For members enrolled in only copayment accumulator programs, CHBRP assumed that drug manufacturer coupons would apply only until member OOP maximum cost-sharing requirements were satisfied through the combination of manufacturer coupons and member contributions to cost-sharing requirements, described above.
- For members enrolled in copayment maximizer programs, CHBRP assumed that drug manufacturer coupons would first be used to satisfy member cost-sharing requirements. Any coupon value remaining after member cost sharing had been satisfied would be used to reduce plan expenses, net of an assumed 25% PBM fee charged to administer these programs.
 - CHBRP assumed that drug manufacturer coupons would apply only until member OOP maximum cost-sharing requirements were satisfied by the sum of coupon payments used to satisfy cost-sharing requirements, member cost-sharing contributions (described below), plus any coupon payments used to offset plan expenses.
- CHBRP assumed the average per member per month (PMPM) allowed cost of total services would increase proportional to the increase in utilization described above and did not assume a change in the average cost per service.
- Prescription drug impacts are only expected to apply to the portion of the population with outpatient prescription drug coverage who are currently covered by a policy that is not compliant with AB 874 and that are using a combined copayment maximizer and accumulator program (NCSL, 2023) or copayment accumulator program (Galloway, 2022).³⁷
- CHBRP assumed that 0.5% of enrollees with outpatient prescription drug coverage fill scripts for specialty drugs that have coupons.

CHBRP assumed that \$2.5M were paid through patient assistance programs funded by the State of California or charities to help members cover the cost of drugs. These payments are understood to occur outside of the insurance market to pay for benefits without existing coverage and are not subject to this mandate. This amount is shown in Table 4 under “Expenses for noncovered benefits.” For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

It should be noted that the cost impacts of AB 874 are dependent on how the bill is implemented by DMHC and CDI; the impacts of the bill could be greater or smaller depending on how the regulators determine drug manufacturer coupons should be applied to the pharmacy benefit.

Baseline and Postmandate Benefit Coverage

At baseline, 35% of enrollees with health insurance that would be subject to AB 874 have coverage that allows for payments using drug manufacturer coupons to count toward deductibles and out-of-pocket maximums.

Postmandate, AB 874 would result in 6.04 million enrollees gaining coverage for drug manufacturer coupons counting toward their deductibles and OOP maximum out of 14.025 million of enrollees with outpatient prescription drug benefits in commercial plans. This represents a 75.64% percent increase from baseline. Although AB 874 does apply to Medi-Cal, it would not have an impact because of the way cost sharing is structured.

Baseline and Postmandate Utilization

Almost all – 95.6% – commercial/CalPERS enrollees in health 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.³⁸ For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and is administered by the Department of Health Care Services (DHCS). Therefore, these beneficiaries have a pharmacy benefit that is not subject to DMHC regulation. In the case of AB 874, the law would not have an impact due to lack of Medi-Cal cost sharing for outpatient prescription drugs. Among commercial /CalPERS enrollees, 1.2% do not have a pharmacy benefit and 3.2% have a pharmacy benefit that is not regulated by DMHC or CDI. Because AB 874 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.

The number of specialty prescriptions filled that have coupons (284,000) will not change due to AB 874. Similarly, the average unit cost of \$6,339 will not change from baseline to postmandate.

Additional utilization of other services would be covered by health plans or insurers due to enrollees reaching their OOP maximum earlier in the year. The amount of spending related to that additional utilization is discussed below.

Baseline and Postmandate Per-Unit Cost

The average unit cost of \$6,339 will not change from baseline to postmandate. However, the amount of manufacturer funding of discounts/coupons will decrease from \$1,772 at baseline to \$863 postmandate due to the increased likelihood that individual enrollees will hit their OOP maximum earlier and will not redeem/use discounts/coupons. Postmandate, manufacturers will contribute on average \$863 to cost sharing that will be used to calculate total enrollee deductible spending and OOP maximum (Table 3).

Baseline and Postmandate Expenditures

Overall, there is a 0.12% increase in total expenditures due to AB 874. Table 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present PMPM premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

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 a \$213,312,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a \$35,719,000 decrease in enrollee expenses for covered and/or noncovered benefits.

Table 4. Impacts of AB 874 on Benefit Coverage, Utilization, and Cost, 2024

	Baseline (2024)	Postmandate Year 1 (2024)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	22,842,000	22,842,000	0	0.00%

³⁸ For more detail, see CHBRP’s resource, *Pharmacy Benefit Coverage in State-Regulated Health Insurance*, available at http://chbrp.org/other_publications/index.php.

Total enrollees with health insurance subject to AB 874 prescription drug out-of-pocket mandate (b)	14,025,000	14,025,000	0	0.00%
Percentage of enrollees with coverage fully compliant with AB 874 drug out-of-pocket mandate	7,985,000	14,025,000	6,040,000	75.64%
Utilization and Cost				
Number of impacted scripts filled (specialty scripts with coupon available in non-compliant plans)	284,000	284,000	—	0.00%
Average unit cost of impacted scripts filled	\$6,339	\$6,339	\$0	0.00%
Average manufacturer funding used to offset member cost sharing requirements (total)	\$1,438	\$863	-\$575	-40.00%
Average manufacturer discount/coupon used to reduce member cost sharing requirement (but not tracked to deductible / OOP max) for impacted scripts filled	\$1,438	\$0	-\$1,438	-100.00%
Average discount/coupon used to reduce member cost sharing requirement (and tracked to deductible / OOP max) for impacted scripts filled	\$0	\$863	\$863	0.00%
Average member contribution towards cost sharing requirement for impacted scripts filled	\$89	\$35	-\$53	-59.96%
Average discount/coupon used to offset plan costs beyond member cost sharing for impacted scripts filled	\$334	\$0	-\$334	-100.00%
Average net plan expense for impacted scripts filled	\$4,479	\$5,441	\$962	21.49%
Additional Expenditure from Increased Utilization due to lower Cost Sharing (h)		\$32,534,000	\$32,534,000	
Expenditures				
<i>Premiums</i>				
Employer-sponsored (b)	\$57,647,993,000	\$57,762,057,000	\$114,064,000	0.20%
CalPERS employer (c)	\$6,158,262,000	\$6,161,140,000	\$2,878,000	0.05%
Medi-Cal (excludes COHS) (d)	\$29,618,383,000	\$29,618,383,000	\$0	0.00%
<i>Enrollee Premiums (expenditures)</i>				
Enrollees, individually purchased insurance	\$21,229,233,000	\$21,286,104,000	\$56,871,000	0.27%
Outside Covered California	\$4,867,955,000	\$4,902,439,000	\$34,484,000	0.71%
Through Covered California	\$16,361,278,000	\$16,383,665,000	\$22,387,000	0.14%
Enrollees, group insurance (e)	\$18,263,775,000	\$18,303,274,000	\$39,499,000	0.22%
<i>Enrollee out-of-pocket expenses</i>				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	\$13,857,141,000	\$13,821,422,000	-\$35,719,000	-0.26%
Expenses for non-covered benefits (f) (g)	\$2,514,000	\$2,514,000	\$0	0.00%
Total Expenditures	\$146,777,301,000	\$146,954,894,000	\$177,593,000	0.12%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, and Medi-Cal.

(b) In some cases, a union or other organization. Excludes CalPERS.

(c) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.1% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no

impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(d) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of \$0 million for Medi-Cal beneficiaries enrolled in COHS managed care.

(e) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

(f) 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.

(g) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).

(h) Includes costs for non-specialty drugs and other medical or pharmacy expenses once the enrollee meets their OOP maximum.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health; OOP = out-of-pocket.

Premiums

Changes in premiums due to AB 874 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 5, and Table 6) with health insurance that would be subject to AB 874 as well as the average benefit plan design in each market segment.

Premium increases due to AB 874 are relatively lower in the DMHC-regulated commercial market than the CDI-regulated commercial market. Among DMHC-regulated plans, large-group premiums would increase by 0.12%, individual market premiums would increase by 0.25%, and CalPERS would increase by 0.05%. However, DMHC-regulated small-group premiums would increase by 0.43%. In the CDI-regulated market the large-group market would face the smallest increase (0.45%), while individual (0.62%) and small group (0.85%) would have the highest increase across all markets.

Table 5. AB 874 Impacts on Other Payment Sources and Pricing Concessions, 2024

	Baseline (2024)	Postmandate Year 1 (2024)	Increase/ Decrease	Change Postmandate
Expenditures				
<i>Other payments for covered —benefits – patient assistance programs</i>				
Expenses for noncovered benefits (a) (b)	\$2,514,000	\$2,514,000	\$0	0.00%
Pricing concessions to enrollees				
<i>Pricing concessions for covered benefits considered by AB 874</i>				
Pricing concessions for covered benefits	\$570,476,000	\$407,344,000	-\$163,132,000	-28.60%
Drug manufacturer coupons for plans with accumulator programs only	\$209,684,000	\$130,465,000	-\$79,219,000	-37.78%
	\$198,187,000	\$114,274,000	-\$83,913,000	-42.34%
Drug manufacturer coupons for plans with maximizer programs	\$162,605,000	\$162,605,000	\$0	0.00%
Drug manufacturer coupons for plans that are compliant at baseline				
Enrollee impact				
<i>Coupons, discounts, copayment assistance, etc.</i>				
Total other expenditures and pricing concessions	\$572,990,000	\$409,858,000	-\$163,132,000	-28.47%

Accumulating to deductibles, copayments, and maximum out-of-pocket	\$162,605,000	\$407,344,000	\$244,739,000	150.51%
Not accumulating to deductibles, copayments, and maximum out-of-pocket	\$412,899,000	\$2,514,000	-\$410,385,000	-99.39%

Source: California Health Benefits Review Program, 2023.

(a) 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. These expenses are linked to the patient assistance programs, but not cash card programs.

(b) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).

Enrollee Expenses

AB 874–related changes in cost sharing for covered benefits (deductibles, copayments, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 5, and Table 6) with health insurance that would be subject to AB 874 expected to use the relevant outpatient prescription drugs during the year after enactment as well as the average benefit plan design in each market segment.

AB 874 would cause enrollees in non-CalPERS commercial plans in all markets to pay less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a \$0.05 reduction in enrollee expenses on the low end, with small group DMHC-regulated enrollees experiencing a \$0.48 decrease in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group (\$1.74 decrease) and individual market (\$1.18 decrease) plans would benefit the most, while large-group enrollees would experience \$0.36 in reduced enrollee expenses on average. Overall, enrollee expenses would decrease by \$35,719,000 across all markets.

Average enrollee out-of-pocket expenses per user

Due to the decreases in cost sharing, measurable impacts at the population level may occur if it results in increased adherence to a prescription drug.

The presence of a deductible not yet met for the year³⁹ could result in the enrollee paying the full unit cost, but hitting the annual OOP maximum⁴⁰ would result in the enrollee having no further cost sharing.

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 because 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. In this case, the infrastructure for tracking cost sharing already exists in the PBMs and specialty pharmacies that implement these discount/coupon programs.

³⁹ For estimates of enrollees in plans and policies with deductibles, see CHBRP’s resource, *Deductibles in State-Regulated Health Insurance*, available at https://chbrp.org/other_publications/index.php.

⁴⁰ For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copayments and coinsurance is limited to \$250, or \$500 for enrollees in the “bronze plans” available from Covered California, the state’s ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 3, Table 5, and Table 6), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 874.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 874.

Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans Medi-Cal (excludes COHS) (c)			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Under 65	65+	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 874	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,310	127,000	14,025,310
Premium costs										
Average portion of premium paid by employer (e)	\$473.17	\$417.10	\$0.00	\$581.85	\$254.61	\$543.16	\$490.57	\$517.32	\$0.00	\$93,424,638,000
Average portion of premium paid by enrollee	\$122.17	\$180.13	\$645.33	\$113.49	\$0.00	\$0.00	\$180.61	\$168.99	\$626.90	\$39,493,007,000
Total premium	\$595.34	\$597.23	\$645.33	\$695.34	\$254.61	\$543.16	\$671.18	\$686.31	\$626.90	\$132,917,645,000
Enrollee expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	\$40.98	\$127.06	\$168.73	\$49.17	\$0.00	\$0.00	\$99.22	\$184.48	\$208.51	\$13,857,141,000
Expenses for noncovered benefits (f)	\$0.01	\$0.03	\$0.02	\$0.00	\$0.00	\$0.00	\$0.04	\$0.05	\$0.04	\$2,514,000
Total expenditures	\$636.34	\$724.32	\$814.08	\$744.51	\$254.61	\$543.16	\$770.43	\$870.85	\$835.44	\$146,777,300,000

Source: California Health Benefits Review Program, 2023.

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

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total on CalPERS).

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(e) In some cases, a union or other organization – or Medi-Cal for its beneficiaries.

(f) 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 includes all health care services covered by insurance.

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

Table 7. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (excludes COHS) (c) Under 65	65+	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 874	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,310	127,000	14,025,310
Premiums										
Average portion of premium paid by employer (e)	\$0.5857	\$1.7941	\$0.0000	\$0.2719	\$0.0000	\$0.0000	\$2.2274	\$4.3785	\$0.0000	\$116,942,000
Average portion of premium paid by enrollee	\$0.1512	\$0.7748	\$1.6204	\$0.0530	\$0.0000	\$0.0000	\$0.8200	\$1.4303	\$3.9140	\$96,371,000
Total premium	\$0.7370	\$2.5689	\$1.6204	\$0.3249	\$0.0000	\$0.0000	\$3.0474	\$5.8088	\$3.9140	\$213,313,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copayments, etc.)	-\$0.0468	-\$0.4752	-\$0.4590	-\$0.0176	\$0.0000	\$0.0000	-\$0.3597	-\$1.7381	-\$1.1816	-\$35,719,000
Expenses for noncovered benefits (f)	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0
Total expenditures	\$0.6902	\$2.0937	\$1.1614	\$0.3073	\$0.0000	\$0.0000	\$2.6878	\$4.0707	\$2.7324	\$177,594,000
Percent change										
Premiums	0.1238%	0.4301%	0.2511%	0.0467%	0.0000%	0.0000%	0.4540%	0.8464%	0.6243%	0.1605%
Total expenditures	0.1085%	0.2891%	0.1427%	0.0413%	0.0000%	0.0000%	0.3489%	0.4674%	0.3271%	0.1210%

Source: California Health Benefits Review Program, 2023.

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

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(e) In some cases, a union or other organization – or Medi-Cal for its beneficiaries.

(f) 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 includes all health care services covered by insurance.

Key:= California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of AB 874, 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

There is an existing workaround that could be applied more broadly to avoid implementation/enforcement of AB 874. Currently, health plans and insurance carriers remove specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary. They will still provide the drug through a specialty pharmacy based on medical necessity (which requires prior authorization). When a patient obtains the drug through that pharmacy, the copayment accumulator or maximizer-related discounts will be applied to make their copayment zero dollars, but it will not be counted toward their deductible or OOP maximum because it is off-formulary and is not considered a covered benefit. The use of this approach could increase to avoid AB 874 oversight for drugs that can be provided off-formulary (they have a substitute in a class of medication, etc.). This approach is used frequently in the self-insured market, but there are circumstances where a fully-insured, DMHC or CDI-regulated plan could use the same approach and still comply with state law.

It is also possible that PBMs, drug manufacturers, and health plans/insurers may make strategic changes related to benefit design and drug manufacturer coupons. In addition, relationships between businesses are constantly shifting; for example, the PBM Express Scripts began a partnership at the beginning of 2023 with GoodRx, a prescription discount card provider.⁴¹ CHBRP is unable to predict such changes and therefore did not include them in this analysis, nor can predictions be made about related long-term impacts.

⁴¹CHBRP did not include impacts from this relationship in the analysis due to a lack of data.

APPENDIX A TEXT OF BILL ANALYZED

On February 17, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 874 as introduced on February 14, 2023.

ASSEMBLY BILL

NO. 874

Introduced by Assembly Member Weber

February 14, 2023

An act to add Section 132010 to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 874, as introduced, Weber. Health care coverage: out-of-pocket expenses.

Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved.

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.

This bill would require a health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan, health insurance policy, or other health care coverage. The bill would make a willful violation of that requirement by a health care service plan a crime. The bill would limit the application of the section to health care service plans and health insurance policies issued,

amended, delivered, or renewed on or after January 1, 2024. Because a willful violation of these requirements by a health care service plan would be a crime, this 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 132010 is added to the Health and Safety Code, to read:

132010. (a) A health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan, health insurance policy, or other health coverage, shall apply any amounts paid by either the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses permitted under Sections 132000 and 132002 toward the enrollee's or insured's out-of-pocket maximum, deductible, copayment, coinsurance, or any applicable cost-sharing requirement when calculating the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan, health insurance policy, or other health care coverage.

(b) If under federal law, application of subdivision (a) would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of a plan after the enrollee or insured has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this subdivision shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(c) A willful violation of this section by a health care service plan shall be subject to enforcement pursuant to Section 1390.

(d) This section does not include self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

(e) This section shall only apply to health care service plans and health care insurance policies issued, amended, delivered, or renewed on or after January 1, 2024.

(f) For purposes of this section, the following definitions apply:

(1) “Cost-sharing requirement” means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, required by, or on behalf of, an enrollee or insured in order to receive a specific health care service, including a prescription drug, covered by a health care service plan, health insurance policy, other health coverage, or pharmacy benefit manager. When calculating an enrollee’s or insured’s overall contribution to the annual limitation on cost sharing set forth in Sections 18022(c) and 300gg-6(b) of Title 42 of the United States Code, a health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan, health insurance policy, or other health coverage carrier, shall include expenditures for any item or service covered by a health care service plan, health insurance policy, or other health coverage carrier, and include within a category of essential health benefits as described in Section 18022(b)(1) of Title 42 of the United States Code, which expenditures shall be considered expenditures for essential health coverage benefits covered under the plan or policy.

(2) “Pharmacy Benefit Manager” means a person or business that administers the prescription drug or device program of one or more health care service plans, health insurance policies, or other health coverage carriers on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

SEC. 2. 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.⁴² 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.⁴³

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

Analysis-Specific Data Sources

Current application of cost sharing amounts paid by sources other than the member was determined by a survey of the largest (by enrollment) providers of health insurance in California. The cost sharing amounts funded by drug manufacturers and other payers such as discount cards, copay cards, and copay assistance will be referred to as 'coupons.' Responses to this survey represented 86% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS and DHCS were queried regarding related benefit coverage.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

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

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act that include coverage of outpatient prescription drugs.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage that is already compliant with AB 874. For carriers who did not respond to the survey, non-compliance was assumed.

Methodology and Assumptions for Baseline Utilization

Prescription Drugs

- Prescription drugs with available coupons were identified using historical claims experience from a large employer group. Drugs with other sources of payment identified (beyond member contribution to cost sharing and plan payments) were assumed to be included in drug manufacturer coupon programs. The generic product identifiers (GPI) from these prescription fills were used to generate a list of national drug codes (NDCs) corresponding to drugs offering

⁴² 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.

⁴³ See method documents posted at www.chbrp.org/about/analysis-methodology/cost-impact-analysis; in particular, see *Cost Analyses: Data Sources, Caveats, and Assumptions*.

coupons. Brand drugs with generic equivalents were removed from this list using the Medi-Span Master Drug Data Base (MDDB).

- CHBRP estimated the number of 30-day equivalents filled per 1,000 commercially insured enrollees based on Milliman’s proprietary 2021 Consolidated Health Cost Guidelines™ Sources Database. Each fill was categorized as generic, brand or specialty based on the Milliman Health Cost Guidelines™ (HCG) classification. Each fill was also categorized as being a coupon drug or a non-coupon drug based on the ND—codes identified as described above.
- The 30-day equivalent fills per 1,000 rates were trended from 2021 to 2024 using an annual utilization trend of 6.5% for specialty drugs based on the 2023 Commercial HCG trend assumptions.
- CHBRP assumed that the proportion of specialty drugs that are included in manufacturer coupon programs will decrease 20% from 2021 to 2024 as drug manufacturers rollback the use of these programs. CHBRP’s content expert expects these programs to begin phasing out in 2024. This percentage will increase over time.

Methodology and Assumptions for Baseline Cost

Prescription Drugs – Unit Cost

- CHBRP estimated the average cost per script based on Milliman’s proprietary 2021 Consolidated Health Cost Guidelines™ Sources Database. Each fill was categorized as generic, brand or specialty based on the Milliman HCG classification of drugs. Each fill was also categorized as a coupon drug or a non-coupon drug based on the NDC codes identified as described above.
- The average costs per script were trended from 2021 to 2024 using an annual cost trend of 2.5% for specialty drugs based on the 2023 Commercial HCG trend assumptions.

Total Services – PMPM Total Allowed Cost

- Baseline PMPM medical expenses were measured using the results of Commercial and CalPERS surveys. The premium amounts provided by carriers were reduced by the reported administrative and profit loads to determine the expected annual plan covered expenses. The plan covered expenses were increased by the reported average member cost sharing amounts to determine the average allowed total expenses on a PMPM basis.
- Total expenses PMPM were trended from 2021 to 2024 using historical market-specific trends and projected assumptions based on historical patterns.

Methodology and Assumptions for Baseline Cost Sharing

CHBRP assumed that cost-sharing requirements for both prescription drug and medical services were assumed to be the same as the average cost sharing for all services covered under major medical policies. Cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost of the service. For medical services, it is assumed that the member is responsible for the total cost sharing requirement. For enrollees in high deductible health plans (HDHPs) cost sharing is assumed to be 100% of expenses until the deductible is satisfied and the average cost sharing rate for expenses incurred after the deductible is satisfied.

Drug Manufacturer Coupons

- CHBRP assumed the drug manufacturer cost sharing contribution for drugs with coupons was limited to the lesser of the total cost-sharing requirement and 20% of the drug cost.
- For members enrolled in only copay accumulator programs, CHBRP assumed that drug manufacturer coupons would apply only until member out-of-pocket maximum cost-sharing requirements were satisfied through member contributions to cost-sharing requirements, described above.
- For members enrolled in copay maximizer programs, CHBRP assumed that drug manufacturer coupons would first be used to satisfy member cost-sharing requirements. Any coupon value remaining after member cost sharing had been satisfied would be used to reduce plan expenses, net of an assumed 25% pharmacy benefit manager (PBM) fee charged to administer these programs.

Member Cost Sharing – Prescription Drugs

- For members enrolled in noncompliant policies offering outpatient prescription drug benefits, CHBRP assumed that 50% were enrolled in copay accumulator programs only and 50% were enrolled in combination copay accumulator and copay maximizer programs at baseline. The member cost sharing requirements for these two programs were assumed to differ.
- CHBRP assumed that coupon amounts will be applied toward the plan-required cost-sharing amount first and the member out-of-pocket cost sharing would be equal to the total cost-sharing requirement minus the coupon amount.
- CHBRP assumed that members in copay accumulator programs would utilize the coupon to satisfy the full member cost-sharing amount as long as the annual coupon limit had not been reached. After annual coupon limits had been reached, members would be required to fully satisfy any required cost sharing.
- CHBRP assumed that members in copay maximizer plans had their cost-sharing requirement offset by coupons by an even amount across all fills in the year. Any cost-sharing requirement in excess of the evenly applied coupon amount is assumed to be paid by the member.
- CHBRP assumed that member cost sharing would apply only until member out-of-pocket maximum cost-sharing requirements were satisfied through member cost-sharing contributions.

Member Cost Sharing – Total Services

- The member cost-sharing requirement is assumed to be the same as the average cost sharing for all services covered under major medical policies. The member cost share is equal to one minus the line of business paid-to-allowed ratio multiplied by the average PMPM medical expense.

Methodology and Assumptions for Postmandate Utilization

Prescription Drugs

- CHBRP assumed that the utilization of 30-day equivalent fills per 1,000 commercially insured enrollees for specialty drugs that are coupon eligible would not increase postmandate.

Drug Manufacturer Coupons

- CHBRP assumed the drug manufacturer cost-sharing contribution for drugs with coupons is limited to the lesser of the total cost-sharing requirement and 20% of the drug cost.
- The total cost-sharing requirements were assumed to be the same as the average cost sharing for all services covered by the plan or policy. For enrollees in non-HDHP plans or enrollees in HDHP after \$1,500 of deductible has been satisfied, cost sharing is equal to one minus the line of business paid-to-allowed ratio multiplied by the average cost per service. For enrollees in HDHPs within the deductible phase of coverage, cost sharing is equal to 100% of drug expenses.
- For members enrolled in only copayment accumulator programs, CHBRP assumed that drug manufacturer coupons would apply only until member out-of-pocket maximum cost-sharing requirements were satisfied through the combination of manufacturer coupons and member contributions to cost-sharing requirements, described above.
- For members enrolled in copayment maximizer programs, CHBRP assumed that drug manufacturer coupons would first be used to satisfy member cost-sharing requirements. Any coupon value remaining after member cost sharing had been satisfied would be used to reduce plan expenses, net of an assumed 25% PBM fee charged to administer these programs.
 - CHBRP assumed that drug manufacturer coupons would apply only until member out-of-pocket maximum cost-sharing requirements were satisfied by the sum of coupon payments used to satisfy cost-sharing requirements, member cost-sharing contributions (described below), plus any coupon payments used to offset plan expenses.

Member Cost Sharing – Prescription Drugs

- The total cost-sharing requirements were assumed to be the same as the average cost sharing for all services covered by the plan or policy for enrollees in non-HDHP plans or enrollees in HDHP after the minimum \$1,500 deductible has been satisfied. For enrollees in HDHPs within the deductible phase of coverage, cost sharing is equal to 100% of drug expenses.
- CHBRP assumed that, for specialty drugs offering coupons, the manufacturer cost-sharing amount will be applied first and the member cost sharing is equal to the total cost sharing requirement minus the drug manufacturer coupon amount.
- CHBRP assumed that member cost sharing would apply only until member out-of-pocket maximum cost-sharing requirements were satisfied through member cost-sharing contributions plus drug manufacturer coupons used to offset member cost-sharing contributions and coupon payments used to offset plan expenses.

Member Cost Sharing – Total Services

- For members filling specialty drugs with coupons in plans where monthly cost-sharing requirements for prescription drugs alone were high enough to satisfy the OOP maximum, the member cost sharing on total services was reduced by the number of months in the year when member out-of-pocket maximums would be satisfied based on coupon-eligible specialty drug fills alone, divided by 12. For all other plans, the average cost-sharing rate was assumed postmandate.

Methodology and Assumptions for Impacted Population

- Prescription drug impacts are only expected to apply to the portion of the population with outpatient prescription drug coverage who are currently covered by a policy that is not compliant at baseline with AB 874 and that are using a copay adjustment⁴⁵ or copay accumulator program.⁴⁶
- CHBRP assumed that 0.5% of enrollees with outpatient prescription drug coverage fill scripts for specialty drugs that have coupons.
- CHBRP assumed that \$2.5M were paid through copay assistance programs funded by the State of California or charities to help members cover the cost of drugs. These payments are understood to occur outside of the insurance market to pay for benefits without existing coverage and are not subject to this mandate. This amount is shown in Table 1 under “Expenses for noncovered benefits.”
- CHBRP did not assume enrollees would switch plans as a result of this mandate. However, some enrollees taking drugs with coupons who have multiple plan options available may select plans with leaner benefits and lower premiums, if coupons will satisfy some or all of their cost-sharing requirements. This behavioral change could cause a rise in overall premiums beyond the increase reflected in this report.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

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 874 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 874 would be substantially the same as the impacts in the first year (see Table 3). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

⁴⁵ NCSL, 2023.

⁴⁶ Galloway, 2022.

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ABOUT CHBRP

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.

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** works with Task Force members in preparing parts of the analysis, and manages 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. 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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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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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org