Patients Before Profits: Making Rebates Make Sense
SB 873: Prescription Drugs: Cost Sharing

FREQUENTLY ASKED QUESTIONS

Q: What is the current rebate system?

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

The average amount of these rebates is 40% off the list price of the medication. For example, if the list price of a drug is $100, a PBM may negotiate a rebate of $40 on the medication. The PBM and their insurer client then only pay $60 for the medication. However, for some drug classes, the average rebate is much higher. For example, a 2021 IQVIA report found that the average rebate in the diabetes class was 60%.

Q: How does this rebate system help patients?

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

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

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

Instead of sharing the rebates with patients through lower out-of-pocket costs, the PBMs keep part of the rebates as profit and give the rest to their insurance company client.

To make matters worse, patients who have not met their deductible (in 2022, more than 3.5 million Californians were enrolled in state regulated health plans with a pharmacy deductible) and have to pay out-of-pocket at the pharmacy counter are often forced to pay the full list price of the medication – not the rebated price. So, the PBMs and insurers only pay $60 for a prescription, but the patient pays $100.

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

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

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

In 2021 alone, PBMs in the U.S. negotiated $236 billion in rebates overall – with not a dime of that money going to offset the high cost of medications for patients at the pharmacy counter. In

California, a 2021 report from the Department of Managed Health Care showed that health plans in the state received $1.7 billion in rebates, up from $1.4 billion in 2020 and $1.2 billion in 2019.

In addition, a January 2022 report of a similar policy measure by the California Health Benefits Review Program (CHBRP) found that three large PBMs (CVS Caremark, Express Scripts, OptumRx) account for more than 70% of prescription drug claim volume. And, a February 2020 white paper found that rising rebates demanded by PBMs are associated with rising list prices for prescription drugs.

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

Because there is no transparency in the current rebate system, patients have no idea how much, if any, rebate money goes to lowering insurance premiums. The January 2022 CHBRP analysis of a similar policy measure found that PBMs play a large role in drug pricing as they negotiate directly with drug manufacturers but reveal little about how those savings are passed onto consumers.

That same report estimated that in 2022, consumers would see $70,833,000 million in savings at the pharmacy counter while premiums would only increase by 0.3% on average.

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

Reforming California's rebate system will reduce patients' out-of-pocket costs at the pharmacy counter and improve health outcomes. Senate Bill 873 by Senator Bradford:

- Will make prescriptions more affordable by requiring patients receive at least 90% of rebates at the point-of-sale.
- Will not significantly increase premiums – even if health insurance companies were required to share 100% of negotiated rebates with patients, premiums would increase at most 1% while patients could save up to $800 each year on their medicine costs.

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

SB 873 certainly will create winners – the patients. The January 2022 CHBRP analysis of a similar measure found that while premiums would increase, on average, 0.3%, patients will end up saving nearly $71,000,000 yearly. It's likely the CHBRP report underestimates savings for some patients as some drug classes have average rebates higher than 40%, which is the number CHBRP used to calculate cost savings.

Health insurance plans and their middleman will argue this bill is just cost-shifting and ends up taking away a tool to lower premium costs. Health insurance has always been a dynamic marketplace, and health insurers are making substantial profits, and many are sitting on billions of dollars of reserves.

With this legislation, the average diabetic patient will experience an average of a $630 decrease in out-of-pocket costs per plan year. And, for patients with asthma, they will see an average decrease in out-of-pocket costs of approximately $270 annually.

The sickest patients in the healthcare system drive expenditures so decreasing out-of-pocket costs and increasing adherence for those patients will benefit the system as a whole. This bill will provide immediate relief for Californians by lowering the costs they pay for the medicines they need. In virtually every other scenario, consumers receive the rebate. Take buying a toaster for example. Once purchased, a consumer receives a rebate in the mail from the company. Why isn't this the case

for prescriptions? Rather than health plans providing patients with rebates or lowering health care costs, they take the savings to line their own pockets.

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

The convoluted prescription drug rebate system lacks structure and transparency. Currently, rebates are often triggered annually, meaning they don't happen at the point of sale. Therefore, health plans claim it would be too hard to pass 90% of savings through to patients.

Fortunately, SB 873 includes a nod to reconciliation in that there will be a "true-up" period at the end of each calendar year for any additional cost-sharing reductions owed to the insurer not passed on to the insured though the estimated amount at the point-of-sale.

Q: PBMs claim that passing along rebates at the pharmacy counter is difficult to calculate. How will this legislation be implemented?

Health plans and PBMs saying they can't do this is false. Some national PBMs have even started incorporating this process as of late to provide better care to patients, meaning health plans in California have the ability to change their process too. And, due to the existence of pharmacy software that allows for point-of-sale variation in prices, cost-sharing amounts, benefit coverage, and formulary information, the January 2022 CHBRP report found that it is clearly possible for pharmacy software to be updated to calculate new cost-sharing amounts and net allowed retail costs after rebates to allow for compliance with rebate reform policies.

In 2018, CVS Health, which operates the PBM Caremark and owns health insurance company Aetna, launched a "guaranteed net cost" pricing model that the company says returns 100% of drug rebates to the consumer at the point of sale.

Starting in 2019, UnitedHealth's OptumRx began sharing discounts as part of a broader effort to improve and simplify pharmacy benefits by delivering lower out-of-pocket costs directly to members and helping make prescriptions more affordable at the pharmacy counter. As long as a rebate is available for the drug, a member will receive savings during the deductible or coinsurance phase of their plan.

UnitedHealth's practices of passing along the rebate to consumers has already saved people an average of $130 per eligible prescription and data shows that when consumers do not have a deductible or large out-of-pocket expense, medication adherence improves between 4 and 16 percent.

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

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

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

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

Since rebate passthrough at the point of sale has already been implemented in several health plans across the nation, health plans in California are more than capable of doing the same.

Q: Have other states implemented similar laws?

West Virginia became the first state to pass rebate reform legislation in 2021. The legislation, HB2263, called for 100% of rebates to be shared with patients at the pharmacy counter.

Indiana is debating a similar policy this year (SB 8), as well as Virginia (HB 1782) and Washington (SB 5445).

Although not a rebate reform bill, Texas' Insurance Code Section 1369.502 requires PBMs to file annual reports on rebates, fees, and other payments. An analysis of these reports found that "a teeny amount of manufacturers' funds were shared directly with the beneficiaries whose prescriptions generated the rebate funds." In 2021, $11.9 million (0.2%) out of $5.7 billion in rebates were shared as point-of-sale savings to plan beneficiaries.

Q: Is there any current opposition to this bill, as written?

Yes. According to current opposition, they believe that this bill will increase premiums and won't do anything to save money for anyone. This is false. Although premiums will go up, on average, by 0.3%, patients will save $70,833,000 at the pharmacy counter.

The January 2022 CHBRP report of a similar policy measure even found that "the average retail allowed cost of brand and specialty drugs, prior to rebates, was estimated to be $992. CHBRP estimated that the net cost of brand and specialty drugs after rebates was $675..." That is a $318 reduction in cost that would directly benefit California consumers.

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