PATIENTS BEFORE PROFIT$

REFORMING RX REBATES

A CAMPAIGN BY CALIFORNIA ACCESS COALITION
ADVOCATING FOR ACCESS TO BEHAVIORAL HEALTH TREATMENT

AB 2942: Prescription Drug Affordability

Frequently Asked Questions

Q: What is the current rebate system?

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

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

The average amount of these drug rebates is 40% off the list price of the medication. For example, if the list price of a drug is $100, a PBM may negotiate a rebate of $40 on the medication. The PBM and their insurer client then only pay $60 for the medication. However, for some drug classes, the average rebate is much higher. For example, a recent 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, and does nothing to lower the price patients pay for medications at the pharmacy counter. In fact, patients often end up paying more for the prescription than the PBM and insurer paid for it.

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

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

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

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

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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 2019 alone, PBMs in the U.S. negotiated $89.5 billion dollars in rebates overall – with not a dime of that money going to offset the high cost of medications for patients at the pharmacy counter. In California, a report from the Department of Managed Health Care showed that health plans in the state received more than $1.4 billion in rebates from manufacturers in 2020, up 57% from 2017.

In addition, a January 2022 report by the California Health Benefits Review Program (CHBRP) found that three large PBMs (CVS, Express Scripts, Optum) 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 found that pharmacy benefits managers (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 if AB 2942 was passed into law, while premiums would only increase by 0.3% on average.

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

Assembly Bill 2942 authored by Assemblymember Tom Daly (D-Anaheim) requires that insurance companies pass on at least 90% of rebates to patients. This bill should be approved immediately by the Legislature and signed by Governor Newsom to help ensure *all* patients can afford their medications, especially now as Californians are continuing to experience economic hardships due to the COVID-19 pandemic.

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

This bill certainly will create winners – the patients. The January 2022 CHBRP analysis 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.

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

With this legislation, the average diabetic patient will experience an average of a $630 decrease in out-of-pocket costs per plan year. 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, the bill language 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 report by the California Health Benefits Review Program 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 AB 2942.

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.

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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. AB 2942 will help the more than 450,000 Californians on Bronze Covered California plans (high deductible plans) by ensuring that 90 percent of rebates are shared with patients to lower their out-of-pocket costs at the pharmacy counter.

Q: Have other states implemented similar laws?

California had the opportunity to lead the nation but fell flat in 2021. Similar bills regarding sharing rebates with patients and instituting transparency were also proposed in several states last year, but due to California's delay, West Virginia became the first state to make it into law. Their legislation called for 100% of rebates to be shared with patients at the pharmacy counter.

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 report by the California Health Benefits Review Program 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.

Q: Does a decrease in cost-sharing for certain prescription drugs and medical services lead to a decrease in the use of other more costly services?

While CHBRP was unable to estimate the savings that would result from AB 2942 due to decreased hospitalizations and emergency room visits, the analysis notes, "*In the long run, we may anticipate some modest reduction in medical expenditure driven by improved medication adherence. CHBRP is unable to quantify this reduction given the range of chronic conditions impacted by AB 2942.*"

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