ASSEMBLY BILL No. 1917

Introduced by Assembly Member Gordon

February 19, 2014

An act to add Section 1367.0095 to the Health and Safety Code, and to add Section 10112.298 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1917, as introduced, Gordon. Outpatient prescription drugs: cost sharing.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires that a health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package, as defined. PPACA requires the essential health benefits package to limit cost-sharing for the coverage in a specified manner. PPACA also requires a group health plan to ensure that any annual cost-sharing imposed under the plan does not exceed those limitations. PPACA specifies that certain of its reforms do not apply to grandfathered plans, as defined. PPACA also requires each state to establish an American Health Benefits Exchange for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans and provides reduced cost sharing for certain low-income individuals who enroll in a qualified health plan in the silver level of coverage through the Exchange.

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 also provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires a nongrandfathered individual or group health care service plan contract that provides coverage for essential health benefits, as defined, and that is issued, amended, or renewed on or after January 1, 2015, to provide for an annual limit on out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits.

With respect to a health care service plan contract or health insurance policy that is subject to those annual out-of-pocket limits, this bill would require that the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days not exceed $\frac{1}{24}$ of the annual out-of-pocket limit. The bill would also require that an enrollee who is eligible for a reduction in cost sharing through a qualified health plan offered through the Exchange not be required to pay in any single month more than $\frac{1}{24}$ of the annual limit on out-of-pocket expenses for that product. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the 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. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.0095 is added to the Health and Safety Code, to read:

1367.0095. (a) (1) With respect to a nongrandfathered individual or group health care service plan contract subject to Section 1367.006, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not

exceed 1/24 of the annual out-of-pocket limit set forth in Section 1367.006.

(2) For a health care service plan contract that meets the definiton of a high deductible health plan set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an enrollee's deductible has been satisfied for the plan year.

(3) Paragraph (1) shall not apply to coverage under a health care service plan contract for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(b) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(c) An enrollee who is eligible for a reduction in cost sharing pursuant to Section 1402 of PPACA shall not be required to pay in any single month more than 1/24 of the annual limit on out-of-pocket expenses for the cost sharing reduction product.

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

(1) "Outpatient prescription drug" means a drug approved by the federal Food and Drug Administration that is self-administered by a patient, administered by a licensed health care professional in an outpatient setting, or administered in a clinical setting that is not an inpatient setting.

(2) For nongrandfathered health care service plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health care service plan contracts sold in the individual market, "plan year" means the calendar year.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 2. Section 10112.298 is added to the Insurance Code, to read:

10112.298. (a) (1) With respect to a nongrandfathered individual or group health insurance policy subject to Section

10112.28, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed $\frac{1}{24}$ of the annual out-of-pocket limit set forth in Section 10112.28.

(2) For a health insurance policy that meets the definiton of a high deductible health plan set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an insured's deductible has been satisfied for the plan year.

(3) Paragraph (1) shall not apply to coverage under a health insurance policy for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(b) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(c) An insured who is eligible for a reduction in cost sharing pursuant to Section 1402 of PPACA shall not be required to pay in any single month more than $\frac{1}{24}$ of the annual limit on out-of-pocket expenses for the cost sharing reduction product.

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

(1) "Outpatient prescription drug" means a drug approved by the federal Food and Drug Administration that is self-administered by a patient, administered by a licensed health care professional in an outpatient setting, or administered in a clinical setting that is not an inpatient setting.

(2) For nongrandfathered health insurance policies in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, "plan year" means the calendar year.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 3. 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.

O