

AMENDED IN ASSEMBLY APRIL 10, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL

No. 2180

Introduced by Assembly Member Weber

February 7, 2024

An act to add Section 1367.0062 to the Health and Safety Code, and to add Section 10192.292 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2180, as amended, Weber. Health care coverage: cost sharing.

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, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer 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~~ *a third-party patient assistance program, as defined,* 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 contract or health insurance policy.~~ *cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness.* 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, 2025. 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.
State-mandated local program: yes.

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

- 1 SECTION 1. Section 1367.0062 is added to the Health and
- 2 Safety Code, to read:
- 3 1367.0062. (a) (1) To the extent permitted by federal law,
- 4 and consistent with Sections 132000 and 132002, a health care
- 5 service plan or a pharmacy benefit manager that administers
- 6 pharmacy benefits for a health care service plan shall apply any
- 7 amounts paid by either the enrollee or third-party patient assistance
- 8 program to the enrollee's cost-sharing requirement. This
- 9 requirement shall be limited to only those enrollees who have a
- 10 chronic disease or terminal illness.

1 (2) *When calculating an enrollee’s overall contribution to the*
2 *annual limitation on cost sharing set forth in Sections 18022(c)*
3 *and 300gg-6(b) of Title 42 of the United States Code, a health care*
4 *service plan shall include expenditures for any item or service*
5 *covered by the health care service plan, and include within a*
6 *category of essential health benefits, as described in Section*
7 *18022(b)(1) of Title 42 of the United States Code, which*
8 *expenditures shall be considered expenditures for essential health*
9 *coverage benefits covered under the health care service plan*
10 *contract.*

11 ~~(2)~~

12 (3) This section shall only apply with respect to health care
13 service plan contracts issued, amended, delivered, or renewed on
14 or after January 1, 2025.

15 (b) If under federal law, application of subdivision (a) would
16 result in health savings account ineligibility under Section 223 of
17 the Internal Revenue Code, this requirement shall apply for health
18 savings account-qualified high deductible health plans with respect
19 to the deductible of a policy after the enrollee has satisfied the
20 minimum deductible under Section 223 of the Internal Revenue
21 Code, except with respect to items or services that are preventive
22 care pursuant to Section 223(c)(2)(C) of the Internal Revenue
23 Code, in which case the requirements of this subdivision shall
24 apply regardless of whether the minimum deductible under Section
25 223 of the Internal Revenue Code has been satisfied.

26 (c) This section does not apply with respect to self-insured
27 employer plans governed by the Employee Retirement Income
28 Security Act of 1974 (ERISA) (Public Law 83-406).

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

30 (1) “Cost-sharing requirement” means any copayment,
31 coinsurance, deductible, or annual limitation on cost-sharing,
32 including a limitation subject to Sections 18022(c) and 300gg-6(b)
33 of Title 42 of the United States Code, required by, or on behalf of,
34 an enrollee in order to receive a specific health care service,
35 including a prescription drug, covered by a health care service plan
36 contract. ~~When calculating an enrollee’s overall contribution to~~
37 ~~the annual limitation on cost sharing set forth in Sections 18022(c)~~
38 ~~and 300gg-6(b) of Title 42 of the United States Code, a health care~~
39 ~~service plan shall include expenditures for any item or service~~
40 ~~covered by the health care service plan, and include within a~~

1 ~~category of essential health benefits as described in Section~~
2 ~~18022(b)(1) of Title 42 of the United States Code, which~~
3 ~~expenditures shall be considered expenditures for essential health~~
4 ~~coverage benefits covered under the health care service plan~~
5 ~~contract.~~

6 (2) ~~“Pharmacy-Benefit-Manager”~~ *benefit manager*” means a
7 person or business that administers the prescription drug or device
8 program of one or more health care service plans on behalf of a
9 third party in accordance with a pharmacy benefit program. This
10 term includes any agent or representative of a pharmacy benefit
11 manager hired or contracted by the pharmacy benefit manager to
12 assist in the administering of the drug program and any wholly or
13 partially owned or controlled subsidiary of a pharmacy benefit
14 manager.

15 (3) ~~“Third-party patient assistance program” shall include, but~~
16 ~~is not limited to, manufacturer or other charitable~~ *cost-sharing or*
17 *copay assistance* programs that provide financial assistance
18 ~~intended to augment existing prescription drug coverage.~~
19 ~~“Third-party patient assistance program” does not include~~
20 ~~discounts, drug vouchers, or general manufacturer coupons.~~ *assist*
21 *patients in paying their out-of-pocket cost-sharing obligations for*
22 *prescription drugs. “Third-party patient assistance program”*
23 *does not include discounts, product vouchers, or coupons that*
24 *provide a percentage-based discount off the list price of a*
25 *prescription drug.*

26 (4) “Chronic disease” is defined as conditions that have a
27 tendency to last one year or more and require ongoing medical
28 attention or limit activities of daily living or both.

29 (5) “Terminal illness” is defined as a medical condition that is
30 life-limiting and expected to result in death.

31 SEC. 2. Section 10192.292 is added to the Insurance Code, to
32 read:

33 10192.292. (a) (1) To the extent permitted by federal law,
34 and consistent with Sections 132000 and 132002 of the Health and
35 Safety Code, a health insurer or a pharmacy benefit manager that
36 administers pharmacy benefits for a health insurer shall apply any
37 amounts paid by either the insured, or third-party patient assistance
38 program to the insured’s cost-sharing requirement. This
39 requirement shall be limited to only those insureds who have a
40 chronic disease or terminal illness.

1 (2) *When calculating an insured's overall contribution to the*
2 *annual limitation on cost sharing set forth in Sections 18022(c)*
3 *and 300gg-6(b) of Title 42 of the United States Code, a health*
4 *insurer shall include expenditures for any item or service covered*
5 *by the health insurer, and include within a category of essential*
6 *health benefits, as described in Section 18022(b)(1) of Title 42 of*
7 *the United States Code, which expenditures shall be considered*
8 *expenditures for essential health coverage benefits covered under*
9 *the health insurance policy.*

10 ~~(2)~~

11 (3) This section shall only apply with respect to health insurance
12 policies issued, amended, delivered, or renewed on or after January
13 1, 2025.

14 (b) If under federal law, application of subdivision (a) would
15 result in health savings account ineligibility under Section 223 of
16 the Internal Revenue Code, this requirement shall apply for Health
17 Savings Account-qualified High Deductible Health Plans with
18 respect to the deductible of a policy after the insured has satisfied
19 the minimum deductible under Section 223 of the Internal Revenue
20 Code, except with respect to items or services that are preventive
21 care pursuant to Section 223(c)(2)(C) of the Internal Revenue
22 Code, in which case the requirements of this subdivision shall
23 apply regardless of whether the minimum deductible under Section
24 223 of the Internal Revenue Code has been satisfied.

25 (c) This section does not apply with respect to self-insured
26 employer plans governed by the Employee Retirement Income
27 Security Act of 1974 (ERISA) (Public Law 83-406).

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

29 (1) "Cost-sharing requirement" means any copayment,
30 coinsurance, deductible, or annual limitation on cost-sharing,
31 including a limitation subject to Sections 18022(c) and 300gg-6(b)
32 of Title 42 of the United States Code, required by, or on behalf of,
33 an enrollee in order to receive a specific health care service,
34 including a prescription drug, covered by a health insurance policy.
35 ~~When calculating an insured's overall contribution to the annual~~
36 ~~limitation on cost sharing set forth in Sections 18022(c) and~~
37 ~~300gg-6(b) of Title 42 of the United States Code, a health insurer~~
38 ~~shall include expenditures for any item or service covered by the~~
39 ~~health insurer, and include within a category of essential health~~
40 ~~benefits as described in Section 18022(b)(1) of Title 42 of the~~

1 ~~United States Code, which expenditures shall be considered~~
 2 ~~expenditures for essential health coverage benefits covered under~~
 3 ~~the health insurance policy.~~

4 (2) ~~“Pharmacy Benefit Manager”~~ *benefit manager*” means a
 5 person or business that administers the prescription drug or device
 6 program of one or more health insurance policies on behalf of a
 7 third party in accordance with a pharmacy benefit program. This
 8 term includes any agent or representative of a pharmacy benefit
 9 manager hired or contracted by the pharmacy benefit manager to
 10 assist in the administering of the drug program and any wholly or
 11 partially owned or controlled subsidiary of a pharmacy benefit
 12 manager.

13 (3) ~~“Third-party patient assistance program” shall include, but~~
 14 ~~is not limited to, manufacturer or other charitable~~ *cost-sharing or*
 15 *copay assistance* programs that provide financial assistance
 16 intended to ~~augment existing prescription drug coverage.~~ *“Third*
 17 ~~party patient assistance program” does not include discounts, drug~~
 18 ~~vouchers or general manufacturer coupons.~~ *assist patients in paying*
 19 *their out-of-pocket cost-sharing obligations for prescription drugs.*
 20 *“Third-party patient assistant program” does not include*
 21 *discounts, product vouchers, or coupons that provide a*
 22 *percentage-based discount off the list price of a prescription drug.*

23 (4) ~~“Chronic disease” is defined as conditions that have a~~
 24 ~~tendency to last one year or more and require ongoing medical~~
 25 ~~attention or limit activities of daily living or both.~~

26 (5) ~~“Terminal illness” is defined as a medical condition that is~~
 27 ~~life-limiting and expected to result in death.~~

28 SEC. 3. No reimbursement is required by this act pursuant to
 29 Section 6 of Article XIII B of the California Constitution because
 30 the only costs that may be incurred by a local agency or school
 31 district will be incurred because this act creates a new crime or
 32 infraction, eliminates a crime or infraction, or changes the penalty
 33 for a crime or infraction, within the meaning of Section 17556 of
 34 the Government Code, or changes the definition of a crime within
 35 the meaning of Section 6 of Article XIII B of the California
 36 Constitution.