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 introduced, 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 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. 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.


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

SECTION 1. Section 1367.0062 is added to the Health and Safety Code, to read:

1367.0062. (a) (1) To the extent permitted by federal law, and consistent with Sections 132000 and 132002, a health care service plan or a pharmacy benefit manager that administers pharmacy benefits for a health care service plan shall apply any amounts paid by either the enrollee or third-party patient assistance program to the enrollee’s cost-sharing requirement. This requirement shall be limited to only those enrollees who have a chronic disease or terminal illness.

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

(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 policy after the enrollee has satisfied the
minimum deductible under Section 223 of the Internal Revenue
Code, except 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) This section does not apply with respect to self-insured
employer plans governed by the Employee Retirement Income

(d) 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 in order to receive a specific health care service,
including a prescription drug, covered by a health care service plan
contract. When calculating an enrollee’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 shall include expenditures for any item or service
covered by the health care service plan, 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 health care service plan
contract.

(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 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.

(3) “Third-party patient assistance program” shall include, but
is not limited to, manufacturer or other charitable programs that
provide financial assistance intended to augment existing
prescription drug coverage. “Third-party patient assistance
program” does not include discounts, drug vouchers, or general manufacturer coupons.

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

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

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

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

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

(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 policy after the insured has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except 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) This section does not apply with respect to self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 83-406).

(d) 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 in order to receive a specific health care service,
including a prescription drug, covered by a health insurance policy.

When calculating an 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 insurer
shall include expenditures for any item or service covered by the
health insurer, 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 health insurance policy.

(2) “Pharmacy Benefit Manager” means a person or business
that administers the prescription drug or device program of one or
more health insurance policies 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.

(3) “Third-party patient assistance program” shall include, but
is not limited to, manufacturer or other charitable programs that
provide financial assistance intended to augment existing
prescription drug coverage. “Third party patient assistance
program” does not include discounts, drug vouchers or general
manufacturer coupons.

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

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

SEC. 3. No reimbursement is required by this act pursuant to
Section 6 of Article XIIIB 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 XIIIB of the California
Constitution.