ASSEMBLY BILL No. 874

Introduced by Assembly Member Weber

February 14, 2023

An act to add Section 132010 to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 874, as introduced, Weber. Health care coverage: out-of-pocket expenses.

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, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits 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, health insurance policy, or other health care coverage. The bill would make a willful violation of that requirement by a health care service plan a crime. 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, 2024. 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 132010 is added to the Health and Safety Code, to read:

132010. (a) A health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan, health insurance policy, or other health coverage, shall apply any amounts paid by either 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 permitted under Sections 132000 and 132002 toward the enrollee’s or insured’s out-of-pocket maximum, deductible, copayment, coinsurance, or any applicable cost-sharing requirement when calculating the enrollee’s or insured’s overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable

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cost-sharing requirement under the enrollee’s or insured’s health

care service plan, health insurance policy, or other health care

coverage.

(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 plan after the enrollee or insured has

satisfied the minimum deductible under Section 223 of the Internal

Revenue Code, except for 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) A willful violation of this section by a health care service

plan shall be subject to enforcement pursuant to Section 1390.

(d) This section does not include self-insured employer plans

governed by the Employee Retirement Income Security Act of


(e) This section shall only apply to health care service plans and

health care insurance policies issued, amended, delivered, or

renewed on or after January 1, 2024.

(f) 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 or insured in order to receive a specific health care

service, including a prescription drug, covered by a health care

service plan, health insurance policy, other health coverage, or

pharmacy benefit manager. When calculating an enrollee’s or

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 care service plan, health

insurance policy, other health coverage carrier, or pharmacy benefit

manager that administers pharmacy benefits for a health care

service plan, health insurance policy, or other health coverage

carrier, shall include expenditures for any item or service covered

by a health care service plan, health insurance policy, or other

health coverage carrier, 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 plan or policy.

(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, health insurance policies, or other
health coverage carriers 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.

SEC. 2. 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 XIII B of the California
Constitution.