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.

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 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

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 1974 (ERISA) (Public Law 83–406).

(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 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.

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