

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 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.

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

1 savings account-qualified high deductible health plans with respect
2 to the deductible of a policy after the enrollee has satisfied the
3 minimum deductible under Section 223 of the Internal Revenue
4 Code, except with respect to items or services that are preventive
5 care pursuant to Section 223(c)(2)(C) of the Internal Revenue
6 Code, in which case the requirements of this subdivision shall
7 apply regardless of whether the minimum deductible under Section
8 223 of the Internal Revenue Code has been satisfied.

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

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

13 (1) “Cost-sharing requirement” means any copayment,
14 coinsurance, deductible, or annual limitation on cost-sharing,
15 including a limitation subject to Sections 18022(c) and 300gg-6(b)
16 of Title 42 of the United States Code, required by, or on behalf of,
17 an enrollee in order to receive a specific health care service,
18 including a prescription drug, covered by a health care service plan
19 contract. When calculating an enrollee’s overall contribution to
20 the annual limitation on cost sharing set forth in Sections 18022(c)
21 and 300gg-6(b) of Title 42 of the United States Code, a health care
22 service plan shall include expenditures for any item or service
23 covered by the health care service plan, and include within a
24 category of essential health benefits as described in Section
25 18022(b)(1) of Title 42 of the United States Code, which
26 expenditures shall be considered expenditures for essential health
27 coverage benefits covered under the health care service plan
28 contract.

29 (2) “Pharmacy Benefit Manager” means a person or business
30 that administers the prescription drug or device program of one or
31 more health care service plans on behalf of a third party in
32 accordance with a pharmacy benefit program. This term includes
33 any agent or representative of a pharmacy benefit manager hired
34 or contracted by the pharmacy benefit manager to assist in the
35 administering of the drug program and any wholly or partially
36 owned or controlled subsidiary of a pharmacy benefit manager.

37 (3) “Third-party patient assistance program” shall include, but
38 is not limited to, manufacturer or other charitable programs that
39 provide financial assistance intended to augment existing
40 prescription drug coverage. “Third-party patient assistance

1 program” does not include discounts, drug vouchers, or general
2 manufacturer coupons.

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

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

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

10 10192.292. (a) (1) To the extent permitted by federal law,
11 and consistent with Sections 132000 and 132002 of the Health and
12 Safety Code, a health insurer or a pharmacy benefit manager that
13 administers pharmacy benefits for a health insurer shall apply any
14 amounts paid by either the insured, or third-party patient assistance
15 program to the insured’s cost-sharing requirement. This
16 requirement shall be limited to only those insureds who have a
17 chronic disease or terminal illness.

18 (2) This section shall only apply with respect to health insurance
19 policies issued, amended, delivered, or renewed on or after January
20 1, 2025.

21 (b) If under federal law, application of subdivision (a) would
22 result in health savings account ineligibility under Section 223 of
23 the Internal Revenue Code, this requirement shall apply for Health
24 Savings Account-qualified High Deductible Health Plans with
25 respect to the deductible of a policy after the insured has satisfied
26 the minimum deductible under Section 223 of the Internal Revenue
27 Code, except with respect to items or services that are preventive
28 care pursuant to Section 223(c)(2)(C) of the Internal Revenue
29 Code, in which case the requirements of this subdivision shall
30 apply regardless of whether the minimum deductible under Section
31 223 of the Internal Revenue Code has been satisfied.

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

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

36 (1) “Cost-sharing requirement” means any copayment,
37 coinsurance, deductible, or annual limitation on cost-sharing,
38 including a limitation subject to Sections 18022(c) and 300gg-6(b)
39 of Title 42 of the United States Code, required by, or on behalf of,
40 an enrollee in order to receive a specific health care service,

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

11 (2) “Pharmacy Benefit Manager” means a person or business
12 that administers the prescription drug or device program of one or
13 more health insurance policies on behalf of a third party in
14 accordance with a pharmacy benefit program. This term includes
15 any agent or representative of a pharmacy benefit manager hired
16 or contracted by the pharmacy benefit manager to assist in the
17 administering of the drug program and any wholly or partially
18 owned or controlled subsidiary of a pharmacy benefit manager.

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

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

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

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

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