

AMENDED IN ASSEMBLY MAY 7, 2014

AMENDED IN ASSEMBLY APRIL 23, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 2418

**Introduced by Assembly Members Bonilla and Skinner
(Coauthors: Assembly Members Bonta, Maienschein, and Nestande)**

February 21, 2014

An act to add Sections 1367.247, 1367.248, and 1367.249 to the Health and Safety Code, and to add Sections 10123.207, 10123.208, and 10123.209 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2418, as amended, Bonilla. Health care coverage: prescription drugs: refills.

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 also provides for the regulation of health insurers by the Department of Insurance. Existing law imposes various requirements on contracts and policies that cover prescription drug benefits. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and prohibits the refilling of a prescription without the authorization of the prescriber, except as specified.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, that provides coverage for prescription drug benefits and imposes a mandatory mail-order restriction for all or some covered prescription

drugs to establish a process allowing enrollees and insureds to opt out of the restriction, as specified. The bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2016, that provides coverage for prescription drug benefits to permit and apply a prorated daily cost-sharing rate to refills of prescriptions that are dispensed by a ~~network~~ *participating* pharmacy for less than the standard refill amount if the prescriber or pharmacist indicates that the refill ~~could be~~ *is* in the best interest of the enrollee or insured and is for the purpose of synchronizing the *refill dates of the* enrollee's or insured's medications, provided that certain requirements are satisfied. The bill would also require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, that provides coverage for prescription drug benefits to allow for the early refill of covered topical ophthalmic products at 70% of the predicted days of use. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the 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. The Legislature hereby finds and declares all of
- 2 the following:
- 3 (a) As much as 75 percent of patients do not take their
- 4 medications as prescribed. Poor adherence to prescribed treatments
- 5 poses serious health risks to nonadhering patients, particularly
- 6 those with chronic diseases.
- 7 (b) Poor adherence to prescribed treatments leads to unnecessary
- 8 disease progression, avoidable utilization of inpatient and outpatient
- 9 medical care, higher mortality rates, and increased medical
- 10 spending. According to the New England Healthcare Institute,
- 11 poor adherence to medication results in \$100 billion in excess
- 12 hospital visits and a total of \$290 billion in avoidable medical

1 spending each year — 13 percent of all health care expenditures
2 in the United States. Adherence to prescription medication prevents
3 these unnecessary complications and is a cost-effective and simple
4 tool in the treatment of health conditions.

5 (c) Given the evidence showing benefits to patients, the federal
6 Centers for Medicare and Medicaid Services requires Medicare
7 Part D plans to permit beneficiaries to choose between mail-order
8 delivery or community pharmacy access to prescription drugs,
9 requires Part D plans to allow for the synchronization of refill dates
10 for patients with multiple prescriptions, and recommends that Part
11 D plans authorize early refills of topical ophthalmic products at
12 70 percent of the predicted days of use.

13 (d) It is the intent of the Legislature to enact legislation that
14 promotes policies designed to improve patient medication
15 adherence.

16 SEC. 2. Section 1367.247 is added to the Health and Safety
17 Code, to read:

18 1367.247. (a) A health care service plan contract issued,
19 amended, or renewed on or after January 1, 2016, that provides
20 coverage for prescription drug benefits and that imposes a
21 mandatory mail-order restriction for some or all covered
22 prescription drugs shall establish a process for enrollees to opt out
23 of that restriction. The opt out process may require the use of a
24 plan's ~~network~~ *participating* pharmacy that, at the discretion of
25 the plan, is suited to special handling of the prescription drug and
26 patient care. The opt out process may require 30 days' written
27 notice before the election to opt out is effective. The opt out process
28 shall comply with all of the following requirements:

29 (1) Not impose conditions or restrictions on an enrollee opting
30 out of the mandatory mail-order restriction. For purposes of this
31 subparagraph, "conditions or restrictions" include, but are not
32 limited to, requiring prescriber approval or submission of
33 documentation by the enrollee or prescriber.

34 (2) Allow an enrollee to opt out of the mandatory mail-order
35 restriction, and revoke his or her prior opt out of the restriction, at
36 any time.

37 (3) The choice by an enrollee to opt out shall be valid for the
38 duration of the plan year or until the enrollee elects to revoke the
39 opt out, whichever occurs first, provided that the enrollee remains
40 enrolled in the same product with either the same subscriber, with

1 respect to individual plan contracts, or the same plan sponsor, with
 2 respect to group plan contracts.

3 (4) A health care service plan shall provide an enrollee who
 4 obtains a covered prescription drug that is subject to the mandatory
 5 mail-order restriction with a separate written notice of the
 6 restriction and any exceptions upon dispensing of the first fill of
 7 the drug or no less than 30 days prior to the restriction taking effect
 8 for the first refill of the drug. This written notice shall be in addition
 9 to any information contained in the plan's evidence of coverage
 10 or evidence of benefits. The notice shall inform the enrollee of the
 11 right to opt out of the mandatory mail-order restriction and
 12 instructions on how to do so.

13 (b) This section shall not apply to a drug that is not available at
 14 a ~~network~~ *participating* community pharmacy due to any of the
 15 following:

16 (1) An industry shortage listed on the Current Drug Shortages
 17 Index maintained by the federal Food and Drug Administration
 18 (FDA).

19 (2) A manufacturer's instructions or restrictions.

20 (3) Any risk evaluation and management strategy approved by
 21 the FDA.

22 (4) A special shortage affecting the plan's ~~pharmacy network~~
 23 *network of participating pharmacies*.

24 (c) Nothing in this section shall be construed to establish a new
 25 mandated benefit or to prevent the application of deductible or
 26 copayment provisions in a plan contract.

27 *(d) Nothing in this section shall be construed to limit or prohibit*
 28 *differential copayments in the form of financial incentives whereby*
 29 *an enrollee's cost sharing is reduced when he or she uses mail*
 30 *order rather than a community pharmacy.*

31 ~~(d)~~

32 (e) For purposes of this section, the following definitions shall
 33 apply:

34 (1) For group health care service plan contracts, "plan year" has
 35 the meaning set forth in Section 144.103 of Title 45 of the Code
 36 of Federal Regulations.

37 (2) For individual health care service plan contracts, "plan year"
 38 means the calendar year.

39 SEC. 3. Section 1367.248 is added to the Health and Safety
 40 Code, to read:

1 1367.248. (a) A health care service plan contract issued,
2 amended, or renewed on or after January 1, 2016, that provides
3 coverage for prescription drug benefits shall permit and apply a
4 prorated daily cost-sharing rate to the refills of prescriptions that
5 are dispensed by a ~~network~~ *participating* pharmacy for less than
6 the standard refill amount if the prescriber or pharmacist indicates
7 that the refill for less than the standard amount ~~could be~~ *is* in the
8 best interest of the enrollee and is for the purpose of synchronizing
9 the *refill dates of the* enrollee's medications and all of the following
10 apply:

11 (1) The prescription drugs being synchronized are covered and
12 authorized by the health care service plan contract.

13 (2) The prescription drugs being refilled for less than the
14 standard amount are not subject to quantity limits or other
15 utilization management controls that are inconsistent with the
16 synchronization plan, including, but not limited to, controlled
17 substance prescribing and dispensing guidelines intended to prevent
18 misuse or abuse.

19 (3) The prescription drugs being synchronized are dispensed
20 by a single ~~network~~ *participating* pharmacy.

21 (4) The patient has completed at least 90 consecutive days on
22 the prescription drugs being synchronized.

23 (5) The prescription drugs being refilled for less than the
24 standard amount are of a formulation that can be effectively split
25 over the required short fill period to achieve synchronization.

26 (6) The prescriber has not done either of the following with
27 respect to the prescriptions drugs being refilled for less than the
28 standard amount:

29 (A) Indicated, either orally or in his or her own handwriting,
30 "No change to quantity," or words of similar meaning.

31 (B) Checked a box on the prescription marked "No change to
32 quantity," and personally initialed the box or checkmark.

33 (b) This section shall not apply to a drug that is not available at
34 a ~~network~~ *participating* community pharmacy due to any of the
35 following:

36 (1) An industry shortage listed on the Current Drug Shortages
37 Index maintained by the federal Food and Drug Administration
38 (FDA).

39 (2) A manufacturer's instructions or restrictions.

1 (3) Any risk evaluation and management strategy approved by
2 the FDA.

3 (4) A special shortage affecting the plan’s ~~pharmacy network~~
4 *network of participating pharmacies*.

5 (c) Nothing in this section shall be construed to establish a new
6 or mandated benefit or to prevent the application of deductible or
7 copayment provisions in a plan contract.

8 SEC. 4. Section 1367.249 is added to the Health and Safety
9 Code, to read:

10 1367.249. (a) A health care service plan contract issued,
11 amended, or renewed on or after January 1, 2016, that provides
12 coverage for prescription drug benefits shall allow for early refills
13 of covered topical ophthalmic products at 70 percent of the
14 predicted days of use.

15 (b) Nothing in this section shall be construed to establish a new
16 mandated benefit or to prevent the application of deductible or
17 copayment provisions in a plan contract.

18 SEC. 5. Section 10123.207 is added to the Insurance Code, to
19 read:

20 10123.207. (a) A health insurance policy issued, amended, or
21 renewed on or after January 1, 2016, that provides coverage for
22 prescription drug benefits and that imposes a mandatory mail-order
23 restriction for some or all covered prescription drugs shall establish
24 a process for insureds to opt out of that restriction. The opt out
25 process may require the use of a plan’s ~~network~~ *participating*
26 *pharmacy* that, at the discretion of the plan, is suited to special
27 handling of the prescription drug and patient care. The opt out
28 process may require 30 days’ written notice before the election to
29 opt out is effective. The opt out process shall comply with all of
30 the following requirements:

31 (1) Not impose conditions or restrictions on an insured opting
32 out of the mandatory mail-order restriction. For purposes of this
33 subparagraph, “conditions or restrictions” include, but are not
34 limited to, requiring prescriber approval or submission of
35 documentation by the insured or prescriber.

36 (2) Allow an insured to opt out of the mandatory mail-order
37 restriction, and revoke his or her prior opt out of the restriction, at
38 any time.

39 (3) The choice by an insured to opt out shall be valid for the
40 duration of the plan year or until the insured elects to revoke the

1 opt out, whichever occurs first, provided that the insured remains
2 enrolled in the same product with either the same policyholder,
3 with respect to individual policies, or the same plan sponsor, with
4 respect to group policies.

5 (4) A health insurer shall provide an insured who obtains a
6 covered prescription drug that is subject to the mandatory
7 mail-order restriction with a separate written notice of the
8 restriction and any exceptions upon dispensing of the first fill of
9 the drug or no less than 30 days prior to the restriction taking effect
10 for the first refill of the drug. This written notice shall be in addition
11 to any information contained in the insurer's evidence of coverage
12 or evidence of benefits. The notice shall inform the insured of the
13 right to opt out of the mandatory mail-order restriction and
14 instructions on how to do so.

15 (b) This section shall not apply to a drug that is not available at
16 ~~an in-network~~ a participating community pharmacy due to any of
17 the following:

18 (1) An industry shortage listed on the Current Drug Shortages
19 Index maintained by the federal Food and Drug Administration
20 (FDA).

21 (2) A manufacturer's instructions or restrictions.

22 (3) Any risk evaluation and management strategy approved by
23 the FDA.

24 (4) A special shortage affecting the insurer's ~~pharmacy network~~
25 *network of participating pharmacies*.

26 (c) Nothing in this section shall be construed to establish a new
27 mandated benefit or to prevent the application of deductible or
28 copayment provisions in a policy.

29 (d) *Nothing in this section shall be construed to limit or prohibit*
30 *differential copayments in the form of financial incentives whereby*
31 *an insured's cost sharing is reduced when he or she uses mail*
32 *order rather than a community pharmacy.*

33 ~~(e)~~

34 (e) For purposes of this section, the following definitions shall
35 apply:

36 (1) For group health insurance policies, "plan year" has the
37 meaning set forth in Section 144.103 of Title 45 of the Code of
38 Federal Regulations.

39 (2) For individual health insurance policies, "plan year" means
40 the calendar year.

1 SEC. 6. Section 10123.208 is added to the Insurance Code, to
2 read:

3 10123.208. (a) A health insurance policy issued, amended, or
4 renewed on or after January 1, 2016, that provides coverage for
5 prescription drug benefits shall permit and apply a prorated daily
6 cost-sharing rate to the refills of prescriptions that are dispensed
7 by a ~~network~~ *participating* pharmacy for less than the standard
8 refill amount if the prescriber or pharmacist indicates that the refill
9 for less than the standard amount ~~could be~~ *is* in the best interest
10 of the insured and is for the purpose of synchronizing *the refill*
11 *dates of* the insured’s medications and all of the following apply:

12 (1) The prescription drugs being synchronized are covered and
13 authorized by the health insurance policy.

14 (2) The prescription drugs being refilled for less than the
15 standard amount are not subject to quantity limits or other
16 utilization management controls that are inconsistent with the
17 synchronization plan, including, but not limited to, controlled
18 substance prescribing and dispensing guidelines intended to prevent
19 misuse or abuse.

20 (3) The prescription drugs being synchronized are dispensed
21 by a single ~~network~~ *participating* pharmacy.

22 (4) The insured has completed at least 90 consecutive days on
23 the prescription drugs being synchronized.

24 (5) The prescription drugs being refilled for less than the
25 standard amount are of a formulation that can be effectively split
26 over the required short fill period to achieve synchronization.

27 (6) The prescriber has not done either of the following with
28 respect to the prescriptions drugs being refilled for less than the
29 standard amount:

30 (A) Indicated, either orally or in his or her own handwriting,
31 “No change to quantity,” or words of similar meaning.

32 (B) Checked a box on the prescription marked “No change to
33 quantity,” and personally initialed the box or checkmark.

34 (b) This section shall not apply to a drug that is not available at
35 a ~~network~~ *participating* community pharmacy due to any of the
36 following:

37 (1) An industry shortage listed on the Current Drug Shortages
38 Index maintained by the federal Food and Drug Administration
39 (FDA).

40 (2) A manufacturer’s instructions or restrictions.

1 (3) Any risk evaluation and management strategy approved by
2 the FDA.

3 (4) A special shortage affecting the insurer's ~~pharmacy network~~
4 *network of participating pharmacies*.

5 (c) Nothing in this section shall be construed to establish a new
6 or mandated benefit or to prevent the application of deductible or
7 copayment provisions in a policy.

8 SEC. 7. Section 10123.209 is added to the Insurance Code, to
9 read:

10 10123.209. (a) A health insurance policy issued, amended, or
11 renewed on or after January 1, 2016, that provides coverage for
12 prescription drug benefits shall allow for early refills of covered
13 topical ophthalmic products at 70 percent of the predicted days of
14 use.

15 (b) Nothing in this section shall be construed to establish a new
16 mandated benefit or to prevent the application of deductible or
17 copayment provisions in a policy.

18 SEC. 8. No reimbursement is required by this act pursuant to
19 Section 6 of Article XIII B of the California Constitution because
20 the only costs that may be incurred by a local agency or school
21 district will be incurred because this act creates a new crime or
22 infraction, eliminates a crime or infraction, or changes the penalty
23 for a crime or infraction, within the meaning of Section 17556 of
24 the Government Code, or changes the definition of a crime within
25 the meaning of Section 6 of Article XIII B of the California
26 Constitution.

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