ASSEMBLY BILL No. 1800

Introduced by Assembly Member Ma

February 21, 2012

An act to amend, repeal, and add Section 1342.7 of the Health and Safety Code, and to add Section 10123.197.5 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1800, as introduced, Ma. Prescription drugs.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides that the willful violation of provisions regulating health care service plans is a crime. Existing law provides for the licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plans and health insurers to provide certain benefits, but generally does not require plans and insurers to cover prescription drugs. Existing law imposes various requirements on plans and insurers if they offer coverage for prescription drugs. Existing law, with respect to health care service plans, authorizes a plan to file information with the department to seek the approval of, among other things, a copayment, deductible, or exclusion to a plan's prescription drug benefit and specifies that an approved exclusion shall not be subject to review through the independent medical review process.

Existing federal law, the Patient Protection and Affordable Care Act, commencing January 1, 2014, imposes an annual limitation on cost sharing incurred under a health plan that shall not exceed a specified

amount and defines "essential health benefits" to include, among other things, prescription drugs.

This bill would, commencing January 1, 2013, require a health care service plan contract and a health insurance policy offering outpatient prescription drug coverage to provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit, except as specified. The would bill also specify that this limit shall not exceed that federal limit. The bill would also provide, commencing January 1, 2013, that these provisions shall not be construed to affect the reduction in cost sharing for eligible insureds described in federal law. The bill would, commencing January 1, 2014, with respect to health care service plans, delete the provision specifying that an approved exclusion shall not be subject to review through the independent medical review process. The bill would, commencing January 1, 2014, provide that any deductible for basic health care services or essential health benefits shall also apply to covered prescription drugs.

Because this bill would impose new requirements on health care service plans, the willful violation of which would be a crime, it would thereby 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 1342.7 of the Health and Safety Code is amended to read:

1342.7. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352

to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of

its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit.

~~(f)~~

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(g) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

~~(g)~~

(h) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health *Care* Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

~~(h)~~

(i) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.

~~(i)~~

(j) (1) The department shall periodically review its regulations developed pursuant to this section.

(2) On or before July 1, 2004, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.

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(k) This section shall become operative on January 2, 2003, and shall only apply to contracts issued, amended, or renewed on or after that date.

(l) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1342.47 is added to the Health and Safety Code, to read:

1342.47. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.

(b) (1) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.

(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

(d) The department, in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:

(1) Different out-of-pocket costs for consumers, including copayments and deductibles.

(2) Different limitations, including caps on benefits.

(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.

(4) Different packages negotiated between purchasers and plans.

(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.

(6) Current and past practices.

(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.

(f) (1) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2014, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the enrollee's out-of-pocket costs of covered prescription drugs in that limit.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act,

as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(g) Notwithstanding any other provision of law, any deductible for basic health care services as defined in subdivision (b) of Section 1345 shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and basic health care services.

(h) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.

(i) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.

(j) (1) The department shall periodically review its regulations developed pursuant to this section.

(2) On or before July 1, 2014, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.

(j) This section shall become operative on January 1, 2014.

SEC. 3. Section 10123.197.5 is added to the Insurance Code, to read:

10123.197.5. (a) (1) A health insurance policy that is issued, amended, or renewed on or after January 1, 2013, that offers outpatient prescription drug coverage, shall provide for a limit on annual out-of-pocket expenses for outpatient prescription drug coverage and include the insured's out-of-pocket costs of covered prescription drugs in that limit.

(2) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for covered benefits, including prescription drugs, if covered.

(3) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section except that this limit shall take effect on January 1, 2013, and shall remain in effect thereafter.

(4) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

(b) Notwithstanding any other provision of law, on and after January 1, 2014, any deductible for essential health benefits, as described in subsection (b) of Section 1302 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section, shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and essential health benefits.

SEC. 4. 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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