AMENDED IN SENATE JUNE 24, 2014

AMENDED IN ASSEMBLY MAY 23, 2014

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CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1917

Introduced by Assembly Member Gordon

February 19, 2014

An act to add Section 1367.0095 to the Health and Safety Code, and to add Section 10112.298 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1917, as amended, Gordon. Outpatient prescription drugs: cost sharing.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires that a health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package, as defined. PPACA requires the essential health benefits package to limit ~~cost-sharing~~ *cost sharing* for the coverage in a specified manner. PPACA also requires a group health plan to ensure that any annual ~~cost-sharing~~ *cost sharing* imposed under the plan does not exceed those limitations. PPACA specifies that certain of its reforms do not apply to grandfathered plans, as defined.

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 requires an individual or group health care service plan contract or health insurance policy, including a specialized plan contract or policy, but excluding a grandfathered health plan, that provides coverage for essential health benefits, as defined, and that is issued, amended, or renewed on or after January 1, 2015, to provide for ~~an~~ *a specified* annual limit on out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits. *Existing law specifies an annual limit on these expenses for self-only coverage and requires that the annual limit on these expenses for other forms of coverage not exceed twice the annual limit applicable to self-only coverage.*

With respect to a health care service plan contract or health insurance policy that is subject to those annual out-of-pocket limits, and is issued, amended, or renewed on or after January 1, 2016, for an individual contract or policy, or July 1, 2015, for a group contract or policy, this bill would require that the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription not exceed $\frac{1}{12}$ of the annual out-of-pocket limit *applicable to self-only coverage* for a supply of up to 30 days of a drug that does not have a time-limited course of treatment or that has a time-limited course of treatment of more than 3 months. For a drug that has a time-limited course of treatment of 3 months or less, the bill would require that the copayment, coinsurance, or other form of cost sharing not exceed $\frac{1}{2}$ of the annual out-of-pocket limit *applicable to self-only coverage* for the time-limited course of treatment. The bill would specify that its provisions also apply to specialized plan contracts and policies that offer essential health benefits, as specified. 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:

SECTION 1. Section 1367.0095 is added to the Health and Safety Code, to read:

1367.0095. (a) (1) With respect to an individual or group health care service plan contract subject to Section 1367.006, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription shall not exceed the following:

(A) For a prescription drug that does not have a time-limited course of treatment or that has a time-limited course of treatment of more than three months, $1/12$ of the annual out-of-pocket limit applicable *to self-only coverage* under Section 1367.006 for a supply of up to 30 days.

(B) For a prescription drug that has a time-limited course of treatment of three months or less, $1/2$ of the annual out-of-pocket limit applicable *to self-only coverage* under Section 1367.006 for the time-limited course of treatment.

(2) For a health care service plan contract that meets the definition of a high deductible health plan set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an enrollee's deductible has been satisfied for the plan year.

(3) Paragraph (1) shall not apply to coverage under a health care service plan contract for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(b) The cost-sharing limits established in subdivision (a) shall only apply to outpatient prescription drugs covered by the contract that constitute essential health benefits, as defined in Section 1367.005.

(c) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(d) If an essential health benefit, as defined in Section 1367.005, is offered or provided by a specialized health care service plan contract, this section shall apply to the outpatient prescription drugs covered by the contract that constitute essential health benefits. This section shall not apply to a specialized health care service

plan contract that does not offer or provide an essential health benefit, as defined in Section 1367.005.

(e) This section shall only apply to an individual health care service plan contract that is issued, amended, or renewed on or after January 1, 2016, and to a group health care service plan contract that is issued, amended, or renewed on or after July 1, 2015.

(f) For purposes of this section, the following definitions shall apply:

(1) "Outpatient prescription drug" means a drug approved by the federal Food and Drug Administration, and prescribed by a licensed health care professional acting within his or her scope of practice, that is self-administered by a patient, administered by a licensed health care professional in an outpatient setting, or administered in a clinical setting that is not an inpatient setting.

(2) For nongrandfathered health care service plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health care service plan contracts sold in the individual market, "plan year" means the calendar year.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 2. Section 10112.298 is added to the Insurance Code, to read:

10112.298. (a) (1) With respect to an individual or group health insurance policy subject to Section 10112.28, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription shall not exceed the following:

(A) For a prescription drug that does not have a time-limited course of treatment or that has a time-limited course of treatment of more than three months, $1/12$ of the annual out-of-pocket limit applicable *to self-only coverage* under Section 10112.28 for a supply of up to 30 days.

(B) For a prescription drug that has a time-limited course of treatment of three months or less, $1/2$ of the annual out-of-pocket

limit applicable *to self-only coverage* under Section 10112.28 for the time-limited course of treatment.

(2) For a health insurance policy that meets the definition of a high deductible health plan set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an insured's deductible has been satisfied for the plan year.

(3) Paragraph (1) shall not apply to coverage under a health insurance policy for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(b) The cost-sharing limits established in subdivision (a) shall only apply to outpatient prescription drugs covered by the policy that constitute essential health benefits, as defined in Section 10112.27.

(c) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(d) If an essential health benefit, as defined in Section 10112.27, is offered or provided by a specialized health insurance policy, this section shall apply to the outpatient prescription drugs covered by the policy that constitute essential health benefits. This section shall not apply to a specialized health insurance policy that does not offer or provide an essential health benefit, as defined in Section 10112.27.

(e) This section shall only apply to an individual health insurance policy that is issued, amended, or renewed on or after January 1, 2016, and to a group health insurance policy that is issued, amended, or renewed on or after July 1, 2015.

(f) For purposes of this section, the following definitions shall apply:

(1) "Outpatient prescription drug" means a drug approved by the federal Food and Drug Administration, and prescribed by a licensed health care professional acting within his or her scope of practice, that is self-administered by a patient, administered by a licensed health care professional in an outpatient setting, or administered in a clinical setting that is not an inpatient setting.

(2) For nongrandfathered health insurance policies in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For

nongrandfathered health insurance policies sold in the individual market, "plan year" means the calendar year.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 3. 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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