Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 1199
Author: Weber Pierson (D)
Amended: 4/27/26
Vote: 21

SENATE HEALTH COMMITTEE: 9-0, 4/22/26
AYES: Weber Pierson, Caballero, Durazo, Gonzalez, Menjivar, Padilla, Pérez, Rubio, Smallwood-Cuevas
NO VOTE RECORDED: Valladares, Grove

SENATE APPROPRIATIONS COMMITTEE: 5-0, 5/14/26
AYES: Cervantes, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Seyarto, Dahle

SUBJECT: Prescription drug cost sharing

SOURCE: California Insurance Commissioner Ricardo Lara/California Department of Insurance

DIGEST: This bill requires health plans and health insurers to count any amount paid for an enrollee's or insured's drug cost-sharing toward the enrollee's or insured's annual limit on cost-sharing and deductible including any form of direct support offered by drug manufacturers permitted under existing state law.

ANALYSIS:

Existing federal law:

Federal regulation states that, beginning plan year January 1, 2020, to the extent consistent with state law, amounts paid toward cost-sharing, using any form of direct support offered by drug manufacturers to enrollees to reduce or eliminate immediate out-of-pocket costs for certain prescription brand drugs that have an available and medically appropriate generic equivalent, are not required to be counted toward the annual limitation on cost-sharing. [45 Code of Federal

Regulations (CFR) §156.130]

Existing state law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the Department of Insurance (CDI) to regulate health insurance. [Health and Safety Code (HSC) §1340, et seq. and Insurance Code (INS) §106, et seq.]

2) Establishes as California's Essential Health Benefits (EHB) benchmark pursuant to the federal Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California mandates, and ten ACA mandated benefits, including prescription drugs. [HSC §1367.005 and INS §10112.27]

3) Prohibits a person who manufactures a prescription drug, from offering in California a discount repayment, product voucher, or other reduction in an individual’s out-of-pocket expenses associated with the individual’s health coverage, including but not limited to, a copayment, coinsurance, or deductible, for a prescription drug if:

   a) A lower cost generic drug is covered under the individual’s health coverage on a lower cost-sharing tier that is designated to be therapeutically equivalent by the U.S. Food and Drug Administration (FDA), as specified; or,
   b) The active ingredients of the drug are contained in FDA-regulated products that are available without a prescription at a lower cost and are not otherwise contraindicated for treatment of the condition for which the prescription drug is approved. [HSC §132000 and §132002]

4) Excludes from the prohibition in 3) above:

   a) The first three calendar months of the availability of a drug designated in the U.S. as therapeutically equivalent to a branded drug;
   b) A discount, repayment, product voucher, or other payment to a patient or another person on the patient’s behalf for a prescription drug required under an FDA Risk Evaluation and Mitigation Strategy for the purpose of monitoring or facilitating the use of that prescription drug in a manner consistent with the approved labeling of the prescription drug;

c) A single-tablet drug regimen for treatment or prevention of HIV or AIDS that is as effective as a multi-tablet regimen, unless consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multi-tablet regimen is clinically equally effective or more effective and is more likely to result in adherence to the drug regimen;
d) When an individual has completed any applicable step therapy or prior authorization requirements for the branded prescription drug as mandated by the individual's health insurance, or other coverage;
e) A discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses that is not associated with his or her health insurance, health plan, or other health coverage;
f) Rebates received by a state agency; or,
g) Assistance provided by an independent charity patient assistance program that does not allow a pharmaceutical manufacturer or affiliate or others to exert any direct or indirect influence or control over the program or assistance. [HSC §132000 and §132004]

This bill:

1) Requires, when calculating an enrollee's or insured's contribution to their out-of-pocket maximum or cost-sharing requirement, a non-grandfathered health plan or insurer to count any amount paid for a drug by the enrollee/insured or on behalf of the enrollee/insured, including any form of direct support offered by drug manufacturers when permitted under existing law, as specified.

2) Applies this bill to the annual limit on cost-sharing and the applicable in-network deductible.

3) Exempts a grandfathered health plan and insurance policy, a specialized health plan or policy that does not provide EHBs, a Medicare supplement plan contract, or accident-only, specified disease, or hospital indemnity plan contract or policy.

4) Requires any direct support offered by a drug manufacturer to an enrollee/insured to reduce or eliminate immediate out-of-pocket expenses to comply with existing law described in 3) and 4) above.

Comments

According to the author of this bill:

This bill addresses a hidden barrier in our healthcare system that drives up costs for patients who can least afford it. Too many Californians rely on copay assistance programs to access life-saving medications, only to find that those payments do not count toward their deductible or out-of-pocket maximum, leaving them with unexpected and often unaffordable costs. This bill fixes this by requiring health plans and insurers to count all payments made on a patient's behalf toward their cost-sharing obligations, ensuring that financial assistance benefits the patient as intended. This is especially critical for individuals managing chronic and serious conditions, who can face thousands of dollars in additional costs when these payments are excluded. By closing this loophole, this bill improves affordability, promotes medication adherence, and protects patients from unfair insurance practices. It is a commonsense step to ensure that Californians can access the care they need without facing unnecessary financial hardship.

Background

The final 2020 federal ACA regulation described in existing law above allows plans to exclude manufacturer coupons from counting for specific prescription brand drugs that have a generic equivalent. The preamble to the regulation states where there is no generic equivalent available or medically appropriate, it is less likely that the manufacturer's coupon would disincentivize a lower cost alternative and thereby distort the market. Similarly, when an enrollee is determined through an appeals process or drug exception process to require a brand drug because the generic or other alternative may not be available or medically appropriate, the manufacturer coupon would not disincentivize a less expensive choice. These federal regulations were adopted under the first Trump Administration. Under the Biden Administration in 2021, these regulations were rescinded and replaced with a rule that allowed any form of manufacturer direct support paid on behalf of a consumer to be excluded from the maximum out-of-pocket limit. However, that regulation was challenged in 2022, and ruled invalid in 2023. The U.S. District Court for the District of Columbia reinstated the original 2020 regulation in December of 2023.

1) *California Health Benefits Review Program (CHBRP) report.*
   - *Background.* The high cost of certain specialty drugs impacts the enrollee's out-of-pocket costs. CHBRP cites a study that for every 10% increase in cost-sharing, there was 2% to 6% decrease in utilization, resulting in people with chronic conditions who have increased cost-sharing having decreased adherence and worst health outcomes. Drug manufacturers offer assistance

to help offset those costs so that prescribers will be more inclined to prescribe and enrollees will be more inclined to use those high-cost treatments. Typically, once an enrollee has spent up to their deductible the plan covers more health care costs. When an enrollee reaches the limit on out-of-pocket costs for the year, the plan is required to cover all the remaining costs for covered services. In response to drug assistance programs plans have used copayment adjustment programs as a plan design to affect how drug assistance affects an enrollee's out-of-pocket limit. A plan copay accumulator program excludes copayments paid by drug assistance from counting toward an enrollee's out-of-pocket limit. In this case an enrollee may use up the drug assistance in the first few months of the year and then have to pay large amounts out-of-pocket to maintain treatment on the drug. A copay maximizer uses the drug assistance to help offset patient costs over a longer term to shield the enrollee throughout the year. But again, the payments made through the drug assistance program do not count toward the enrollee's out-of-pocket limit.

- *Coverage impacts and enrollees covered*. CHBRP assumes approximately 5.8 million Californians have health insurance that is subject to this bill.
- *Medical effectiveness.* CHBRP found some evidence that copayment adjustment programs impact utilization of prescription drugs; the specific impact utilization of prescription drugs; the specific impacts, however, depend on multiple factors including drug type, patient condition, the type of copayment adjustment program, and other factors.
- *Utilization*. Claims data and underlying cost models were used to estimate the utilization and unit cost of drugs with eligible drug coupons. Drugs with a generic equivalent available were excluded from this list. CHBRP determined that roughly 9% of prescription drugs with coupons and a generic equivalent have a generic drug covered on a lower tier of the formulary, and would not be impacted by this bill, due to existing restrictions on drug coupons in California law. CHBRP assumed that for every $1 of cost-sharing "saved," there would be $0.05 in additional spending due to utilization of other services. CHBRP estimates that 44,300 enrollees would fill approximately 253,500 prescriptions because of this bill. CHBRP projects an increase of 300 specialty drug prescriptions filled. Because the elimination of copay adjustment programs would allow patients to reach their out-of-pocket limits sooner, CHBRP assumed this would also lead to an increase in utilization of other medical services. In total, CHBRP estimates an additional $9.5 million would be spent on other health care services that patients would otherwise forego if they had not yet reached their annual out-of-pocket limit.

- *Impact on expenditures*. Total premiums paid by employers and enrollees would be $355 million of this $187 million would be paid by employers, $60 million would be paid by employees, and $108 million would be paid by individuals and families who purchase coverage directly from insurance companies without the benefit of employer subsidy. This translates to premium increases ranging from $1.11 per member per month to $6.57 per member per month. CalPERS premiums would increase by $16 million ($1.74 per member per month). For those individuals benefiting from the use of drug manufacturer assistance, cost-sharing would decrease by $76 million.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, DMHC estimates costs of approximately $165,000 in 2026-27, $537,000 in 2027-28, and $501,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund), CDI estimates costs of $7,000 in 2026-27 and $19,000 in 2027-28 for state administration (Insurance Fund) and unknown ongoing General Fund costs, potentially low millions, due to increased CalPERS plan premiums.

SUPPORT: (Verified 5/14/26)

California Insurance Commissioner Ricardo Lara/California Department of Insurance (sponsor)
Alliance for Gout Awareness
Alliance for Patient Access
ALS Association
Association for Clinical Oncology
Association of Northern California Oncologists
Autoimmune and Autoinflammatory Arthritis
Biocom
Bleeding Disorders Council of California
California Access Coalition
California Academy of Family Physicians
California Chapter American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Chronic Care Coalition
California Life Sciences Association
California Pharmacists Association
California Podiatric Medical Association
California Rheumatology Alliance

Children’s Specialty Care Coalition
Community Oncology Alliance
Crohn’s and Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
EB Research Partnership
Equality California
HIV + Hepatitis Policy Institute
International Foundation for Autoimmune and Autoinflammatory Arthritis
Los Angeles LGBT Center
Medical Oncology Association of Southern California
Mental Health America of California
Movement Disorders Policy Coalition
National Bleeding Disorders Foundation
National Health Law Program
National Multiple Sclerosis Society
Osteopathic Physicians and Surgeons of California
San Francisco AIDS Foundation
Spondylitis Association of America
The EveryLife Foundation for Rare Diseases
U.S. Pain Foundation
Vision Health Advocacy Coalition
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 5/14/26)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
Pharmaceutical Care Management Association
One individual

ARGUMENTS IN SUPPORT: This bill’s sponsor, Insurance Commissioner Ricardo Lara, writes, “Copay accumulators are harmful policies used by health plans, health insurers, and pharmacy benefit managers to prevent copay cost-sharing assistance given to qualified patients from counting towards the patient’s deductible and maximum cost-sharing obligation. While patients can initially use the assistance to afford their medications, they are often shocked by the substantial costs later in the year when the assistance runs out, leaving them unable to pay for their prescriptions and leading to poor health outcomes. When copay assistance is excluded from patients’ cost-sharing obligations, patients receive no credit toward

their deductible or out-of-pocket maximum, despite insurers collecting the manufacturer's assistance. As a result, patients often face unaffordable copays at refill, effectively paying twice. This double-dipping practice places an unfair burden on patients and threatens their ability to maintain essential treatments,". The National Multiple Sclerosis Society writes that "people living with MS often face high deductible and cost-sharing burdens and are responsible for thousands of dollars in out-of-pocket costs, even with health insurance. Because patients are responsible for all their health care costs until the deductible is satisfied, prolonging the deductible period can also put other medical needs—such as doctors' visits, rehabilitation therapies, MRIs, or other medications—financially out-of-reach." The Bleeding Disorders Council of California writes patients with bleeding disorders rely on specialized medications and obstacles to obtaining these medications can have life-threatening consequences, and this bill would take meaningful steps to protect bleeding disorder patients' ability to obtain their life-saving medications by requiring insurers to include all copays, including those made by third parties on the patient's behalf, to contribute to the patient's out-of-pocket maximum or other forms of patient cost-sharing. The Community Oncology Alliance (COA) indicates insurers and pharmacy benefit managers use copay accumulators to shift financial responsibility away from themselves and onto patients already struggling under the weight of cancer care. COA writes that they undermine the affordability and continuity of treatment and violate the basic principle that a patient's financial assistance should directly support their ability to stay on therapy.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans believe this bill would lower cost-sharing for some and not others depending on whether a particular drug manufacturer has assistance available. The opposition writes that this bill encourages patients to choose high-cost name brand drugs when lower-cost, clinically appropriate options may be available, and it lowers pressure on drug manufacturers to reduce list prices, because they can maintain higher prices while using coupons or other direct support to help patients meet their cost-sharing. Opponents indicate these dynamics can increase total drug spending and drive higher premiums for all enrollees. Opponents believe this may set a precedent laying the groundwork for similar requirements on other non-prescription-drug cost-sharing, such as medical devices.

1) *Oppose unless amended.* The Pharmaceutical Care Management Association (PCMA) writes "By making the brand seem less expensive at the pharmacy counter, these coupons steer patient away from lower cost generics and toward drugs that cost employers and unions more overall. Nationwide, the use of

coupons has increased health care costs by up to $2.7 billion. For this reason, heath plans implement programs to minimize the impact the use of coupons has on premiums." PCMA requests amendments to add the following limits for when drug assistance can be used and counted pursuant to this bill:

- If the prescription drug does not have a generic or therapeutic equivalent (as referenced California Business and Professions Code § 4073) preferred under the enrollee's health care service plan contract; or
- The prescription drug has a generic or therapeutic equivalent preferred under the health care service plan contract and the enrollee obtained coverage through prior authorization, a step therapy protocol, or the health care service plan's exceptions and appeals process.
- Has not been deemed medically unnecessary by a provider.

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5/16/26 10:44:27

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