

Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
SB 1199 (Weber Pierson) – As Amended April 27, 2026

**SENATE VOTE:** 26-0

**SUBJECT:** Prescription drug cost sharing.

**SUMMARY:** Requires a health plan or insurer, when calculating an enrollee's or insured's overall contribution to an out-of-pocket (OOP) maximum or cost-sharing requirement, to count any amount paid by the enrollee or insured or on behalf of the enrollee or insured toward their cost-sharing. Specifically, **this bill:**

- 1) Requires a health plan or insurer, when calculating an enrollee's overall contribution to an OOP maximum or cost-sharing requirement to count any amount paid by the enrollee or on behalf of the enrollee for a drug toward an enrollee's cost-sharing, including any form of direct support offered by drug manufacturers when permitted under existing law.
- 2) Requires amounts in 1) above to count toward the annual limit on cost-sharing and the applicable in-network deductible.
- 3) Requires any direct support offered by a drug manufacturer to reduce or eliminate immediate OOP expenses to comply with existing law.
- 4) Applies the provisions of this bill to all nongrandfathered plans and insurers. Exempts grandfathered plans, specialized health plans and insurers that don't cover essential health benefits (EHBs), Medicare supplements, or accident-only, specific disease, or hospital indemnity contracts or policies.
- 5) Defines "cost-sharing" to mean any expenditure required by or on behalf of an enrollee or insured with respect to EHBs, including deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for non-network providers, and spending for non-covered services.

**EXISTING 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) Requires a health plan contract or health insurance policy that provides prescription drugs to cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with the law. [HSC § 1342.71 and INS § 10123.193]
- 3) Establishes as California's Essential Health Benefits (EHB) benchmark pursuant to the federal Patient Protection and 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]

- 4) Limits cost-sharing for a covered outpatient prescription drug for up to a 30-day supply from exceeding \$250, \$500 for bronze level plans, or for federally defined high-deductible health plans, those amounts after the deductible is met. [HSC § 1342.73 and INS § 10123.1932]
- 5) 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]
- 6) Excludes from the prohibition in 5) 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 multitablet regimen, unless consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet 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]

**FISCAL EFFECT:** 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.

#### COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, this bill addresses a hidden barrier in our health care system that drives up costs for patients who can least afford it. The author states that 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 OOP maximum, leaving them with unexpected and often unaffordable costs. The author continues that 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 actually benefits the patient as intended. The author argues 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. The author concludes that by closing this loophole, this bill improves affordability, promotes medication adherence, and protects patients from unfair insurance practices.
- 2) **BACKGROUND.** Copayment adjustment programs exist, in part, because of divergent economic interests between drug manufacturers and health insurers and payers regarding high-cost specialty drugs. According to DMHC, the portion of California insurance premiums driven by prescription drug spending has grown from 12.7% in 2020 to 15.4% in 2024. One of the primary drivers of these increases is the rising cost of specialty drugs, which account for 63% of prescription drug spending but make up less than 2% of the total number of drugs dispensed in the state.
  - a) **High-cost drugs & copay coupons.** According to the California Health Benefits Review Program (CHBRP), studies point to a wide range of factors that influence the cost and prices of specialty drugs. These include, among other factors, lack of competition in the biosimilar market, high drug development costs, regulatory challenges, and exclusive sales rights to manufacturers of newly approved brand-name drugs. Specialty and other high-cost drugs are typically assigned a coinsurance (a percentage of cost) regarding patient cost sharing responsibility, rather than a copay (a flat-rate amount) to help mitigate the costs to the health plan or insurer. Thus, the high cost of specialty drugs increases OOP costs for patients. In response to these cost increases, drug manufacturers, nonprofit organizations, and other entities have established several strategies to reduce some of the OOP costs patients face when purchasing prescriptions. Examples include drug copay coupons, which lower OOP costs at the pharmacy to encourage the use of specific drugs, and patient assistance programs, which provide direct financial aid to patients.

While it is recognized that these coupons may help with unaffordable copays, the availability of a coupon may cause physicians and enrollees to choose an expensive brand-name drug when a less expensive and equally effective generic or other alternative is available. When consumers are relieved of copayment obligations, manufacturers are relieved of a market constraint on drug prices which can distort the true costs of drugs. Such coupons can add significant long-term costs to the health care system that may outweigh the short-term benefits of allowing the coupons, and counter-balance issuers'

efforts to point enrollees to more cost-effective drugs. For example, a 2016 study titled “Effect of Coupons on Use of Generics” by Harvard, Kellogg, and UCLA Business Schools found that payment coupons reduced the sale of effective generic drugs and increased the use of brand name drugs by 60%. The study estimated that the use of payment coupons would, over the ensuing five years, increase spending per drug in the range of \$30 to \$120 million and increase total spending for the study sample by \$700 million to \$2.7 billion. Multiple states, including California under AB 265 (Wood), Chapter 611, Statutes of 2017, have prohibited prescription drug manufacturers from offering coupons or other discounts in an individual's OOP expenses if a lower cost therapeutically equivalent generic drug is available.

- b) Copay adjustment programs.** According to CHBRP, copayment adjustment programs emerged as a benefit design response to the potential for third-party financial assistance, such as drug manufacturer coupons, to affect how patient cost-sharing requirements function within a health plan. They are a type of pharmacy benefit design that limits how third-party financial assistance counts towards a patient's OOP costs. Specifically, they exclude the contributions made by a third party (like drug manufacturer coupons) from counting towards the enrollee's OOP maximum or deductible. The programs typically target specialty drugs, which tend to have higher OOP costs and the most financial assistance from third parties. There are two types of copayment adjustment programs:
- i) Copay accumulators:** programs that exclude any amounts collected at the point of sale when using financial assistance from a third party for a prescription drug from counting towards a person's deductible or annual OOP maximum.
  - ii) Copay maximizers:** programs that adjust the cost-sharing at the point-of-sale to an amount that utilizes the entire amount of the financial assistance available from a third party. This approach ensures that: (1) the plan captures the full value of available manufacturer copay assistance and (2) the member does not pay OOP for the targeted drugs, but (3) none of the copay assistance counts towards deductibles or OOP maximums.

In effect, this bill would prohibit both of these types of copay adjustment programs.

- c) Federal Regulations.** Federal regulations 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 OOP 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. Not counting such amounts toward the annual limitation on cost-sharing would promote prudent prescribing and purchasing choices by physicians and patients based on true costs of drugs and price competition in the pharmaceutical market. Further, it was noted that the regulation is permissive and would apply to non-grandfathered group health plans, to which the annual OOP limitation applies, under the ACA and the Employee Retirement Income Security Act (ERISA).

The final 2020 regulation allows plans to exclude manufacturer coupons from counting for specific prescription brand drugs that have a generic equivalent. The preamble 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.

- d) **CHBRP.** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:
- i) **Premium increases and OOP savings.** CHBRP estimates this bill would result in approximately 44,300 enrollees having third-party financial assistance for 253,800 prescriptions applied to their annual cost sharing requirements. This would lead to an annual premium increase of approximately \$355 million for all enrollees, regardless of their access to third-party financial assistance. Enrollees using drugs impacted by this bill would see a total decrease in cost sharing of \$75.6 million, with an annual OOP savings ranging from \$530 to \$2,600 per utilizer, depending on the market segment.
  - ii) **Reducing racial disparities.** CHBRP found literature showing that copayment adjustment programs disproportionately affect non-white patient populations because these patients are significantly more likely to be enrolled in them than white patients. If this bill were to be enacted, disparities related to enrollment in copayment adjustment programs would dissipate due to the elimination of these programs.
  - iii) **Rising biologic costs.** CHBRP noted that the global biologics market continues to experience significant growth. This bill would not impose any requirements that would change the initial prices of biologics or other drugs; these would still be set by drug manufacturers. As these are high-cost specialty drugs, manufacturers would likely continue to offer coupons for new biologics to offset patient OOP costs. This bill may compound this effect by removing a barrier to patient access. Combined, this may increase utilization of specialty drugs and subsequently increase premiums.
- e) **Growing consumer premiums and affordability concerns.** Over the last two decades, significant federal policy changes have reshaped the health insurance landscape in California, expanding coverage, increasing affordability, and strengthening consumer protections for millions of residents. These policies drove historic reductions in the uninsured rate and provided greater stability for families, providers, and health systems

across the state. These gains, however, are under threat as the expiration and rollback of key federal supports, combined with broader economic uncertainty and rising health care costs, risk reversing hard-won progress and increasing the number of Californians who are struggling to access affordable health care. According to the California Health Care Foundation 2026 Health Policy Survey (CHCF Survey), half of Californians (51%) reported that their health care expenses have increased faster than their incomes, and a vast majority (71%) are experiencing financial strain due to health care costs. About 6 in 10 Californians overall (59%), and 70% of Californians with low incomes, say they skipped or postponed care due to cost in the past year. Nearly half of Californians (47%) say it is “very” or “somewhat” difficult to afford health care.

- i) Covered California.** Covered California is the state’s ACA marketplace where small-businesses and individuals can directly purchase coverage. Over 90% of Covered California enrollees receive some combination of state and federal subsidies to afford their premiums. However, the expiration of federal enhanced premium tax credits at the end of 2025 is creating stark affordability concerns. Covered California estimates that about 1.7 million Californians will see significant increases to their costs in 2026; on average, enrollees will notice 97% increases to their monthly health insurance premiums. As of February, Covered California estimated a 3% decrease in enrollment overall, with a 32% decrease in new enrollments compared to 2025. One-third of enrollees are opting for lower-cost Bronze plans, compared to 25% in 2025, and 75% of renewals who switched plans downgraded to Bronze-level coverage. About 14% of previous enrollees cancelled their plans, and for those making over 400% of the federal poverty level (FPL), policy termination rates are double what they were in 2025 (22% up from 11%).
- ii) Employer coverage.** For those on employer-based individual and family plans, the California Health Benefits Survey found that the average total premium for family coverage in California has increased by 24% since 2022 – rapidly outpacing the national rates of inflation (12%) and wages (14%). This continues a 20-year trend: according to the UC Labor Center, family health care premiums for private-sector workers have grown by 129% since 2005, faster than the state’s median household income (94%) and the inflation rate (69%). Because health insurance is part of an employee’s total compensation plan, higher premiums cut into employee wage increases and other benefits.
- f) OHCA cost targets.** OHCA was established in 2022 in response to widespread cost-related access challenges across California. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA’s spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity’s costs exceed the target. Some entities have raised concerns that new legislative insurance mandates will make it difficult for them to meet the established cost growth target.

Current law does not explicitly require OHCA to adjust the cost growth targets based on changes to state policy, such as insurance mandates, that may increase spending. However, it does require OHCA to consider state benefit mandates in its development

and enforcement of cost growth targets. Specifically, when establishing cost growth target methodology, OHCA is required to review relevant state policy changes impacting covered benefits, provider reimbursement, and costs, among other factors. In addition, in enforcing cost growth targets, OHCA is required to consider factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

- 3) SUPPORT.** This bill is sponsored by Insurance Commissioner Ricardo Lara (Commissioner). The Commissioner argues that 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. The Commissioner continues that 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. The Commissioner states that 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. The Commissioner concludes that this bill will help ensure Californians receive the credit they deserve and are not burdened financially when accessing life-saving medications. No one should have to choose between essential medication and their basic needs.
- 4) OPPOSITION.** The California Association of Health Plans, Association of California Life and Health Insurance Companies, and America's Health Insurance Plans are opposed to this bill, stating that this bill would effectively result in lower cost-sharing for some conditions over others depending on whether a particular drug has manufacturer assistance available. The opposition continues that as a result, similarly situated patients could face very different cost-sharing outcomes (for example, heart patients versus lung cancer patients, or individuals with high blood pressure versus other chronic conditions) based not on medical need, but on the presence of a manufacturer assistance program tied to a specific drug. The opposition argues that this bill lowers pressure on drug manufacturers to reduce list prices, because manufacturers can maintain higher prices while using coupons or other direct support to help members meet their cost-sharing obligations. The opposition notes that there are implementation issues with the bill, as plans and their vendors cannot reliably identify, validate, and track in real time the assistance a drug manufacturer provides to offset a member's required cost-sharing. The opposition argues that this bill leaves unanswered key questions, including what burden of proof plans may require, what documentation would be sufficient, and whether plans can consistently track these third-party payments across pharmacies, benefit managers, and manufacturer programs. Lastly, the opposition argues that this bill lays the groundwork for similar requirements across non-prescription-drug cost sharing, including medical devices and other provider types.
- 5) PREVIOUS LEGISLATION.**

  - a)** AB 2180 (Weber) of 2024, would have required a health plan, insurer, or pharmacy benefit manager to apply any amounts paid by the enrollee, insured, or third-party patient assistance program for prescription drugs towards the enrollee or insured's cost-sharing requirement for those who have a chronic disease or terminal illness. AB 2180 was held on the Assembly Appropriations Committee suspense file.

- b) AB 874 (Weber) of 2023 was similar to AB 2180 but was never heard in Assembly Health Committee.
- c) AB 265 (Wood), Chapter 611, Statutes of 2017 prohibits prescription drug manufacturers from offering discounts or other reductions in an individual's OOP expenses associated with their insurance coverage, if a lower cost therapeutically equivalent generic drug is available. Specifies several exceptions that allow discounts even if a lower cost therapeutically equivalent generic drug is available.

## 6) PROPOSED AMENDMENTS.

- a) **Reducing consumer premium impact.** As detailed in the CHBRP analysis, this bill could incentivize pharmaceutical manufacturers to offer additional cost-sharing assistance, such as coupons, to encourage the utilization of more high-cost, biologic specialty drugs. As a result, premiums would continue to increase in the long term. Existing law prohibits manufacturer funded copay coupons when a lower-cost generic is available, meaning such coupons wouldn't apply to the provisions of this bill. The committee may wish to amend the bill to also exempt biologics from the provisions of this bill when there is a lower-cost biosimilar covered by the health plan.
- b) **Addressing logistical hurdles.** The health plans have raised the issue that cost-sharing assistance is utilized at the point-of-sale, generally at the pharmacy. The use of assistance is not required to be reported to the health plan, meaning they don't have the ability to accurately track it to offset a member's required cost-sharing as required under this bill. The committee may wish to clarify that cost-sharing assistance can only be counted if it is reported by the pharmacy to the health plan.

## REGISTERED SUPPORT / OPPOSITION:

### Support

Insurance Commissioner Ricardo Lara (sponsor)  
 Aids Healthcare Foundation  
 Association for Clinical Oncology  
 Association of Northern California Oncologists  
 Bleeding Disorders Council of California  
 California Academy of Family Physicians  
 California Chapter American College of Cardiology  
 California Chronic Care Coalition  
 California Pharmacists Association  
 California Rare Disease Access Coalition  
 California Rheumatology Alliance  
 Children's Specialty Care Coalition  
 Community Liver Alliance  
 Crohn's and Colitis Foundation  
 Cystic Fibrosis Foundation  
 EB Research Partnership  
 Los Angeles LGBT Center  
 Medical Oncology Association of Southern California  
 National Health Law Program

National Infusion Center Association (NICA)  
National Multiple Sclerosis Society  
National Psoriasis Foundation  
Neuropathy Action Foundation  
The Everylife Foundation for Rare Diseases  
Western Center on Law & Poverty  
Several individuals

**Opposition**

America's Health Insurance Plans  
Association of California Life & Health Insurance Companies  
California Agents and Health Insurance Professionals  
California Association of Health Plans  
California Association of Joint Powers Authorities

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