Date of Hearing: August 5, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 1199 (Weber Pierson) – As Amended July 2, 2026

Policy Committee: Health Vote: 13 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health plan or health insurer (collectively, health plan), when calculating an enrollee's overall contribution to an out-of-pocket maximum or cost sharing requirement, to count any amount paid by the enrollee or on behalf of the enrollee for a covered drug toward the enrollee's cost sharing requirement, except as provided.

More specifically, this bill:

1) Requires, when calculating an enrollee's overall contribution to an out-of-pocket maximum (MOOP) or cost sharing requirement under the enrollee's health plan contract or policy, a health plan count any amount paid by the enrollee or on the enrollee's behalf for a covered drug toward the enrollee's cost sharing, unless (a) there is a covered generic equivalent at a lower cost sharing tier or a covered interchangeable biosimilar or biosimilar drug at the same or lower cost sharing, or (b) active ingredients of the drug are contained in products regulated by the U.S. Food and Drug Administration (FDA), are available without prescription at a lower cost, and are not otherwise contraindicated for treatment of the condition for which the prescription drug is approved.

2) Requires a health plan count toward an enrollee's MOOP any amount paid by an enrollee or on the enrollee's behalf if an enrollee has obtained coverage for a medically necessary nonformulary or nonpreferred prescription drug under existing law.

3) Requires a health plan apply amounts paid on behalf of the enrollee, including direct assistance offered by drug manufacturers, towards an enrollee's MOOP or cost sharing requirement only if the pharmacy notifies the enrollee's health plan of the use of the assistance, the enrollee to whom it was provided, and the amount of assistance that was provided.

4) Applies the provisions of this bill to all nongrandfathered plans and insurers and exempts grandfathered plans, specialized health plans and insurers, Medicare supplements, and 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 essential health benefits, including deductibles, coinsurance, copayments, or similar charges, but not premiums, balance billing amounts for non-network providers, and spending for non-covered services.

FISCAL EFFECT:

The California Health Benefits Review Program (CHBRP) estimates annual costs of $16.4 million to the California Public Employees' Retirement System (CalPERS) in increased premium costs ($1.74 per member per month) for DMHC- regulated plans. Of these costs, approximately $6.5 million would be General Fund costs. General Fund liability for CDI-regulated CalPERS insurance premiums would likely also increase by an unknown amount, potentially in the low millions of dollars per year. CHBRP states recent amendments do not change CHBRP's cost estimate.

The Department of Managed Health Care (DMHC) estimates costs of approximately $165,000 in fiscal year (FY) 2026-27, $537,000 in FY 2027-28, and $501,000 in FY 2028-29 and annually thereafter for additional workload and staffing, primarily to address an increased volume of consumer complaints to the DMHC Help Center (Managed Care Fund).

The California Department of Insurance (CDI) anticipates minor and absorbable costs to review insurance policies (Insurance Fund).

CHBRP estimates this bill would increase total premiums paid by all employers and enrollees statewide by approximately $354.5 million per year.

COMMENTS:

1) **Purpose.** This bill is sponsored by Insurance Commissioner Ricardo Lara. According to the author:

> 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.
>
> SB 1199 fixes this by requiring health plans and insurers to count all payments made on a patient's behalf toward their cost-sharing obligations…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, SB 1199 improves affordability, promotes medication adherence, and protects patients from unfair insurance practices.

2) **Background.** To help mitigate costs to the health plan, health plans often assign specialty and other high-cost drugs a coinsurance (a percentage of cost), rather than a copay (a flat-rate amount) as the enrollee's cost-sharing responsibility. Thus, the high cost of specialty drugs increases out-of-pocket (OOP) costs for patients. In response, drug manufacturers, nonprofit organizations, and other entities have established strategies to reduce patients' OOP costs, such as drug copay coupons, which lower OOP costs at the pharmacy to encourage the use of specific drugs.

   While these coupons may help with unaffordable copays and coinsurance, 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 through coupons, the costs of drugs are distorted. 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 thwart health plans' efforts to point enrollees to more cost-effective drugs. A 2016 study found that payment coupons reduced the use of effective generic drugs and increased the use of brand name drugs by 60%. The study estimated that the use of payment coupons would increase total spending for the study sample by $700 million to $2.7 billion over the ensuing five years. Multiple states, including California with 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.

According to CHBRP, the estimated 0.70% to 0.77% of enrollees who would use the benefits provided by this bill would experience significant decreases in annual spending, estimated at $530 per CalPERS enrollee in DMHC-regulated plans to $2600 per enrollee in small-group plans. However, for the more than 99% of enrollees who do not use prescriptions affected by this bill, average annual costs could increase by $10 for a large group market enrollee to $50 for an enrollee in the small group market.

3) **Prior Legislation.** AB 2180 (Weber), of the 2023-24 Legislative Session, was similar to this bill but applied only to enrollees with a chronic disease or terminal illness. AB 2180 was held in this committee.

AB 874 (Weber), of the 2023-24 Legislative Session, was similar to AB 2180 and was referred to, but did not receive a hearing in, Assembly Health Committee.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081