ASSEMBLY BILL No. 369

Introduced by Assembly Member Huffman
(Coauthors: Assembly Members Beall and Feuer)
(Coauthor: Senator Pavley)

February 14, 2011

An act to add Section 1367.243 to the Health and Safety Code, and to add Section 10123.192 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 369, as introduced, Huffman. Health care coverage: prescription drugs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the 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 provides for the regulation of health insurers by the Department of Insurance. Commonly referred to as utilization review, existing law governs the procedures that apply to every health care service plan and health insurer that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees or insureds, as specified.

Existing law also imposes various requirements and restrictions on health care service plans and health insurers, including, among other things, requiring a health care service plan that provides prescription drug benefits to maintain an expeditious process by which prescribing providers, as described, may obtain authorization for a medically
necessary nonformulary prescription drug, according to certain procedures. Existing law also requires every health care service plan that provides prescription drug benefits that maintains one or more drug formularies to provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary.

This bill would impose specified requirements on health care service plans or health insurers that restrict medications for the treatment of pain pursuant to step therapy or fail first protocol. The bill would authorize the duration of any step therapy or fail first protocol to be determined by the prescribing physician and would prohibit a health care service plan or health insurer from requiring that a patient try and fail on more than two pain medications before allowing the patient access to other pain medication prescribed by the physician, as specified.

Because a willful violation of the bill’s provisions relative to health care service plans 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.


The people of the State of California do enact as follows:

SECTION 1. Section 1367.243 is added to the Health and Safety Code, to read:

1367.243. (a) Notwithstanding any other provision of law, a health care service plan that restricts medications for the treatment of pain pursuant to step therapy or fail first protocol shall be subject to the requirements of this section.

(b) The duration of any step therapy or fail first protocol shall be determined by the prescribing physician.

(c) The health care service plan shall not require a patient to try and fail on more than two pain medications before allowing the patient access to the pain medication, or generically equivalent drug, prescribed by the physician.

(d) Once a patient has tried and failed on two pain medications, prior authorization is no longer required and the physician may
write the prescription for the appropriate pain medication. A note
in the patient’s chart that a patient has tried and failed on the health
care service plan’s step therapy or fail first protocol shall suffice
as prior authorization from the plan.
(e) When the physician notes on the prescription that the health
care service plan’s step therapy or fail first protocols have been
met, a pharmacist may process the prescription without additional
communication with the plan.
(f) For the purposes of this section, “generically equivalent
drug” means drug products with the same active chemical
ingredients of the same strength, quantity, and dosage form, and
of the same generic drug name, as determined by the United States
Adopted Names and accepted by the federal Food and Drug
Administration, as those drug products having the same chemical
ingredient.
(g) This section does not prohibit a health care service plan from
charging a subscriber or enrollee a copayment or a deductible for
prescription drug benefits or from setting forth, by contract,
limitations on maximum coverage of prescription drug benefits,
provided that the copayments, deductibles, or limitations are
reported to, and held unobjectionable by, the director and
communicated to the subscriber or enrollee pursuant to the
disclosure provisions of Section 1363.
(h) Nothing in this section shall be construed to require coverage
of prescription drugs not in a plan’s drug formulary or to prohibit
generically equivalent drugs or generic drug substitutions as
authorized by Section 4073 of the Business and Professions Code.
SEC. 2. Section 10123.192 is added to the Insurance Code, to
read:
10123.192. (a) Notwithstanding any other provision of law,
a health insurer that restricts medications for the treatment of pain
pursuant to step therapy or fail first protocol shall be subject to the
requirements of this section.
(b) The duration of any step therapy or fail first protocol shall
be determined by the prescribing physician.
(c) The health insurer shall not require a patient to try and fail
on more than two pain medications before allowing the patient
access to the pain medication, or generically equivalent drug,
prescribed by the physician.
(d) Once a patient has tried and failed on two pain medications, prior authorization is no longer required and the physician may write the prescription for the appropriate pain medication. A note in the patient’s chart that a patient has tried and failed on the health insurer’s step therapy or fail first protocol shall suffice as prior authorization from the insurer.

(e) When the physician notes on the prescription that the health insurer’s step therapy or fail first protocols have been met, a pharmacist may process the prescription without additional communication with the insurer.

(f) For the purposes of this section, “generically equivalent drug” means drug products with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name, as determined by the United States Adopted Names and accepted by the federal Food and Drug Administration, as those drug products having the same chemical ingredient.

(g) This section does not prohibit a health insurer from charging an insured or policyholder a copayment or a deductible for prescription drug benefits or from setting forth, by contract, limitations on maximum coverage of prescription drug benefits, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and communicated to the insured or policyholder pursuant to the disclosure provisions of Section 10603.

(h) Nothing in this section shall be construed to require coverage of prescription drugs not in an insurer’s drug formulary or to prohibit generically equivalent drugs or generic drug substitutions as authorized by Section 4073 of the Business and Professions Code.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB 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.