CAHP IMPLEMENTATION GUIDELINE

AB 2352 (Nazarian)
Chapter 590, Statutes of 2022

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

PRESCRIPTION DRUG COVERAGE

BACKGROUND

Assembly Bill 2352 was introduced by Assemblymember Adrin Nazarian (D-North Hollywood) and sponsored by the Chronic Care Coalition and supported by the pharmaceutical industry. The measure requires health plans and insurers to furnish specified information about a prescription drug upon request by an enrollee or their health care provider.

The stated intent behind AB 2352 is to ensure patients and their healthcare providers receive accurate, patient-specific pharmacy benefit cost and coverage information at the point of care, empowering them to make informed medical decisions that will lead to better health outcomes. AB 2352 is a repeat of a CAHP opposed bill from 2021, AB 752 (Nazarian), that was stopped in the Assembly Appropriations Committee.

Health plans recognized the idea of providing useful information to consumers to assist them in making important decisions about their prescription drugs. CAHP nevertheless took an Oppose unless Amended position on the initial version of AB 2352 because it was administratively burdensome to implement and would not have achieved its intended goals.

CAHP removed its opposition to the bill late in the legislative session after a series of amendments were included. Among several other changes, the Assembly Health Committee deleted provisions that seemingly required vendor and technology specific disclosures of the information. Amendments were added that were intended to allow more flexibility in ensuring enrollee access to information.

AB 2352 was very popular in the Legislature. The bill passed both houses with almost unanimous support.

REQUIREMENTS

AB 2352 adds Section 1367.207 to the Health and Safety Code, and adds Section 10123.204 to the Insurance Code, relating to health care coverage.

Specifically, AB 2352 does the following:

1) Requires a health plan contracts or health insurance policies issued, amended, delivered, or renewed on or after July 1, 2023, that provides prescription drug benefits and maintains one or more drug formularies to do all the following:

    a) Upon request of an enrollee/insured or an enrollee's/insured's prescribing provider, furnish all the following information regarding a prescription drug to the enrollee/insured or the enrollee's/insured's health care provider:

        i) The enrollee's/insured's eligibility for the prescription drug;

        ii) The most current formulary or formularies;

        iii) Cost-sharing information for the prescription drug and other formulary alternatives, consistent with cost-sharing requirements as set forth in the contract and accurate at the time it is provided, including any variance in cost sharing based on the patient's preferred dispensing pharmacy, whether retail or mail order, or the health care provider; and,

        iv) Applicable utilization management requirements for the prescription drug and other formulary alternatives.

    b) Respond in real time to a request made through a "Standard Application Programming Interface (API)," as defined;

    c) Allow the use of an interoperability element to provide the required information;

    d) Ensure that the information provided is current no later than one business day after a change is made and is provided in real time; and,

    e) Provide the information if the request is made using the drug's unique billing code and National Drug Code.

2) Prohibits a health plan or insurer from doing any of the following:

    a) Denying or delaying a response to a request for the purpose of blocking the release of the information;

    b) Restricting, prohibiting, or otherwise hindering a prescribing provider from communicating or sharing information to an enrollee, including additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the enrollee's health plan contract or insured's health insurance policy, and, information about the cash price of the drug;

    c) Except as required by law, interfering with, preventing, or materially discouraging access, exchange, or use of the information in 1) above, which includes charging fees for access to the information, not responding to a request at the time made consistent with this bill, or instituting enrollee/insured consent requirements;

d) Penalizing a prescribing provider for disclosing the information, which includes an action intended to punish a provider for disclosing the information set forth in this bill or intended to discourage a provider from disclosing this information in the future; and,

e) Penalizing a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug, which includes an action intended to punish a provider who has prescribed, administered, or ordered a lower cost or clinically appropriate alternative drug, or intended to discourage a provider from prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug in the future.

3) Establishes the following definitions:

a) "Cost-sharing information" is the actual out-of-pocket amount an enrollee or insured would be required to pay a dispensing pharmacy or prescribing provider for a prescription drug under the terms of the enrollee's contract or insured's policy;

b) "Interoperability element" means integrated technologies or services necessary to provide a response to an enrollee/insured or an enrollee's/insured's prescribing provider;

c) "Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition including prescriptions to treat mental health and substance use disorders, for a health plan enrollee or insured; and,

d) "Standard API" means an application interface that is standardized for vendors to conform to in order to access the information, pursuant to federal regulations.

4) Prohibits this bill from being construed to authorize further disclosure inconsistent with HIPAA and CMIA.

COMPLIANCE DATES

Plans will be required to implement the provisions of this bill beginning on July 1, 2023.

IMPLEMENTATION ISSUES

Applicability:

This law applies to all health care service plans and health insurers that provide prescription drug benefits and maintain one or more drug formularies.

Implementation Issues:

Health and Safety Code section 1367.207 will require health plans to respond to requests for prescription drug information made by an enrollee/insured or their prescribing provider. There is an interoperability element requiring these responses to be provided "in real time" through a standard API as defined above.

Health plans will need to ensure administrative processes are in place to accommodate requests and responses in the form and format required. Additionally, plans should ensure adequate monitoring of formulary information, cost-sharing information, and utilization management (UM) requirements for

prescription drugs so the response can be current no later than one business day after changes are made.

All disclosures made pursuant to the requirements of this bill must still be in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) and the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

Plans and contracted vendors should ensure that the API being utilized conforms to the standards and implementation specifications found in Section 170.215 of Title 45 of the Code of Federal Regulations.

Plans should also review their internet websites, member handbooks/Evidence of Coverage (EOC), and any contracts with providers, vendors, etc. and update them accordingly.