SPONSOR: Sen. Mantzavinos & Rep. Griffith & Rep. Heffernan & Rep. Dorsey Walker
Sens. Ennis, Gay, Hansen, Pinkney, Poore; Reps. Bolden, Bush, K. Johnson, Minor-Brown, Mitchell, Osienski, Michael Smith, K. Williams, Wilson-Anton

DELAWARE STATE SENATE
151st GENERAL ASSEMBLY

SENATE BILL NO. 267
AS AMENDED BY
HOUSE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE TO ENSURE FAIRNESS IN COST-SHARING FOR PRESCRIPTION DRUGS.

WHEREAS, some residents of Delaware rely on state-regulated commercial carriers to secure access to the prescription medicines needed to protect their health; and

WHEREAS, commercial insurance designs may require patients to bear significant out-of-pocket costs for their prescription medicines; and

WHEREAS, high out-of-pocket costs on prescription medicines may impact the ability of patients to start new and necessary medicines and to stay adherent to their current medicines; and

WHEREAS, high or unpredictable cost-sharing requirements are a main driver of elevated patient out-of-pocket costs and may allow carriers to capture discounts and price concessions that are intended to benefit patients at the pharmacy counter; and

WHEREAS, carriers may increase cost-sharing burdens on patients by refusing to count third party assistance toward patients' cost-sharing contributions; and

WHEREAS, the burdens of high or unpredictable cost-sharing requirements are borne disproportionately by patients with chronic or debilitating conditions; and

WHEREAS, restrictions are needed on the ability of carriers and intermediaries to use unfair cost-sharing design to retain rebates and price concessions that instead should be passed on to patients as cost savings; and

WHEREAS, patients need equitable and accessible health coverage that does not impose unfair cost-sharing burdens upon them; and

WHEREAS, it is important that, to the full extent permissible and consistent with applicable law, state-regulated carriers and the entities with which they contract do not restrict patient access to medicines through the consumer-unfriendly practice of refusing to count third party cost-sharing assistance toward patient cost-sharing obligations.

NOW, THEREFORE:

SD : FJM : ALW : 2711510014
LC : HVW : CBM : 5081510300
Released: 06/30/2022 06:10 PM

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating accordingly:

§ 3350B. Copayment or coinsurance for prescription drugs limited.

(a) Definitions.

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(2) "Contract price" means the lowest price a pharmacy is paid for the acquisition of a prescription drug based on a contract that a pharmacy has with a carrier or pharmacy benefits manager. "Contract price" includes a dispensing fee set by a contract between a pharmacy and a carrier or pharmacy benefits manager.

(3) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(4) "Health benefit plan" means as defined in § 3343 of this title.

(5) "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) "Person" means as defined in § 102 of this title.

(~~3~~7) "Pharmacy" means as defined in § 2502 of Title 24.

(4~~8~~) "Pharmacy benefit manager" means as defined under § 3302A of this title.

(b) Application.- This section applies to a carrier that provides coverage, either directly or through a pharmacy benefits manager, for prescription drugs under a health insurance policy, health benefit plan, or contract that is issued or delivered in this State.

(c) A carrier subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of 1 of the following:

(1) The applicable copayment or coinsurance that would apply for the prescription drug in the absence of this section.

(2) The amount an individual would pay for the prescription drug if the individual were paying the usual and customary price.

(3) The contract price for the prescription drug.

(d) Cost-Sharing Calculation. When calculating an enrollee contribution to any applicable cost sharing requirement, a carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under § 223 of the federal Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under § 223, except with respect to items or services that are preventive care pursuant to § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under § 223 has been satisfied.

(f) Rule-Making. The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

Section 2. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating accordingly:

§ 3566A. Copayment or coinsurance for prescription drugs limited.

(a) Definitions.

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(2) "Contract price" means the lowest price a pharmacy is paid for the acquisition of a prescription drug based on a contract that a pharmacy has with a carrier or pharmacy benefits manager. "Contract price" includes a dispensing fee set by a contract between a pharmacy and a carrier or pharmacy benefits manager.

(3) "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(4) "Health benefit plan" means as defined in § 3343 of this title.

(5) "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) "Person" means as defined in § 102 of this Title.

(~~3~~7) "Pharmacy" means as defined in § 2502 of Title 24.

(4~~8~~) "Pharmacy benefit manager" means as defined under § 3302A of this title.

(b) Application.- This section applies to a carrier that provides coverage, either directly or through a pharmacy benefits manager, for prescription drugs under a health insurance policy, health benefit plan, or contract that is issued or delivered in this State.

(c) A carrier subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following:

(1) The applicable copayment or coinsurance that would apply for the prescription drug in the absence of this section.

(2) The amount an individual would pay for the prescription drug if the individual were paying the usual and customary price.

(3) The contract price for the prescription drug.

(d) Cost-Sharing Calculation. When calculating an enrollee contribution to any applicable cost sharing requirement, a carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under § 223 of the federal Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under § 223, except with respect to items or services that are preventive care pursuant to § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under § 223 has been satisfied.

(f) Rule-Making. The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

Section 3. Amend Chapter 33A, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

Subchapter III. Fairness in Cost-Sharing for Pharmacy Benefits Managers.

§ 3381A. Definitions.

For purposes of this subchapter:

(1) “Cost-sharing requirement” means any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health benefit plan.

(2) “Enrollee” means any individual entitled to health care services from an insurer.

(3) “Health benefit plan” means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(4) “Health care service” means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) “Insurer” means as defined under § 3321A of this title.

(6) “Person” means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

(7) “Pharmacy benefits manager” means as defined under § 3302A of Title 18, and shall include any person, business, or other entity that, pursuant to a contract or under an employment relationship with an insurer, either directly or through an intermediary, manages the prescription drug benefit provided by the insurer, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, and/or controlling the cost of covered prescription drugs.

§ 3382A. Fairness in Cost-Sharing.

(a) Cost-Sharing Calculation. When calculating an enrollee’s contribution to any applicable cost-sharing requirement, a pharmacy benefits manager shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under § 223 of the federal Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under § 223, except with respect to items or services that are preventive care pursuant to § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under § 223 has been satisfied.

(c) Rule-Making. The Insurance Commissioner may promulgate rules and regulations as may be necessary or appropriate to implement and administer this section.

Section 4. This Act is effective immediately and applies to health benefit plans that are entered into, amended, extended, or renewed on or after January 1, 2024.