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DELAWARE STATE SENATE
151st GENERAL ASSEMBLY

SENATE BILL NO. 265

AN ACT TO AMEND TITLE 18 AND TITLE 29 OF THE DELAWARE CODE TO ENSURE FAIRNESS IN COST-SHARING FOR PRESCRIPTION DRUGS.

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

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

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

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

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

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

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

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

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

21 NOW, THEREFORE:

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

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 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 cost-sharing limitation under 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.

~~(37)~~ "Pharmacy" means as defined in § 2502 of Title 24.

~~(48)~~ "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 a covered person's 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 section 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 section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 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 section 223 of the federal Internal Revenue Code has been satisfied.

(c) Effective Date. This section shall apply with respect to health benefit plans that are entered into, amended, extended, or renewed on or after January 1, 2024.

(d) Implementation of this section is limited to the regulation of carriers to the extent permitted by law.

(e) 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:

§ 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 cost-sharing limitation under 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.

(37) “Pharmacy” means as defined in § 2502 of Title 24.

(48) “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 a covered person’s 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 section 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 section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 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 section 223 of the federal Internal Revenue Code has been satisfied.

(c) Effective Date. This section shall apply with respect to health benefit plans that are entered into, amended, extended, or renewed on or after January 1, 2024.

(d) Implementation of this section is limited to the regulation of carriers to the extent permitted by law.

(e) 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 VIII. 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 cost-sharing limitation under 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 a 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 a carrier 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” shall include any person, business, or other entity that, pursuant to a contract or under an employment relationship with an insurer, either directly or indirectly, manages the prescription drug benefit provided by the insurer, including but not limited to 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 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 section 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 section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 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 section 223 of the federal Internal Revenue Code has been satisfied.

(b) Effective Date. This section shall apply with respect to health benefit plans that are entered into, amended, extended, or renewed on or after January 1, 2024.

(c) In implementing the requirements of this section, the state shall only regulate a pharmacy benefits manager to the extent permissible under applicable law.

(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. Amend Chapter 52, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 5215A. Fairness in Cost-Sharing.

(a) For purposes of this section:

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

(2) “Covered individual” means any individual entitled to health care services from the plan.

(3) “The Plan” means the basic health-care insurance plan for state employees provided under this chapter.

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

(b) Cost-Sharing Calculation. When calculating a covered individual’s contribution to any applicable cost-sharing requirement, the plan shall include any cost-sharing amounts paid by the covered individual or on behalf of the covered individual by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under section 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 covered individual has satisfied the minimum deductible under section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 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 section 223 of the federal Internal Revenue Code has been satisfied.

(c) Effective Date. This section shall apply with respect to coverage offered under the plan that is entered into, amended, extended, or renewed on or after January 1, 2024.

(d) Implementation of this section is limited to the regulation of carriers to the extent permitted by law.

171 (e) Rule-Making. The State Employee Benefit Committee may promulgate rules and regulations as may be
172 necessary or appropriate to implement and administer this section.

SYNOPSIS

The bill requires that third-party cost-sharing assistance utilized by patients is applied toward the covered person's health insurance deductibles and any out-of-pocket limits. Additionally, the bill defines what constitutes a "cost-sharing requirement" as well as how to calculate the assistance when applying to the patient's deductibles and out-of-pocket limits. This bill applies to both carriers and pharmacy benefits managers with an effective date of January 1, 2024.

Author: Senator Mantzavinos