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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

A N A C T

RELATING TO INSURANCE - PRESCRIPTION DRUG BENEFITS

Introduced By: Representatives Kennedy, Ruggiero, Azzinaro, Canario, and Shekarchi

Date Introduced: February 12, 2020

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-20.8-1 and 27-20.8-2 of the General Laws in Chapter 27-20.8 entitled "Prescription Drug Benefits" are hereby amended to read as follows:

27-20.8-1. Definitions.

For the purposes of this chapter, the following terms shall mean:

(1) "Director" shall mean the director of the department of business regulation.

(2) "Health plan" shall mean an insurance carrier as defined in chapters 18, 19, 20 and 41 of this title.

(3) "Insured" shall mean any person who is entitled to have pharmacy services paid by a health plan pursuant to a policy, certificate, contract or agreement of insurance or coverage including those administered for the health plan under a contract with a third-party administrator that manages pharmacy benefits or pharmacy network contracts.

(4) "Out-of-pocket expenditure" means a co-payment, coinsurance, deductible, or other cost-sharing mechanism.

(5) "Pharmacy benefit manager" or "PBM" means an entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any carrier that provides prescription drug benefits to residents of this state.

27-20.8-2. Pharmacy benefit, limits and co-payments.

Any health plan that offers pharmacy benefits shall comply with the following:

(a) When a health plan's pharmacy benefit has a dollar limit, the insured's use of such

benefit shall be determined based on the health plan's contracted rate to purchase the drug minus the enrollee's applicable co-payment for covered drugs. The balance will apply towards the enrollee's dollars limit.

(b) When a health plan charges a co-payment for covered prescription drugs that is based on a percent of the drug cost, the health plan shall disclose within the group policy or individual policy benefits description statement whether the co-payment is based on the plan's contracted rate to purchase the drug or some other cost basis such as retail price.

(c) Health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall not include an annual dollar limit on prescription drug benefits.

(d) A health plan or other health benefit plan offered by a health insurer or pharmacy benefit manager shall limit a beneficiary's out-of-pocket expenditures for prescription drugs, including specialty drugs, to no more for self-only and family coverage per year than the minimum dollar amounts in effect under § 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage.

(e) For prescription drug benefits offered in conjunction with a high-deductible health plan (HDHP), the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under § 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (d) of this section.

(f) The health insurance commissioner may use any of their enforcement powers to obtain a carrier's compliance with this section.

SECTION 2. This act shall take effect upon passage and shall apply to all health plans pursuant to a policy, certificate, contract or agreement of insurance or coverage including those administered for health plans under a contract with a third-party administrator that manages pharmacy benefits or pharmacy network contracts issued on or after January 1, 2021.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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This act would limit a beneficiary's out-of-pocket expenditures for prescription drugs to limits established for self-only and family coverage per year contained in the Internal Revenue Code.

This act would take effect upon passage and would apply to all health plans pursuant to a policy, certificate, contract or agreement of insurance or coverage including those administered for health plans under a contract with a third-party administrator that manages pharmacy benefits or pharmacy network contracts issued on or after January 1, 2021.

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