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SENATE BILL NO. 573

Offered January 8, 2020

Prefiled January 7, 2020

A BILL to amend and reenact § 38.2-3407.20 of the Code of Virginia, relating to health plans; calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement; rebates.

Patron—Dunnavant

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.20 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3407.20. Calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.

A. As used in this section:

"Carrier" shall have the meaning set forth in § 38.2-3407.10; however, "carrier" also includes any person required to be licensed under this title that offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance under this title.

"Cost sharing" means any coinsurance, copayment, or deductible.

"Enrollee" means any person entitled to health care services from a carrier.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under this title. "Health plan" does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Pharmacy benefits manager" has the same meaning as provided in § 38.2-3407.15:4.

"Price protection rebate" means a negotiated price concession that accrues directly or indirectly to the insurer, or other party on behalf of the insurer, in the event of an increase in the wholesale acquisition cost of a drug above a specified threshold.

"Rebate" means (i) negotiated price concessions, including base price concessions and reasonable estimates of any price protection rebates and performance-based price concessions, that may accrue directly or indirectly to the carrier or its pharmacy benefits manager during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug and (ii) reasonable estimates of any negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the carrier and serve to reduce the carrier's liabilities for a prescription drug.

B. To the extent permitted by federal law and regulation, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a carrier shall include *(i)* any amounts paid by the enrollee or paid on behalf of the enrollee by another person *and (ii) the amount of any rebates received or to be received by the carrier or its pharmacy benefits manager in connection with the dispensing or administration of a prescription drug*.

C. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2020.

D. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.