MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representative Zuber To: Insurance

HOUSE BILL NO. 880

AN ACT TO CREATE NEW SECTIONS 83-9-6.5, AND 83-9-6.6, MISSISSIPPI CODE OF 1972, TO REDUCE PATIENTS' COST FOR PRESCRIPTION DRUGS BY ENSURING THAT STATE-REGULATED INSURERS AND PHARMACY BENEFITS MANAGERS APPLY COST-SHARING ASSISTANCE TO PATIENTS' COST-SHARING OBLIGATIONS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following shall be codified as Section 83-9-6.5, Mississippi Code of 1972:

83-9-6.5. (1) For purposes of this section, the following words and phrases shall have the following meanings unless the context clearly indicates otherwise:

(a) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing, including, but not limited to, a limitation subject to 42 USC Section 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.

(b) "Enrollee" means any individual entitled to health care services from an insurer.

(c) "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.

(d) "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.

(e) "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 USC Section 300gg-91, or any state or local governmental employer plan.

(f) "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.

(2) When calculating an enrollee's contribution to any applicable cost sharing requirement, an insurer 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 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, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under Section 223 has been satisfied.

(3) In implementing the requirements of this section, the state shall only regulate an insurer to the extent permissible under applicable law.

(4) The Commissioner of Insurance may promulgate rules and regulations as necessary to implement this section.

SECTION 2. The following shall be codified as Section 83-9-6.6, Mississippi Code of 1972:

83-9-6.6. (1) For purposes of this section, the following words and phrases shall have the following meanings unless the context clearly indicates otherwise:

(a) "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 USC Section 300gg-91, or any state or local governmental employer plan.

(b) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing, including but not limited to, a limitation subject to 42 USC Section 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.

(c) "Enrollee" means any individual entitled to health care services from an insurer.

(d) "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.

(e) "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.

(f) "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.

(g) "Pharmacy benefits manager" means 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, 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/or controlling the cost of covered prescription drugs.

(2) 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 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, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under Section 223 has been satisfied.

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

(4) The Commissioner of Insurance may promulgate rules and regulations as necessary to ensure compliance with this section.

SECTION 3. For purposes of this section, the following words and phrases shall have the following meanings unless the context clearly indicates otherwise:

(a) "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 USC Section 300gg-91, or any state or local governmental employer plan.

(b) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 USC Section 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.

(c) "Enrollee" means any individual entitled to health care services from an insurer.

(d) "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.

(e) "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.

(f) "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.

(g) "Pharmacy benefits manager" means 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, 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/or controlling the cost of covered prescription drugs.

SECTION 4. (1) 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, 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 has been satisfied.

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

(3) Rule-Making. The State Board of Pharmacy may adopt rules and regulations necessary to ensure compliance with this section.

SECTION 5. This act shall take effect and be in force with respect to health benefit plans that are entered into, amended, extended, or renewed on or after January 1, 2022.