LEGISLATURE OF THE STATE OF IDAHO

Sixty-eighth Legislature First Regular Session - 2025

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 353

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; AMENDING CHAPTER 3, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 41-351, IDAHO CODE, TO ESTABLISH PROVISIONS REGARDING COST-SHARING REQUIREMENTS FOR HEALTH BENEFIT PLANS; AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 3, Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 41-351, Idaho Code, and to read as follows:

41-351. COST-SHARING REQUIREMENTS FOR HEALTH BENEFIT PLANS. (1) As used in this section, "cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing required by a health benefit plan for a specific health care service covered by the health benefit plan.

(2) When calculating an enrollee's contribution to any applicable cost-sharing requirement for a covered prescription drug, an insurer shall include any cost-sharing amounts paid:

(a) By the enrollee; or

(b) On behalf of the enrollee by another party.

(3) If a manufacturer pays an amount on behalf of an enrollee or provides other financial assistance for a covered prescription drug, such manufacturer:

(a) Shall provide the full value of the assistance to the enrollee until the enrollee meets the enrollee's cost-sharing requirements, and to the enrollee's health benefit plan thereafter;

(b) May not discontinue a coupon during the calendar year;

(c) Shall notify an enrollee prior to October 1 if financial assistance will be discontinued in the subsequent calendar year;

(d) Shall provide assistance to an individual without health insurance coverage on terms no less favorable than those offered to an insured individual;

(e) May not adjust the amount of assistance it provides to an enrollee if the enrollee's health benefit plan eliminates the enrollee's cost-sharing requirements when payments are made on an enrollee's behalf for a qualified prescription drug; and

(f) May not provide assistance in the form of a post-claim reimbursement to an enrollee.

(4) On or before August 1, 2027, and on or before August 1 of each year thereafter, a manufacturer shall report to the department of insurance the following information for the preceding calendar year for each prescription drug for which assistance, including a discount, rebate, product voucher, or other reduction intended to lower an insured's cost-sharing, is offered:

(a) The number of patients in the state who received assistance;

(b) The total value of such assistance;

(c) The terms and conditions to qualify for assistance and how the eligibility is verified for accuracy; and

(d) The total sales of the prescription drug in the state, based on the wholesale acquisition cost of the prescription drug.

(5) This section applies to any health benefit plan entered into, amended, extended, or renewed on or after January 1, 2027, and applies to a qualified high-deductible health plan only after an enrollee satisfies the deductible of such plan.

(6) The provisions of this section shall not apply to a prescription drug if:

(a) There is a medically appropriate generic equivalent or biosimilar prescription drug that is covered under the health benefit plan; and

(b) The patient's doctor has indicated that the medically appropriate generic equivalent or biosimilar prescription drug is appropriate for the patient.

(7) The department of insurance may promulgate rules, subject to legislative approval, to carry out the provisions of this section.

SECTION 2. This act shall be in full force and effect on and after January 1, 2027.