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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1609 Session of 2011

INTRODUCED BY VEREB, SAYLOR, GINGRICH, CALTAGIRONE, BRENNAN, DALEY, FABRIZIO, GEORGE, HELM, JOSEPHS, MILLARD, PICKETT, VULAKOVICH AND WAGNER, JUNE 6, 2011

REFERRED TO COMMITTEE ON INSURANCE, JUNE 6, 2011

AN ACT

1 Providing requirements for insurers relating to prescription
2 drug coverage.

3 The General Assembly of the Commonwealth of Pennsylvania
4 hereby enacts as follows:
5 Section 1. Legislative findings and intent.
6 (a) Findings.--The General Assembly finds as follows:
7 (1) As prescription drug prices continue to escalate,
8 other states have experienced the creation by insurers of a
9 new cost-sharing mechanism known as prescription drug
10 specialty tiers.
11 (2) Many insurers use a three-tiered drug formulary
12 structure that provides fixed cost prescription drug benefits
13 to insureds, based on generic, brand-name preferred and
14 brand-name nonpreferred designations.
15 (3) Specialty tiers include the costly prescription
16 drugs to which some insurers are instituting percentage cost
17 prescription drug benefits that are causing some insureds to

1 pay more than $3,000 for one month's supply of medication.
2 (4) Such drugs are typically new, infusible biologics or
3 plasma-derived therapies produced in lesser quantities than
4 other drugs and not available as less costly brand name or
5 generic prescription drugs.
6 (5) The cost-sharing, deductible and coinsurance
7 obligations for certain drugs have become cost prohibitive
8 for insureds trying to overcome serious disease such as
9 cancer, hemophilia, multiple sclerosis, myositis, neuropathy,
10 primary immunodeficiency disease and rheumatoid arthritis.
11 (6) Insurers are also increasing prescription drug
12 copays to amounts beyond the reach of most insureds and if an
13 insurer utilizes the three-tiered drug formulary, the amounts
14 charged for brand-name nonpreferred and specialty drug copays
15 should not have the effect of unfairly denying access to
16 prescription drugs covered by the health benefit plan and
17 should not cost more than is necessary to provide a
18 reasonable incentive for insureds to use brand-name preferred
19 prescription drugs.
20 (7) Paying hundreds or even thousands of dollars each
21 month for prescription drugs would be a strain for any
22 person, but for people with chronic illnesses and life-
23 threatening conditions, this unfortunate social policy has
24 the potential to destroy a family's financial solvency or end
25 the ability to take a necessary medication. Specialty tiers
26 are contrary to the original purpose of insurance, which was
27 the spreading of costs. Specialty tiers create a structure
28 where those who are sickest pay more, and those who are
29 healthy pay less, thus, the creation of specialty tiers is a
30 discriminatory practice.

(b) Intent.--It is the intent of the General Assembly that every insured have access to reasonable prescription drug benefits and that the creation of specialty tiers will prevent the achievement of that intent.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Health benefits plan." An arrangement for the delivery of health care, on an individual or group basis, in which a health carrier undertakes to provide, arrange for, pay for or reimburse any of the costs of health care services for a covered person that is offered or governed under this act or the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(2) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Insurer." An insurer delivering, issuing for delivery or renewing in this Commonwealth a health benefit plan that provides prescription drug coverage.

Section 3. Prohibitions.

(a) Payment restrictions.--An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs.

(b) Copay restrictions.--An insurer shall not establish tiers of prescription drug copays in which the maximum

1 prescription drug copay exceeds by more than 500% the lowest
2 prescription drug copay charged under the health benefit plan.
3 (c) Out-of-pocket expense.--If an insurer's health benefit
4 plan provides a limit for out-of-pocket expenses for benefits
5 other than prescription drugs, the insurer shall include one of
6 the following provisions in the plan that would result in the
7 lowest out-of-pocket prescription drug cost to the insured:
8 (1) out-of-pocket expenses for prescription drugs shall
9 be included under the plan's total limit for out-of-pocket
10 expenses for all benefits provided under the plan; or
11 (2) out-of-pocket expenses for prescription drugs per
12 contract year shall not exceed $1,000 per insured or $2,000
13 per insured family, adjusted for inflation.
14 Section 4. Applicability.
15 This act shall apply to all health benefit plans delivered or
16 issued for delivery or renewed on or after January 1, 2012.
17 Section 5. Regulations.
18 Except as provided in section 6, the Insurance Department
19 shall enforce this act. The department shall promulgate rules
20 and regulations to carry out the purposes of this act.
21 Section 6. Additional costs.
22 The Insurance Department shall cease enforcement of this act
23 if it determines that the requirements of this act will result
24 in the assumption by the Commonwealth of additional costs
25 pursuant to section 10104(e) of Title X of the Patient
26 Protection and Affordable Care Act (Public Law 111-148).
27 Section 7. Effective date.
28 This act shall take effect in 60 days.