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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 841 Session of 2015

INTRODUCED BY MENSCH, SCHWANK, VULAKOVICH, McILHINNEY, RAFFERTY, TARTAGLIONE, BOSCOLA, LEACH, KITCHEN AND McGARRIGLE, MAY 28, 2015

REFERRED TO BANKING AND INSURANCE, MAY 28, 2015

AN ACT

Providing requirements for insurers relating to prescription drug coverage; and conferring powers and imposing duties on the Insurance Department.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. 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 benefit plan." An arrangement for the delivery of health care, on an individual or group basis, in which a health care 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).

"Nonpreferred prescription drug." A prescription drug deemed nonpreferred by the health benefit plan and subject to higher cost sharing than preferred prescription drugs.

"Preferred prescription drug." A prescription drug deemed preferred by the health benefit plan and subject to lower cost sharing than nonpreferred prescription drugs.

"Specialty tier prescription drug." A prescription drug for which a health benefit plan imposes cost sharing in excess of preferred prescription drugs and nonpreferred prescription drugs.

"Tiered formulary." A formulary that provides prescription drug coverage, as part of a health benefit plan, for which cost sharing is determined by the category or tier of the prescription drug.

Section 2. Specialty tier prescription drug requirements.

(a) Maximum limitations.--A health benefit plan that provides coverage for prescription drugs shall ensure that any required copayment or coinsurance applicable to a specialty tier prescription drug does not exceed $100 per month for a 30-day supply of the specialty tier drug. The aggregate cost of all specialty tier prescription drugs required by an insured may not exceed $200 per month.

(b) Classification.--A health benefit plan that provides coverage for prescription drugs may not place all prescription drugs of the same class in a specialty tier.

Section 3. Cost-sharing exception.

(a) General rule.--A health benefit plan that provides coverage for prescription drugs and utilizes a tiered formulary shall implement an exceptions process that allows an insured to request an exception to the tiered cost-sharing structure.

(b) Requirements.--To qualify for an exception to the tiered cost-sharing structure, the insured must provide evidence that the insured's prescribing physician has determined that:

(1) the preferred prescription drug would not be as effective as a nonpreferred prescription drug used to treat the same condition; or

(2) the preferred prescription drug would have adverse effects for the insured.

(c) Review.--The Insurance Department shall establish and administer an independent external review process for review of denials to a cost-sharing exception request.

Section 4. Regulations.

The Insurance Department shall promulgate regulations necessary to administer this act.

Section 5. Construction.

The following shall apply:

(1) Nothing in this act shall be construed to require a health benefit plan to:

(i) Provide coverage for any additional prescription drugs not otherwise required by law.

(ii) Implement specific utilization management techniques such as prior authorization or step therapy.

(iii) Cease utilization of tiered cost-sharing structures, including strategies used to encourage use of preventive services, disease management and low-cost

treatment options.

(2) Nothing in this act shall be construed to require a pharmacist to substitute a prescription drug without the written consent of the prescribing physician.

Section 6. Applicability.

This act shall apply to all health benefit plans delivered or issued for delivery or renewed on or after the effective date of this section.

Section 7. Effective date.

This act shall take effect in 60 days.