SENATE DOCKET, NO. 01351 FILED ON: 01/21/2011

SENATE . . . . . No. 00455

The Commonwealth of Massachusetts

PRESENTED BY:

Anthony W. Petruccelli

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act reforming insurance prescription fee practices.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Anthony W. Petruccelli	*First Suffolk and Middlesex*
Eileen M. Donoghue	*First Middlesex*

SENATE . . . . . No. 00455

By Mr. Petruccelli, petition (accompanied by bill, Senate, No. 455) of Donoghue and Petruccelli for legislation to reform insurance prescription fee practices [Joint Committee on Financial Services].

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act reforming insurance prescription fee practices.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 108 of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following 4 paragraphs:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The division may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.

SECTION 2. Section 110 of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following 4 paragraphs:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The division may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.

SECTION 3. Chapter 176A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer

shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The department may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.

SECTION 4. Chapter 176B of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the maximum prescription drug copay exceeds by more than five hundred percent the lowest

prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The division may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.

SECTION 5. Chapter 176G of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the

maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The division may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.

SECTION 6. Chapter 176I of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

(1) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the

maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost to the insured:

(a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or

(b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.

(2) For purposes of this section:

Health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance; and

(i) Insurer means an insurer delivering, issuing for delivery, or renewing in this state a health benefit plan that provides prescription drug coverage.

(3) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 22 2012.

(4) The Division of Insurance shall enforce this section. The division may adopt and promulgate rules and regulations to carry out the purposes of this section. The division shall cease enforcement of this section if it determines that the requirements of this section will result in the assumption by the state of additional costs pursuant to section 1311(d)(3)(B), as such section was amended by section 6 10104(e) of Title X, of the federal Patient Protection and Affordable 7 Care Act, Public Law 111-148, as amended.