

**SENATE . . . . . No. 00455**

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The Commonwealth of Massachusetts

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PRESENTED BY:

*Anthony W. Petruccelli*

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*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

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**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:*

1           SECTION 1. Section 108 of chapter 175 of the General Laws, as appearing in the 2008  
2 Official Edition, is hereby amended by adding the following 4 paragraphs:-  
  
3           (1) An insurer shall not create specialty tiers that require payment of a percentage cost of  
4 prescription drugs. An insurer shall not establish tiers of prescription drug copays in which the  
5 maximum prescription drug copay exceeds by more than five hundred percent the lowest  
6 prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan  
7 provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer  
8 shall include one of the following provisions in the plan that would result in the lowest out-of-  
9 pocket prescription drug cost to the insured:  
  
10           (a) Out-of-pocket expenses for prescription drugs shall be included under the plan's  
11 total limit for out-of-pocket expenses for all benefits provided under the plan; or

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

15 (2) For purposes of this section:

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

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

23 (b) Credit-only insurance;

24 (c) Coverage for specified disease or illness;

25 (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

57 (2) For purposes of this section:

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

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

65 (b) Credit-only insurance;

66 (c) Coverage for specified disease or illness;

67 (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

99 (2) For purposes of this section:

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

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

107 (b) Credit-only insurance;

108 (c) Coverage for specified disease or illness;

109 (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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

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

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



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

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

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

141 (2) For purposes of this section:

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

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

149 (b) Credit-only insurance;

150 (c) Coverage for specified disease or illness;

151 (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

183           (2) For purposes of this section:

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

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

191           (b) Credit-only insurance;

192           (c) Coverage for specified disease or illness;

193           (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

225 (2) For purposes of this section:

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

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

233 (b) Credit-only insurance;

234 (c) Coverage for specified disease or illness;

235 (d) Limited-scope dental or vision benefits;

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

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

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

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

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

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

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