

SENATE No. 455

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 adoption of the accompanying bill:

An Act reforming insurance prescription fee practices.

PETITION OF:

NAME:

DISTRICT/ADDRESS:

Anthony W. Petruccelli

Eileen M. Donoghue

SENATE No. 455

By Mr. Petruccelli, a petition (accompanied by bill, Senate, No. 455) of Anthony W. Petruccelli and Eileen M. Donoghue for legislation to reform insurance prescription fee practices. 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:

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
59 or 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
143 or 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.