LEGISLATURE OF NEBRASKA

ONE HUNDRED FIRST LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1017

Introduced by Cornett, 45.

Read first time January 20, 2010

Committee: Banking, Commerce and Insurance

A BILL

FOR AN ACT relating to insurance; to provide requirements for insurers for prescription drug coverage; and to provide a duty for the Revisor of Statutes.

Be it enacted by the people of the State of Nebraska,

Section 1. (1) The Legislature finds that:

(a) As prescription drug prices continue to escalate, other states have experienced the creation by insurers of a new cost-sharing mechanism known as prescription drug specialty tiers;

(b) Many insurers use a three-tiered drug formulary structure that provides fixed cost prescription drug benefits to insureds, based on generic, brand-name preferred, and brand-name non-preferred designations;

(c) Specialty tiers include the costly prescription drugs to which some insurers are instituting percentage cost prescription drug benefits that are causing some insureds to pay more than three thousand dollars for one month's supply of medication;

(d) Such drugs are typically new, infusible biologics or plasma-derived therapies produced in lesser quantities than other drugs and not available as less costly brand name or generic prescription drugs; and

(e) The cost-sharing, deductible, and coinsurance obligations for certain drugs have become cost prohibitive for insureds trying to overcome serious disease such as cancer, hemophilia, multiple sclerosis, myositis, neuropathy, primary immunodeficiency disease, and rheumatoid arthritis.

(2) The Legislature further finds that insurers are also increasing prescription drug copays to amounts beyond the reach of most insureds and that if an insurer utilizes the three-tiered drug formulary, the amounts charged for brand-name non-preferred

and specialty drug copays should not have the effect of unfairly denying access to prescription drugs covered by the health benefit plan and should not cost more than is necessary to provide a reasonable incentive for insureds to use brand-name preferred prescription drugs.

(3) It is the intent of the Legislature that every insured have access to reasonable prescription drug benefits and that the creation of specialty tiers will prevent the achievement of that intent.

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

(b) An insurer shall not charge a prescription drug copay that exceeds the cost per prescription of the prescription drug to the health benefit plan or a prescription drug copay that exceeds by five hundred percent the lowest prescription drug copay charged under such plan.

(c) 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:

(i) 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

(ii) 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.

(5) For purposes of this section:

(a) 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:

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

(ii) Credit-only insurance;

(iii) Coverage for specified disease or illness;

(iv) Limited-scope dental or vision benefits;

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

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

(vii) 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

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

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

(6) This section shall apply to all health benefit plans delivered or issued for delivery or renewed on or after January 1, 2011.

(7) The Department of Insurance shall enforce this section. The department may adopt and promulgate rules and regulations to carry out the purposes of this section.

Sec. 2. The Revisor of Statutes shall assign section 1 of this act to Chapter 44, article 7.