LEGISLATURE OF NEBRASKA

ONE HUNDRED SECOND LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 322

Introduced by Cornett, 45.

Read first time January 12, 2011

Committee: Banking, Commerce and Insurance

A BILL

FOR AN ACT relating to insurance; to provide requirements for insurers for prescription drug coverage; to state findings and intent; 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 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) The Legislature further finds that paying hundreds or even thousands of dollars each month for prescription drugs would be a strain for any person, but for people with chronic illnesses and life-threatening conditions, this unfortunate social policy has the potential to destroy a family's financial solvency or end the ability to take a necessary medication. Specialty tiers are contrary to the original purpose of insurance, which was the spreading of costs. Specialty tiers create a structure where those who are sickest pay more, and those who are healthy pay less. Therefor, the creation of specialty tiers is a discriminatory practice.

(4) 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.

(5) The Legislature further intends that the Department of Insurance consider the discriminatory practice of specialty tiers and advise the political subdivisions of the State of Nebraska to not obtain insurance coverage that offers such policies that may restrict the use of life-saving therapies due to the extraordinary disparity in cost-sharing, deductibles, and coinsurance.

Sec. 2. (1)(a) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs.

(b) 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.

(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.

(2) 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.

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

(4) Except as provided in subsection (5) of this section, 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.

(5) The department 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 10104(e) of Title X, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended.

Sec. 3. The Revisor of Statutes shall assign sections 1 and 2 of this act to Chapter 44, article 7.