



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB4477

Introduced 2/4/2020, by Rep. Gregory Harris

SYNOPSIS AS INTRODUCED:

215 ILCS 134/45.3 new

Amends the Managed Care Reform and Patient Rights Act. Requires health insurance carriers that provide coverage for prescription drugs to ensure that, within service areas and levels of coverage specified by federal law, at least half of individual and group plans meet one or more of the following criteria: apply a pre-deductible and flat-dollar copayment structure to the entire drug benefit, limit a beneficiary's monthly out-of-pocket financial responsibility for prescription drugs to a specified amount, or limit a beneficiary's annual out-of-pocket financial responsibility for prescription drugs to a specified amount. Provides that all plans for prescription drugs offered under the amendatory Act must be clearly and appropriately named, marketed in the same manner as other plans offered by the health insurance carrier, and offered for purchase to any individual and group plan sponsor. Effective January 1, 2021.

LRB101 18735 BMS 68190 b

1 AN ACT concerning regulation.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Managed Care Reform and Patient Rights Act
5 is amended by adding Section 45.3 as follows:

6 (215 ILCS 134/45.3 new)

7 Sec. 45.3. Prescription drug benefits; plan choice.

8 (a) Notwithstanding any other provision of law, on and
9 after January 1, 2021, every health insurance carrier that
10 provides coverage for prescription drugs shall ensure that no
11 fewer than 50% of individual and group plans offered within
12 each service area and at each level of coverage as defined in
13 42 U.S.C. 18022, if applicable, that are delivered, issued for
14 delivery, renewed, amended, or continued by the health
15 insurance carrier meet one or more of the following criteria:

16 (1) apply a pre-deductible and flat-dollar copayment
17 structure to the entire drug benefit, including all tiers;
18 the flat-dollar copayment tier structure for prescription
19 drugs under this Section must be graduated and
20 proportionate;

21 (2) limit a beneficiary's monthly out-of-pocket
22 financial responsibility, including any copayment or
23 coinsurance, for prescription drugs, including specialty

1 drugs, to no more than \$150 per month for each prescription
2 drug for up to a 30-day supply of any single drug; the
3 out-of-pocket limit established under this Section shall
4 apply pre-deductible, if applicable; or

5 (3) limit a beneficiary's annual out-of-pocket
6 financial responsibility for prescription drugs, including
7 specialty drugs, to no more than the minimum per year
8 dollar amounts in effect under Section 223(c)(2)(A)(i) of
9 the Internal Revenue Code for self-only coverage.

10 (b) All plans offered pursuant to this Section shall be:

11 (1) clearly and appropriately named to aid in the
12 consumer or plan-sponsor plan selection process;

13 (2) marketed in the same manner as other plans offered
14 by the health insurance carrier; and

15 (3) offered for purchase to any individual and group
16 plan sponsor.

17 (c) The Department shall adopt rules necessary to implement
18 and enforce this Section.

19 Section 99. Effective date. This Act takes effect January
20 1, 2021.