HB1745

LRB10214220BMS19572b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB1745

Introduced 2/17/2021, by Rep. Gregory Harris, Theresa Mah, Dagmara Avelar, Jonathan Carroll, Joyce Mason, et al.

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, 2022.

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A BILL FOR

AN ACT concerning regulation.

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

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

(215 ILCS 134/45.3 new)

Sec. 45.3. Prescription drug benefits; plan choice.

(a) Notwithstanding any other provision of law, on and after January 1, 2022, every health insurance carrier that provides coverage for prescription drugs shall ensure that no fewer than 50% of individual and group plans offered within each service area and at each level of coverage as defined in 42 U.S.C. 18022, if applicable, that are delivered, issued for delivery, renewed, amended, or continued by the health insurance carrier meet one or more of the following criteria:

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

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

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

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

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

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

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

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

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

Section 99. Effective date. This Act takes effect January 1, 2022.