HB6277

LRB09821541MGM60146b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB6277

by Rep. Jaime M. Andrade, Jr. - Robyn Gabel - Laura Fine - Marcus C. Evans, Jr. - Christian L. Mitchell, et al.

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.22 new

Amends the Illinois Insurance Code. Provides that a health plan that provides coverage for prescription drugs shall ensure that any required copayment or coinsurance applicable to drugs on a specialty tier does not exceed $100 per month for up to a 30-day supply of any single drug and a beneficiary's annual out-of-pocket expenditures for prescription drugs are limited to no more than fifty percent of the dollar amounts in effect under specified provisions of the federal Affordable Care Act. Provides that a health plan that provides coverage for prescription drugs and uses a tiered formulary shall implement an exceptions process that allows enrollees to request an exception to the tiered cost-sharing structure. Provides that a health plan that provides coverage for prescription drugs shall not place all drugs in a given class on a specialty tier. Effective January 1, 2015.

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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 Illinois Insurance Code is amended by adding Section 356z.22 as follows:

(215 ILCS 5/356z.22 new)

Sec. 356z.22. Specialty tier prescription coverage.

(a) As used in this Section:

"Coinsurance" means a cost-sharing amount set as a percentage of the total cost of a drug.

"Copayment" means a cost-sharing amount set as a dollar value.

"Non-preferred drug" means a drug in a tier designed for certain drugs deemed non-preferred and therefore subject to higher cost-sharing amounts than preferred drugs.

"Preferred drug" means a drug in a tier designed for certain drugs deemed preferred and therefore subject to lower cost-sharing amounts than non-preferred drugs.

"Specialty tier" means a tier of cost sharing that imposes cost-sharing obligations that exceed that amount for non-preferred and preferred drugs.

"Tiered formulary" means a formulary that provides

coverage for prescription drugs as part of a health plan for which cost sharing, deductibles, or coinsurance obligations are determined by category or tier of prescription drugs and includes at least 2 different tiers.

(b) A health plan that provides coverage for prescription drugs shall ensure that:

(1) any required copayment or coinsurance applicable to drugs on a specialty tier does not exceed $100 per month for up to a 30-day supply of any single drug; this limit shall be inclusive of any patient out-of-pocket spending, including payments towards any deductibles, copayments, or coinsurance; further this limit shall be applicable at any point in the benefit design, including before and after any applicable deductible is reached; and

(2) a beneficiary's annual out-of-pocket expenditures for prescription drugs are limited to no more than 50% of the dollar amounts in effect under Section 1302(c)(1) of the federal Affordable Care Act for self-only and family coverage, respectively.

(c) A health plan that provides coverage for prescription drugs and uses a tiered formulary shall implement an exceptions process that allows enrollees to request an exception to the tiered cost-sharing structure. Under an exception, a non-preferred drug may be covered under the cost sharing applicable for preferred drugs if the prescribing health care provider determines that the preferred drug for treatment of

the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. If an enrollee is denied a cost-sharing exception, the denial shall be considered an adverse event and shall be subject to the health plan's internal review process.

(d) A health plan that provides coverage for prescription drugs shall not place all drugs in a given class on a specialty tier.

(e) Nothing in this Section shall be construed to require a health plan to:

(1) provide coverage for any additional drugs not otherwise required by law;

(2) implement specific utilization management techniques, such as prior authorization or step therapy; or

(3) cease utilization of tiered cost-sharing structures, including those strategies used to incentivize use of preventive services, disease management, and low-cost treatment options.

(f) Nothing in this Section shall be construed to require a pharmacist to substitute a drug without the consent of the prescribing physician.

(g) The Director shall adopt rules outlining the enforcement processes for this Section.

Section 99. Effective date. This Act takes effect January 1, 2015.