SPONSOR: Sen. Henry & Rep. Barbieri & Rep. Hudson
Sens. Blevins, McBride, Sokola & Hall-Long;
Reps. Heffernan, Kowalko, Mitchell & Mulrooney

DELAWARE STATE SENATE
146th GENERAL ASSEMBLY

SENATE BILL NO. 252

AN ACT TO INSTITUTE PATIENT PROTECTIONS BY REQUIRING THAT HEALTH PLAN CONTRACTS ISSUED, AMENDED, OR RENEWED ON OR AFTER JANUARY 1, 2013 THAT COVER PRESCRIPTION DRUGS, SHALL COMPLY WITH CERTAIN COST SHARING AND APPEALS REQUIREMENTS.

WHEREAS, as prescription drugs costs increase, the practice of insurers creating a cost-sharing mechanism known as specialty-tiers has increased putting an increasing financial burden on patients; and

WHEREAS, the Delaware Health Care Commission completed a study of the effect of specialty-tiers in Delaware summarizing the issue of specialty tier pricing, the impact on patient access and care when specialty-tier pricing is used; and

WHEREAS, the increased co-pay costs associated with specialty tiers drugs presents a significant burden to Delawareans facing serious health conditions such as: hemophilia, human immunodeficiency virus (HIV), hepatitis, multiple sclerosis, lupus, some cancers, rheumatoid arthritis, and others; and

WHEREAS, the financial burden on insured of specialty tiers unfairly denies access to prescription drugs based on individual health conditions and provides a severe financial strain on seriously ill Delawareans and their families.

NOW THEREFORE:

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33 and 35 Title 18 of the Delaware Code by making insertions as shown by underline and deletions as shown by strike through as follows:

§ 3364. Specialty Tier Prescription ~~Study~~Coverage.

The Delaware Healthcare Commission shall conduct a study for specialty tier prescription drugs to determine the impact on access and patient care. The Delaware Healthcare Commission shall submit a report to the General Assemble summarizing this impact by March 15, 2012.

(a) Unless otherwise specifically provided, the definitions in this section apply throughout this act.

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

"Commissioner" means the Insurance Commissioner of this State.

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

"Health benefit plan" is defined in §3572(4), Title 18 of the Delaware Code.

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

"Preferred drug" means 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 designed for select specialty drugs that imposes cost-sharing obligations that exceed that amount for non-preferred brand drugs or their equivalent (for brand drugs if there is no non-preferred brand drug category) and such a cost sharing amount is based on a coinsurance.

"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, that includes at least two different tiers.

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

(1) any required copayment or coinsurance applicable to covered drugs does not exceed $100 per month for up to a 30-day supply of any single drug; and

(2) such required copayment or coinsurance does not exceed, in the aggregate for all covered drugs, $200 per month per enrollee.

(c) A health plan that provides coverage for prescription drugs and utilizes a tiered formulary as defined in §3344(a) shall implement an exceptions process that allows enrollees to request an exception to the tiered cost-sharing structure. Under such an exception, a non-preferred drug could be covered under the cost sharing applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual, or would have adverse effects for the individual, or both. In the event an enrollee is denied a cost-sharing exception, such denial shall be considered an adverse event and will be subject to the health plan internal review process set forth in 18 Del. C. § 332 and the state external review process set forth in 18 Del. C. § 6416.

(d) For conditions where there is only one class of prescription drug available, a health plan that provides coverage for prescription drugs shall be prohibited from placing such drugs on a specialty tier.

(e) The Commissioner shall promulgate regulations outlining the enforcement processes for this act.

(f) 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 incent use of preventive services, disease management, and low-cost treatment options.

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

§3571G. Specialty Tier Drug Prescription Coverage

(a) Unless otherwise specifically provided, the definitions in this section apply throughout this act.

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

"Commissioner" means the Insurance Commissioner of this State.

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

"Health benefit plan" is defined in §3572(4), Title 18 of the Delaware Code.

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

"Preferred drug" means 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 designed for select specialty drugs that imposes cost-sharing obligations that exceed that amount for non-preferred brand drugs or their equivalent (for brand drugs if there is no non-preferred brand drug category) and such a cost sharing amount is based on a coinsurance.

"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, that includes at least two different tiers.

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

(1) any required copayment or coinsurance applicable to covered drugs does not exceed $100 per month for up to a 30-day supply of any single drug; and

(2) such required copayment or coinsurance does not exceed, in the aggregate for all covered drugs, $200 per month per enrollee.

(c) A health plan that provides coverage for prescription drugs and utilizes a tiered formulary as defined in §3344(a) shall implement an exceptions process that allows enrollees to request an exception to the tiered cost-sharing structure. Under such an exception, a non-preferred drug could be covered under the cost sharing applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual, or would have adverse effects for the individual, or both. In the event an enrollee is denied a

cost-sharing exception, such denial shall be considered an adverse event and will be subject to the health plan internal review process set forth in 18 Del. C. § 332 and the state external review process set forth in 18 Del. C. § 6416.

(d) For conditions where there is only one class of prescription drug available, a health plan that provides coverage for prescription drugs shall be prohibited from placing such drugs on a specialty tier.

(e) The Commissioner shall promulgate regulations outlining the enforcement processes for this act.

(f) 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 incent use of preventive services, disease management, and low-cost treatment options.

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

Section 2. This act shall take effect and be in force from and after January 1, 2013. The provisions above shall apply to a health plan contract issued, amended, or renewed on or after January 1, 2013.

SYNOPSIS

This Bill imposes dollar limits on the prescription drug insurance practice of cost-sharing known as specialty tiers in order to protect patients from unaffordable co-insurance fees. Patient's co-payment or co-insurance fees for specialty tier drugs will be limited to $100 per month for up to a 30-day supply of any single drug; and will not exceed, in the aggregate for all covered drugs, $200 per month per enrollee. The bill goes into effect on January 1, 2013.

Author: Sen. Henry