Sen. Linda Holmes

Filed: 3/9/2015

AMENDMENT TO SENATE BILL 1359

AMENDMENT NO. _____. Amend Senate Bill 1359 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by adding Section 356z.23 as follows:

(215 ILCS 5/356z.23 new)

Sec. 356z.23. 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.

"Tiered formulary" means a formulary that provides coverage for prescription drugs as part of a policy of health and accident insurance 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) On or after the effective date of this amendatory Act of the 99th General Assembly, every insurer that amends, delivers, issues, or renews individual and group accident and health policies providing coverage for prescription drugs shall ensure that:

(1) for insurance plans rated platinum, gold, and silver level, as defined in 45 CFR 156.140, and regardless of whether or not the plan was acquired through an exchange authorized under the federal Patient Protection and Affordable Care Act, any required copayment or coinsurance applicable to drugs does not exceed $100 per month for up to a 30-day supply of any single drug; and

(2) for bronze plans, as defined in 45 CFR 156.140, and regardless of whether or not the plan was acquired through an exchange authorized under the federal Patient Protection and Affordable Care Act, any required copayment or coinsurance applicable to drugs does not exceed $200 per month for up to a 30-day supply of any single drug.

(c) The limits described in subsection (b) of this Section

shall be inclusive of any patient out-of-pocket spending, including payments towards any deductibles, copayments, or coinsurance and shall be applicable before any applicable deductible is reached.

(d) An insurance plan that meets the requirements for a catastrophic plan, as defined in 45 CFR 156.155(a), shall be exempt from the requirements of subsection (b) of this Section.

(e) Subject to subsection (f) of this Section, the limits in subsection (b) of this Section shall apply at any point in the benefit design, including before any after any applicable deductible is reached.

(f) For any enrollee that is enrolled in a policy that, but for the requirements of subsection (b) of this Section, would be a high deductible health plan as defined in Section 223(c)(2)(A) of the Internal Revenue Code of 1986, the limits described in subsection (b) of this Section shall be applicable only after the minimum annual deductible specified in Section 223(c)(2)(A) of the Internal Revenue Code of 1986 is reached.

(g) An insurer that issues policies of accident and health insurance that provides coverage for prescription drugs shall implement an exceptions process that allows enrollees to request an exception to the formulary. An insurer may use its existing medical exceptions process to satisfy this requirement. Under such an exception, a non-formulary drug shall be deemed covered under the formulary if the prescribing physician determines that the formulary 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. If an enrollee is denied an exception, the denial shall be considered an adverse coverage determination and will be subject to the health plan internal and external review processes.

(h) On or after the effective date of this amendatory Act of the 99th General Assembly, every insurer that amends, delivers, issues, or renews individual and group accident and health policies providing coverage for prescription drugs shall ensure that 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 Patient Protection and Affordable Care Act for self-only and family coverage, respectively.

(i) An insurer that issues policies of accident and health policies 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.

(j) Nothing in this Section shall be construed to require an insurer that issues accident and health policies:

(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.

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

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

Section 99. Effective date. This Act takes effect January 1, 2016.".