State Legislation and Studies on Prescription Drugs from January – March 2012			
State	**Summary of Legislation**	**Status**	**Key Proponent(s)**
AK HB 218 Sponsor: Health and Social Services	An Act prohibiting an insurer from using a drug formulary system of specialty tiers under certain circumstances.	Introduced: 3.31.11; referred to Health and Social Services; 4.05 Passed House; 4.06 referred to Senate Health Services Committee; 4.10 referred to Rules; 4.15 amended; referred to House for consent; 4.15 cleared Senate and House; 4.15 Awaits transmittal to Governor.	
AZ SB1401 Sponsors: Senator Murphy; Senator Barto; Senator McComish	Makes access to biologics like MS disease modifying therapies more affordable, accessible and predictable by prohibiting insurers from increasing drug tiers during a contract period and requiring a sixty-day notice to patients if a drug is reclassified. SB 1401 also clarifies that the total out-of-pocket costs for major medical and prescription drug coverage in a policy year shall not exceed *$6,000 per individual and $12,000 per family*.	Introduced 1.30.12; Referred to *Senate Banking and Insurance Committee*; heard 2.14 – *passed and referred to Rules committee.* These amendments pending: Strike catastrophic coverage, if Health Savings Account is included in plan; Eliminate Small group plans (under 50 employees) from scope of law; Adjust out-of-pocket expenses per Consumer Price Index; Amend to permit movement to a lower tier and movement to a generic tier, if one becomes available.	Lead by ***Arizona Alliance for Chronic Care*** (chaired by the Arizona Hemophilia Association) other proponents: Rheumatoid arthritis; Power of Pain Foundation; Neuropathy Action Foundation, American Cancer Society, and others.
CA AB 1800 (AB 310) Representative MA	Establishes cap on out-of-pocket costs for covered benefits to include: consumer costs for hospitalization; physician visits; prescription drugs; co-payments; deductibles; and any other form of cost-	To be amended as summarized; Currently held in Assembly Appropriations Committee	Lead by ***California Health Access*** – includes: Alliance For Plasma Therapies, Psoriasis Foundation, Arthritis Foundation Parkinson's Action Assoc. of Nor Cal; CA Alliance for Retired Americans; Mental Health

	sharing. Aligns with federal health care reform: $5,950 for individuals and $11,900 for families. ~~Prevents health plans and insurers from using the co-insurance method of payment. Places $150 dollar out-of-pocket cap for a one month supply of medication, or its equivalent for prescriptions for longer periods. Ensures that if a health care service plan provides for a limit on patient's annual out-of-pocket expenses, the patient's out-of-pocket costs for covered prescription drugs is included.~~		Association in CA; Neuropathy Action Foundation; American Diabetes Association; Immune Deficiency Foundation; California Medical Association
CT Raised Bill Number 5486 Senator Crisco **2011 HB 1084** Introduced by: (INS)	Section 1. (NEW) (Effective January 1, 2013) Each insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual or a group health insurance policy that provides coverage for prescription drugs shall limit an insured's annual out-of-pocket expenses for prescription drugs, including specialty drugs, to not more than (1) one thousand dollars annually per individual, and (2) two thousand dollars annually per family. The provisions of this section shall not apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes. As used in this section, "specialty drugs" means prescription drugs that require special handling, administration or monitoring and are used to treat chronic conditions.	Referred to Committee on Insurance and Real Estate	New England Coalition for Affordable Prescription Drugs (lead by New England Hemophilia Association) Arthritis Foundation
HI SB2106	As amended, requires all health insurers in Hawaii to provide the same level of benefits and coverage for outpatient prescription drugs, thus promoting fair competition in the	Introduced 1.18.2012; referred to Senate Health. Passed with Amendments; referred to Commerce and	

	insurance marketplace. ~~Each individual and group accident and health or sickness policy, contract, plan, or agreement issued or renewed in this State after December 31, 2012, that covers outpatient prescription drugs: Shall not require coinsurance as a basis for cost sharing with the insured for outpatient prescription drug benefits; and Shall not require an insured to pay a copayment for out-patient prescription drugs in excess of $150 for a one-month supply of a prescription drug, or its equivalent for a longer period, as adjusted for inflation.~~	Consumer Protection. Passed with Amendments. 3.06 Passed from Senate; referred to House Committee on Health; 3.13 Passed from Committee on Health.	
IL [HJR 450]	Requests that the Department of Insurance study the impacts of cost sharing, coinsurance, and specialty-tier pricing for prescription medications.	11.09.2011 Passed by House	[More Information]
IN [SB335]	Prescription drug costs. Specifies limitations on certain out of pocket costs for prescription drugs under coverage provided by a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract.	1.19.201 Passed by Health and Provider Services; Referred to Appropriations	
MA [SB455] Sponsor Sen. Petrucelli	Prohibit specialty tiers that require payment of a percentage cost of prescription drugs. Not to establish tiers of prescription drug copays in which the maximum prescription drug copay exceeds by more than five hundred percent the lowest prescription drug copay charged under the health benefit plan. If an insurer's health benefit plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of-pocket prescription drug cost	Senate referred SB455 to Joint Committee on Financial Services; 1/24/2011. House concurred; Hearing scheduled 1.13.2012; Bill reported favorably by committee and referred to Committee on Health Care Financing; 2.2.2012	New England Coalition for Affordable Prescription Drugs

	to the insured: (a) Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or (b) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation		
NE LB 322 Senator Cornett	An insurer's health benefit plan which provides for an out-of-pocket expenses limit shall include expenses for prescription drugs in that limit or provide for a separate out-of-pocket expenses limit for prescription drugs.	Bill to be amended (as described) and to be priority at 3.14 State Action Day.	The Alliance for Plasma Therapies; National Cornerstone Healthcare Services, Inc. National Psoriasis Foundation; Hemophilia Federation of America – Nebraska Chapter; National MS Society – Nebraska Chapter; Epilepsy Foundation of North/Central IL, IA, NE; Immune Deficiency Foundation; The Leukemia & Lymphoma Society – Nebraska Chapter; American Cancer Society – Nebraska Chapter; NE Chapter of the American Academy of Allergy, Asthma and Immunology; Nebraska Affiliate of Susan G. Komen for the Cure
NM SB0536	Amends sections of the New Mexico Insurance code, the health maintenance organization law and the nonprofit health care plan law to require notice to enrollees before reclassifying prescription drugs or removing prescription drugs from the formulary; providing for contingent applicability.	3.03.2011 Referred to Senate Public Affairs Committee; 17.11 Referred to Senate Judiciary Committee; 3.16.11 Fiscal Impact Note Received	
OK HB2606 Rep Blackwell and Senator Brecheen	Provide in plain language… notice that the plan uses one or more drug formularies, an explanation of what a drug formulary is, a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary, a statement of how often the issuer reviews the contents of each drug formulary, and notice that an enrollee may	2.06.2012 Introduced in House; 2.07 referred to Insurance; 3.13 Amended and Engrossed in House; 3.14 Referred to Senate	

	contact the issuer to determine whether a specific drug is included in a particular drug formulary; Disclose to an individual on request… A health benefit plan issuer may modify drug coverage provided under a health benefit plan if…		
2012 RI H 7573 **2011 RI H 5568** Introduced By: Representative Peter G. Palumbo	No health plan, which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs, shall establish tiers of prescription drug co-pays in which the maximum prescription drug co-pay exceeds by more than five hundred percent (500%) the lowest prescription drug co-pay charged under the health plan. If the health plan provides a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer shall include one of the following provisions in the plan that would result in the lowest out-of- pocket prescription drug cost to the enrollee or subscriber: Out-of-pocket expenses for prescription drugs shall be included under the health plan's total limit for out-of-pocket expenses for all benefits provided under the plan: or Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand dollars ($1,000) per enrollee or subscriber, or two thousand dollars ($2,000) per insured family, adjusted for inflation.	3.08.2012 hearing on specialty tiers; opposition from the insurance companies. NECAPD submitted testimony to support of the RI bill. Apparently, Chairman	New England Coalition for Affordable Prescription Drugs
VA HR 579 Delegate O'Bannon	Directs Joint Commission on Health Care to study the impacts of cost sharing, coinsurance, specialty tier pricing for prescription medications.	Introduced; referred to Rules; Tabled; Referred to Joint Commission on Health Care by Delegate O'Bannon	Endorsed by: American Heart Association, Virginia Association of Free Clinics and the Healthcare For All Virginians Coalition

WA HB 1876 **Rep Green and Kenney**	(1) A health carrier that provides coverage for prescription drugs may not increase a covered person's cost sharing obligations for prescription drugs during a plan year. (2)(a) A health carrier that provides coverage for prescription drugs shall provide a single limit on out-of-pocket expenses in all its health plans. All out-of-pocket expenses incurred by a covered person for medical services, surgical services, mental health services, or prescription drugs shall be included in the limit. The out-of-pocket limit required by this subsection may not exceed five thousand nine hundred fifty dollars for plans that cover a single enrollee or eleven thousand nine hundred dollars for plans that cover more than one enrollee. In July 2013 and every July thereafter, the insurance commissioner shall adjust the out-of-pocket limits in this subsection to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor.	Heard Senate Health Committee; 1.30.2012. Referred to Ways and Means committee with attached fiscal note (b/c state plans would model private insurance); failed to pass 2.8.2012. Died in Committee	Collaborative effort between American Cancer Society and National MS Society

Enacted Legislation			
State	Bill Number	Summary	Date Enacted
DE	SB 137 No health care plan or health insurance policy which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs including, but not limited to, generic drugs, preferred brand drugs and non-preferred brand drugs, shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for any other prescription drug provided under such coverage in the category of non-preferred brand drugs or their equivalents for a period of one year ending July 1, 2012. 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."	Passed Senate on 6.30.2011; 21-0. Referred to House; Passed House on 7.01.2011 28-13; Sent to Governor Markell;	Enrolled ~ 9.14.2011 The Commission is acutely aware of the need to assure access to medications. Delaware cannot allow a situation in which life-saving medications are out of reach for patients in need simply because the drugs are too expensive. The Commission also recognizes that continued increases in health care costs are unsustainable and supports the use of tools to share and manage those costs, as well as incentives to encourage use of cost-effective, well-coordinated preventive health and disease management services. These efforts are critical to reducing the costs that many agree are preventable, and maintaining the capacity to provide critical access to needed drugs. In order to assure access to prescription drugs while retaining tiered pricing as a tool to encourage healthy behaviors and the most cost-effective use of health care resources, the Health Care Commission recommends that use of specialty tiers using co-insurance to control costs should only occur when: Therapeutically similar drugs are available in lower cost tiers; Specific measures to assure affordability are in place; Processes for designating specialty-tier drugs are uniform and transparent to all stakeholder groups, including providing appropriate notice. Potential options to accomplish these recommendations include: Legislation restricting the use of tiered pricing; Implementation of tiered pricing combined with caps for limiting out of pocket expenses – use inpatient payment structure as a model; Creation, implementation and ongoing

			evaluation of disease-specific uniform treatment guidelines/treatment Pathways; Implementation of statewide programs to share cost and risk (e.g. use of captives or reinsurance programs to bear the high cost risks)
LA	HB 345 Provides with respect to coverage by a health benefit plan of prescription drugs, including through the use of a drug formulary, including notice and disclosure, continuation of coverage, appeal of adverse determinations, and modifications of drug coverage.	Passed House on 6.07.2011; 81-5. Received in Senate. Referred to the Committee on Insurance. Passed Senate on 6.20.2011; Sent to Governor Jindal.	Enrolled ~ 7.03.2011 Act 350
ME LD1691	Provides that a health plan covering prescription drugs may not require cost sharing, deductibles or coinsurance obligations for prescription drugs that exceed the dollar amount for non-preferred brand drugs or for brand drugs if there is no non-preferred brand drug category.	Referred to Insurance and Financial Services; heard on 1.25.2012; Passed to be referred to Floor (amendments before passage from committee sought). 3.27 Engrossed by House; 3.28 Engrossed by Senate	Enrolled ~ 4.09.2012 Public Law Chapter 611
NY	S 5000/A 8278 Prohibits the creation of specialty tiers for prescription medications.		Enrolled ~ 2010
TX	SB 1030 Prohibits a large group health benefits plan from increasing prescription drug prices within a contract year.		Enrolled ~ 9.1999
TX	HB 1405 Extends protections already in law for enrollees in large employer plans to enrollees employed by small businesses and to those covered by individual plans that prevent an insurance company from changing the cost of	Introduced in House 3.01.2011; Referred to Insurance. Passed Committee 3.15.2011. 4.06.2011 Passed House,	Enrolled ~ 6.17.2011

	any prescription drug until the plan renewal date. HB 1253 Requires health plans to notify all enrollees of changes to prescription drug coverage no later than the 60th day before a new contract goes into effect.	referred to Senate. 5.16.2011 Amended in Senate State Affairs Committee to encompass HB 1405 and HB 1253. 5.20.2011 Sent to Governor Perry.	
VT	S 104 Prohibits specialty tiering of prescription drugs. A qualified health benefit plan that provides prescription drug benefits may not impose cost sharing, deductibles or coinsurance for prescription drug medications that exceeds the dollar amount for non-preferred brand drugs or the equivalent (or brand drugs if there is no non-preferred brand drug category) VT S 104 .(a) Prior to July 1, 2012, no health insurer or pharmacy benefit manager shall utilize a cost-sharing structure for prescription drugs that imposes on a consumer for any drug a greater co-payment, deductible, coinsurance, or other cost-sharing requirement than that which applies for a nonpreferred brand name drug.		Enrolled ~ 5.26.2011
WV	SCR 71 Study to research the effects and impacts of cost-sharing, coinsurance, and specialty tier pricing for prescription drugs. The study will determine the impact of these practices on access to prescription drugs, for chronic health disorders, and identify and evaluate options for reducing the negative impacts.	Study introduced 3.2011; Approved 5.2011. To be conducted by the Joint Committee of Governance and Finance and released by 2012. 11.2011 Hearing.	Results of Study – No Recommendations