Selected State Legislation Related to Specialty Tier Drug Pricing

State	Example of Language	Status
California	10123.197. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2012, that covers outpatient prescription drugs shall not require coinsurance as a basis for cost sharing with the insured for outpatient prescription drug benefits. (b) A health insurance policy issued, amended, or renewed on or after January 1, 2012, shall not require an insured to pay a copayment for outpatient prescription drugs in excess of one hundred fifty dollars ($150) for a one-month supply of a prescription, or its equivalent for a prescription for a longer period, as adjusted for inflation. (c) If a health insurance policy provides for a limit on the annual out-of-pocket expenses for an insured, the insured's out-of-pocket costs of covered prescription drugs shall be included in that limit. (d) (1) For purposes of this section, "coinsurance" means a cost-sharing payment by an insured that is based on a percentage of the cost for a prescription. (2) For purposes of this section, "copayment" means a flat dollar amount an insured is required to pay in cost sharing for covered health services, items, and supplies, including prescription drugs, after any applicable deductible. The term shall not be construed to include any other forms of cost sharing. (e) Nothing in this section shall be construed to require a health insurance policy to provide coverage not otherwise required by law for any prescription drug. (f) This section shall become inoperative upon a determination by the commissioner that the requirements of this section would result in the assumption by the state of additional costs pursuant to Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by Section 10104(e) of Title X of that act, relative to benefits required by the state to be offered by qualified plans in the California Health Benefit Exchange that exceed the requirements imposed by federal law.	Pending (AB 310)
Connecticut	Section 1. (NEW) (*Effective January 1, 2012*) No 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 health insurance policy that provides coverage for prescription drugs shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for nonpreferred brand name drugs that places a greater financial burden on an insured than for preferred brand name drugs. Sec. 2. (NEW) (*Effective January 1, 2012*) No insurer, fraternal benefit society, hospital service corporation,	Pending (Raised bill No. 1084)

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	medical service corporation, health care center or other entity that delivers, issues for delivery, renews, amends or continues in this state a group health insurance policy that provides coverage for prescription drugs shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for nonpreferred brand name drugs that places a greater financial burden on an insured than for preferred brand name drugs.	
Kansas	New Section 1. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 2011, which provides coverage for prescription medications and for which cost-sharing, deductibles or coinsurance obligations are determined by category of prescription medications shall not impose cost-sharing, deductibles or coinsurance obligations for any prescription medication that exceeds the dollar amount of cost-sharing, deductibles or coinsurance obligations for nonpreferred brand medication or its equivalent, or brand medications if there is no non-preferred brand medication category.	Pending (HB 2136)
Maryland	(C) (1) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE A COST–SHARING OBLIGATION THAT EXCEEDS $100 FOR A MONTH'S SUPPLY OF A COVERED 16 PRESCRIPTION DRUG. (2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, AN ENTITY SUBJECT TO THIS SECTION MAY INCREASE THE COST–SHARING OBLIGATION UNDER PARAGRAPH (1) OF THIS SUBSECTION TO AN AMOUNT THAT EXCEEDS $100: (I) NOT MORE THAN ONCE ANNUALLY; AND (II) BY AN AMOUNT THAT DOES NOT EXCEED THE PERCENTAGE CHANGE IN THE MEDICAL COMPONENT OF THE MARCH CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS, MEDICAL CARE COMPONENT, WASHINGTON–BALTIMORE, FROM THE U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS. (D) SUBSECTION (C) OF THIS SECTION DOES NOT APPLY TO A MONTH'S SUPPLY OF A BRAND–NAME DRUG FOR WHICH A GENERIC EQUIVALENT, AS DEFINED BY THE U.S. FOOD AND DRUG ADMINISTRATION'S "APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS", IS AVAILABLE.	Bill Failed (HB 251)

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Nebraska	(4)(a) An insurer shall not create specialty tiers that require payment of a percentage cost of prescription drugs. (b) An insurer shall not charge a prescription drug copay that exceeds the cost per prescription of the prescription drug to 14 the health benefit plan or a prescription drug copay that exceeds by five hundred percent the lowest prescription drug copay charged under such plan. (c) 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 to the insured: (i) 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 (ii) Out-of-pocket expenses for prescription drugs per contract year shall not exceed one thousand 1 dollars per insured or two thousand dollars per insured family, adjusted for inflation.	Pending (LB 1017); Study
New York	No policy… which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription 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 non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	Enacted (Chapter 536, Laws of New York 2010)
Vermont	Sec. 5. SPECIALTY TIER DRUGS (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. (b) The commissioner of banking, insurance, securities, and health care administration shall not approve any form for a health insurance policy prior to July 1, 2012 that imposes on a consumer for any prescription drug a greater co-payment, deductible, coinsurance, or other cost-sharing requirement than that which applies for a	Enacted (Act No. 0051)

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	nonpreferred brand-name drug.	
Washington	(1)(a) An insurer may not create specialty tiers that require payment of a percentage cost of prescription drugs. (b) An insurer may not 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. (c) 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 to the insured: (i) Out-of-pocket expenses for prescription drugs must be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or (ii) Out-of-pocket expenses for prescription drugs per contract year may not exceed one thousand dollars per insured or two thousand dollars per insured family, adjusted for inflation.	Pending (HB 1876)