

6298

2009-2010 Regular Sessions

I N A S S E M B L Y

February 27, 2009

Introduced by M. of A. TITUS -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to denying policies imposing drug tiers and cost-sharing for prescription medication

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 Section 1. Legislative findings. The legislature finds that:

2 (a) The cost of specialty drugs is a great concern. According to IMS  
3 Health, about \$37.7 billion was spent on specialty drugs in 2003, grow-  
4 ing by as much as 26.6 percent since 2002, nearly double the 13.4  
5 percent growth rate in total drug spending. The growth rate for special-  
6 ty pharmacy drugs is expected to be 20 percent a year for the foreseea-  
7 ble future. Studies and efforts to cope with rising cost drugs, includ-  
8 ing specialty drugs, should strongly consider affordability issues and  
9 minimizing the impact on patients' health.

10 (b) The current health insurance system is increasingly unaffordable,  
11 regularly adding new barriers to access. According to the Kaiser Founda-  
12 tion, health insurance premiums rose 6.1 percent in 2007, faster than  
13 wages rising at 3.7 percent and inflation rising at 2.6 percent. Annual  
14 premiums for family coverage averages \$12,106, with workers paying  
15 \$3,281. Since 2001, premiums for family coverage have increased 78  
16 percent, while wages have gone up 19 percent and inflation has gone up  
17 17 percent. Furthermore, between 2000 and 2003, annual out-of-pocket  
18 spending rose \$900 or 30 percent for employees with family coverage  
19 including insurance premiums, deductibles and drug co-payments, increas-  
20 ing from \$1,890 to \$2,790.

21 (c) Multi-tiered formularies have undoubtedly transformed the pharmacy  
22 benefit landscape. By 2005, most workers with employer-sponsored cover-  
23 age (74 percent) were enrolled in plans with 3 or more tiers, nearly 3  
24 times the rate in 2000 (27 percent). While cost containment measures are  
25 necessary, certain cost-sharing policies, such as tier four measures,

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets  
[ ] is old law to be omitted.

LBD02054-01-9

1 have exacerbated costs and created new barriers to access. Tier four  
2 policies charge a percentage of the total cost of high-priced specialty  
3 medications (20-33 percent) rather than a fixed co-pay, resulting in a  
4 rise in cost-sharing from average co-pays of \$25 per prescription up to  
5 \$325 or even \$4000 in some instances. These policies often target  
6 vulnerable populations by driving prices up for extremely sick patients  
7 in order to reduce costs for healthy patients and/or to improve profit  
8 margins for Health Maintenance Organizations or Pharmacy Benefit Manag-  
9 ers. Families and individuals struggling with diagnoses of anemia,  
10 cancer, multiple sclerosis and hepatitis C who depend on cutting-edge  
11 medications for functioning or survival, have been severely burdened by  
12 a new pricing system implemented in 86 percent of the Medicare plans and  
13 10 percent of private plans. Several studies reveal that various cost-  
14 sharing policies create negative health outcomes by reducing utilization  
15 and increasing hospitalization. One report cited in the Journal of the  
16 American Medical Association identified 132 articles which examined the  
17 association between prescription drug plans cost-containment measures  
18 and salient outcomes. The results revealed that in the short-term,  
19 increased cost-sharing is associated with lower rates of drug treatment,  
20 worse adherence among existing users, and more frequent discontinuation  
21 of therapy. Policies which worsen health outcomes must be prevented or  
22 halted in order to avoid costly long-term consequences, but more impor-  
23 tantly to maintain high-quality healthcare for all New Yorkers.

24 S 2. Subsection (d) of section 3221 of the insurance law is amended by  
25 adding a new paragraph 4 to read as follows:

26 (4) THE SUPERINTENDENT SHALL DENY ANY FORM OF GROUP HEALTH INSURANCE  
27 POLICY WHICH CATEGORIZES PRESCRIPTION MEDICATION BASED ON SPECIFIC  
28 DISEASE OR SPECIFIC COST AND CHARGES A COST-SHARING PERCENTAGE FOR SUCH  
29 PRESCRIPTION MEDICATION.

30 S 3. Subsection (i) of section 3216 of the insurance law is amended by  
31 adding a new paragraph 26 to read as follows:

32 (26) EVERY POLICY WHICH PROVIDES COVERAGE FOR PRESCRIPTION DRUGS SHALL  
33 NOT CATEGORIZE PRESCRIPTION MEDICATIONS BASED ON SPECIFIC DISEASE OR  
34 SPECIFIC COST AND SHALL NOT CHARGE BASED ON A COST-SHARING PERCENTAGE  
35 FOR SUCH PRESCRIPTION MEDICATION.

36 S 4. Section 4303 of the insurance law is amended by adding a new  
37 subsection (ff) to read as follows:

38 (FF) EVERY POLICY WHICH PROVIDES COVERAGE FOR PRESCRIPTION CARE SHALL  
39 NOT CATEGORIZE PRESCRIPTION MEDICATIONS BASED ON SPECIFIC DISEASE OR  
40 SPECIFIC COST AND MAY NOT CHARGE BASED ON A COST-SHARING PERCENTAGE FOR  
41 SUCH PRESCRIPTION MEDICATION.

42 S 5. This act shall take effect on the one hundred twentieth day after  
43 it shall have become a law; provided however, that any rules and regu-  
44 lations necessary for the timely implementation of this act on its  
45 effective date shall be promulgated on or before such date.