S T A T E O F N E W Y O R K

2655

2013-2014 Regular Sessions

I N A S S E M B L Y

January 17, 2013

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:

Section 1. Legislative findings. The legislature finds that:

(a) The cost of specialty drugs is a great concern. According to IMS Health, about $37.7 billion was spent on specialty drugs in 2003, growing by as much as 26.6 percent since 2002, nearly double the 13.4 percent growth rate in total drug spending. The growth rate for specialty pharmacy drugs is expected to be 20 percent a year for the foreseeable future. Studies and efforts to cope with the rising cost of drugs, including specialty drugs, should strongly consider affordability issues and minimizing the impact on patients' health.

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

(c) Multi-tiered formularies have undoubtedly transformed the pharmacy benefit landscape. By 2005, most workers with employer-sponsored coverage (74 percent) were enrolled in plans with 3 or more tiers, nearly 3 times the rate in 2000 (27 percent). While cost containment measures are 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.

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have exacerbated costs and created new barriers to access. Tier four policies charge a percentage of the total cost of high-priced specialty medications (20-33 percent) rather than a fixed co-pay, resulting in a rise in cost-sharing from average co-pays of $25 per prescription up to $325 or even $4,000 in some instances. These policies often target vulnerable populations by driving prices up for extremely sick patients in order to reduce costs for healthy patients and/or to improve profit margins for Health Maintenance Organizations or Pharmacy Benefit Managers. Families and individuals struggling with diagnoses of anemia, cancer, multiple sclerosis and hepatitis C who depend on cutting-edge medications for functioning or survival, have been severely burdened by a new pricing system implemented in 86 percent of the Medicare plans and 10 percent of private plans. Several studies reveal that various cost-sharing policies create negative health outcomes by reducing utilization and increasing hospitalization. One report cited in the Journal of the American Medical Association identified 132 articles which examined the association between prescription drug plans cost-containment measures and salient outcomes. The results revealed that in the short-term, increased cost-sharing is associated with lower rates of drug treatment, worse adherence among existing users, and more frequent discontinuation of therapy. Policies which worsen health outcomes must be prevented or halted in order to avoid costly long-term consequences, but more importantly to maintain high-quality healthcare for all New Yorkers.

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

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

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

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

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

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

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