L.D. 1691

Date: (Filing No. H- )

**INSURANCE AND FINANCIAL SERVICES**

Reproduced and distributed under the direction of the Clerk of the House.

**STATE OF MAINE**

**HOUSE OF REPRESENTATIVES**

**125TH LEGISLATURE**

**SECOND REGULAR SESSION**

COMMITTEE AMENDMENT " " to H.P. 1243, L.D. 1691, Bill, "An Act Related to Specialty Tiers in Prescription Medication Pricing"

Amend the bill by striking out all of section 1 and inserting the following:

'**Sec. 1. 24-A MRSA §4317-A** is enacted to read:

**§4317-A. Prescription drug coverage; out-of-pocket expenses for coinsurance**

**1. Out-of-pocket expenses for coinsurance within health plan's total limit.** If a carrier that provides coverage for prescription drugs does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.

**2. Adjustment of out-of-pocket limits.** A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.

**3. Construction.** This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in accordance with this chapter.

**4. Terms consistent with federal law.** For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.

**Sec. 2. Application.** The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this

State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.'

## SUMMARY

This amendment replaces the bill and is the majority report of the committee. The amendment requires health benefit plans that provide prescription drugs to provide a separate total limit for out-of-pocket expenses for prescription drugs provided under the health plan subject to coinsurance that does not exceed $3,500 per year if the carrier does not include out-of-pocket expenses for prescription drugs subject to coinsurance under the health plan's total limit for out-of-pocket expenses for all benefits provided under the health plan to the extent not inconsistent with the federal Affordable Care Act. The amendment authorizes a carrier to adjust its limit for out-of-pocket expenses to minimize any premium increase that might otherwise result.

The amendment also adds an application clause so that the provisions apply to health insurance policies, contracts and certificates issued or renewed on or after January 1, 2013.