EFFECTIVE WITHOUT THE MAYOR'S SIGNATURE

City of Providence
STATE OF RHODE ISLAND

RESOLUTION OF THE CITY COUNCIL

No. 212

EFFECTIVE May 14, 2023

WHEREAS, House Bill H-5350 would limit the copayment or coinsurance requirement on specialty drugs to one hundred fifty dollars ($150) for a thirty (30) - day supply regarding any specialty drug in any individual or health insurance contract, plan, or policy issued, delivered or renewed on or after January 1, 2024. Specialty drugs would be defined as a drug prescribed to an individual with a complex or chronic medical condition or a rare medical condition.

NOW, THEREFORE, BE IT RESOLVED, That the Providence City Council hereby supports and urges passage of House Bill H-5350, An Act Relating to Insurance - Accident and Sickness Insurance Policies.

BE IT FURTHER RESOLVED, That upon passage, copies of this resolution be transmitted to the Speaker of the House and the Providence Delegation.

IN CITY COUNCIL
MAY 04 2023
READ AND PASSED
RACHEL M. MILLER, PRESIDENT
CLERK

Effective without the
Mayor's Signature
Tina L. Mastroianni
Tina L. Mastroianni
City Clerk

2023 -- H 5350

LC000200

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Morales, Chippendale, Kislak, McNamara, Place, Kazarian, Spears, Donovan, Potter, and Newberry
Date Introduced: February 03, 2023

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

27-18-50.2. Specialty drugs.

(a) The general assembly makes the following findings:

(1) In 2015, an estimated six hundred thirty-five thousand (635,000) Rhode Island residents had at least one chronic disease, and an estimated two hundred forty-nine thousand (249,000) residents had two (2) or more chronic diseases, which significantly increases their likelihood to depend on prescription specialty drugs;

(2) In 2016, twenty-five percent (25%) of Rhode Island residents stopped taking a prescription drug as prescribed due to cost;

(3) Most specialty drugs do not have biosimilars, generic equivalents, or substitutes to create competition and help lower their prices; and

(4) In 2022, the Centers for Medicare and Medicaid Services define any drug for which the negotiated price is six hundred seventy dollars ($670) per month or more, as a specialty drug.

(b) As used in this section, the following words shall have the following meanings:

(1) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that is persistent or otherwise long-lasting in its effects or a disease that advances over time, and:

(i) May have no known cure;

(ii) Is progressive; or

(iii) Can be debilitating or fatal if left untreated or undertreated.

"Complex or chronic medical condition" includes, but is not limited to, multiple sclerosis, hepatitis c, and rheumatoid arthritis.

(2) "Pre-service authorization" means a cost containment method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize coverage for drugs prescribed by a health care provider for a covered individual to control utilization, quality, and claims.

(3) "Rare medical condition" means a disease or condition that affects fewer than:

(i) Two hundred thousand (200,000) individuals in the United States; or

(ii) Approximately one in one thousand five hundred (1,500) individuals worldwide.

"Rare medical condition" includes, but is not limited to, cystic fibrosis, hemophilia, and multiple myeloma.

(4) "Specialty drug" means a prescription drug that:

(i) Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; and

(ii) Has a wholesale acquisition cost or negotiated price that exceeds the Medicare Part D specialty tier threshold, as updated from time to time.

(c) Every individual or group health insurance contract, plan or policy that provides prescription coverage and is delivered, issued for delivery or renewed in this state on or after January 1, 2024, shall not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds one hundred fifty dollars ($150) for up to a thirty (30)-day supply of the specialty drug. A pre-service authorization may be used to provide coverage for specialty drugs. Coverage for prescription specialty drugs shall not be subject to any deductible, unless prohibiting a deductible requirement would cause a health plan to not qualify as a high deductible health plan.

(d) Nothing in this section prevents an insurer, health maintenance plan, or nonprofit medical plan from reducing a covered individual's cost sharing to an amount less than one hundred fifty dollars ($150) for a thirty (30)-day supply of a specialty drug.

(e) The health insurance commissioner may promulgate any rules and regulations necessary to implement and administer this section in accordance with any federal requirements and shall use the commissioner's enforcement powers to obtain compliance with the provisions of this section.

SECTION 2. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service Corporations" is hereby amended by adding thereto the following section:

27-19-42.1. Specialty drugs.

(a) The general assembly makes the following findings:

(1) In 2015, an estimated six hundred thirty-five thousand (635,000) Rhode Island residents had at least one chronic disease, and an estimated two hundred forty-nine thousand (249,000) residents had two (2) or more chronic diseases, which significantly increases their likelihood to depend on prescription specialty drugs;

(2) In 2016, twenty-five percent (25%) of Rhode Island residents stopped taking a prescription drug as prescribed due to cost;

(3) Most specialty drugs do not have biosimilars, generic equivalents, or substitutes to create competition and help lower their prices; and

(4) In 2022, the Centers for Medicare and Medicaid Services define any drug for which the negotiated price is six hundred seventy dollars ($670) per month or more, as a specialty drug.

(b) As used in this section, the following words shall have the following meanings:

(1) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that is persistent or otherwise long-lasting in its effects or a disease that advances over time, and:

(i) May have no known cure;

(ii) Is progressive; or

(iii) Can be debilitating or fatal if left untreated or undertreated.

"Complex or chronic medical condition" includes, but is not limited to, multiple sclerosis, hepatitis c, and rheumatoid arthritis.

(2) "Pre-service authorization" means a cost containment method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize coverage for drugs prescribed by a health care provider for a covered individual to control utilization, quality, and claims.

(3) "Rare medical condition" means a disease or condition that affects fewer than:

(i) Two hundred thousand (200,000) individuals in the United States; or

(ii) Approximately one in one thousand five hundred (1,500) individuals worldwide.

"Rare medical condition" includes, but is not limited to, cystic fibrosis, hemophilia, and multiple myeloma.

(4) "Specialty drug" means a prescription drug that:

(i) Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; and

(ii) Has a wholesale acquisition cost or negotiated price that exceeds the Medicare Part D

specialty tier threshold, as updated from time to time.

(c) Every individual or group health insurance contract, plan or policy that provides prescription coverage and is delivered, issued for delivery or renewed in this state on or after January 1, 2024, shall not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds one hundred fifty dollars ($150) for up to a thirty (30)-day supply of the specialty drug. A pre-service authorization may be used to provide coverage for specialty drugs. Coverage for prescription specialty drugs shall not be subject to any deductible, unless prohibiting a deductible requirement would cause a health plan to not qualify as a high deductible health plan.

(d) Nothing in this section prevents an insurer, health maintenance plan, or nonprofit medical plan from reducing a covered individual's cost sharing to an amount less than one hundred fifty dollars ($150) for a thirty (30)-day supply of a specialty drug.

(e) The health insurance commissioner may promulgate any rules and regulations necessary to implement and administer this section in accordance with any federal requirements and shall use the commissioner's enforcement powers to obtain compliance with the provisions of this section.

SECTION 3. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service Corporations" is hereby amended by adding thereto the following section:

27-20-37.1. Specialty drugs.

(a) The general assembly makes the following findings:

(1) In 2015, an estimated six hundred thirty-five thousand (635,000) Rhode Island residents had at least one chronic disease, and an estimated two hundred forty-nine thousand (249,000) residents had two (2) or more chronic diseases, which significantly increases their likelihood to depend on prescription specialty drugs;

(2) In 2016, twenty-five percent (25%) of Rhode Island residents stopped taking a prescription drug as prescribed due to cost;

(3) Most specialty drugs do not have biosimilars, generic equivalents, or substitutes to create competition and help lower their prices; and

(4) In 2022, the Centers for Medicare and Medicaid Services define any drug for which the negotiated price is six hundred seventy dollars ($670) per month or more, as a specialty drug.

(b) As used in this section, the following words shall have the following meanings:

(1) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that is persistent or otherwise long-lasting in its effects or a disease that advances over time, and:

(i) May have no known cure;

(ii) Is progressive; or

(iii) Can be debilitating or fatal if left untreated or undertreated.

"Complex or chronic medical condition" includes, but is not limited to, multiple sclerosis, hepatitis c, and rheumatoid arthritis.

(2) "Pre-service authorization" means a cost containment method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize coverage for drugs prescribed by a health care provider for a covered individual to control utilization, quality, and claims.

(3) "Rare medical condition" means a disease or condition that affects fewer than:

(i) Two hundred thousand (200,000) individuals in the United States; or

(ii) Approximately one in one thousand five hundred (1,500) individuals worldwide.

"Rare medical condition" includes, but is not limited to, cystic fibrosis, hemophilia, and multiple myeloma.

(4) "Specialty drug" means a prescription drug that:

(i) Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; and

(ii) Has a wholesale acquisition cost or negotiated price that exceeds the Medicare Part D specialty tier threshold, as updated from time to time.

(iii) Is not typically stocked at retail pharmacies; and

(iv)(A) Requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

(B) Requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

(c) Every individual or group health insurance contract, plan or policy that provides prescription coverage and is delivered, issued for delivery or renewed in this state on or after January 1, 2024, shall not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds one hundred fifty dollars ($150) for up to a thirty (30)-day supply of the specialty drug. A pre-service authorization may be used to provide coverage for specialty drugs. Coverage for prescription specialty drugs shall not be subject to any deductible, unless prohibiting a deductible requirement would cause a health plan to not qualify as a high deductible health plan.

(d) Nothing in this section prevents an insurer, health maintenance plan, or nonprofit medical plan from reducing a covered individual's cost sharing to an amount less than one hundred fifty dollars ($150) for a thirty (30)-day supply of a specialty drug.

(e) The health insurance commissioner may promulgate any rules and regulations

necessary to implement and administer this section in accordance with any federal requirements and shall use the commissioner's enforcement powers to obtain compliance with the provisions of this section.

SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following section:

27-41-38.3. Specialty drugs.

(a) The general assembly makes the following findings:

(1) In 2015, an estimated six hundred thirty-five thousand (635,000) Rhode Island residents had at least one chronic disease, and an estimated two hundred forty-nine thousand (249,000) residents had two (2) or more chronic diseases, which significantly increases their likelihood to depend on prescription specialty drugs;

(2) In 2016, twenty-five percent (25%) of Rhode Island residents stopped taking a prescription drug as prescribed due to cost;

(3) Most specialty drugs do not have biosimilars, generic equivalents, or substitutes to create competition and help lower their prices; and

(4) In 2022, the Centers for Medicare and Medicaid Services define any drug for which the negotiated price is six hundred seventy dollars ($670) per month or more, as a specialty drug.

(b) As used in this section, the following words shall have the following meanings:

(1) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that is persistent or otherwise long-lasting in its effects or a disease that advances over time, and:

(i) May have no known cure;

(ii) Is progressive; or

(iii) Can be debilitating or fatal if left untreated or undertreated.

"Complex or chronic medical condition" includes, but is not limited to, multiple sclerosis, hepatitis c, and rheumatoid arthritis.

(2) "Pre-service authorization" means a cost containment method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize coverage for drugs prescribed by a health care provider for a covered individual to control utilization, quality, and claims.

(3) "Rare medical condition" means a disease or condition that affects fewer than:

(i) Two hundred thousand (200,000) individuals in the United States; or

(ii) Approximately one in one thousand five hundred (1,500) individuals worldwide.

"Rare medical condition" includes, but is not limited to, cystic fibrosis, hemophilia, and

multiple myeloma.

(4) "Specialty drug" means a prescription drug that:

(i) Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; and

(ii) Has a wholesale acquisition cost or negotiated price that exceeds the Medicare Part D specialty tier threshold, as updated from time to time.

(c) Every individual or group health insurance contract, plan or policy that provides prescription coverage and is delivered, issued for delivery or renewed in this state on or after January 1, 2024, shall not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds one hundred fifty dollars ($150) for up to a thirty (30)-day supply of the specialty drug. A pre-service authorization may be used to provide coverage for specialty drugs. Coverage for prescription specialty drugs shall not be subject to any deductible, unless prohibiting a deductible requirement would cause a health plan to not qualify as a high deductible health plan.

(d) Nothing in this section prevents an insurer, health maintenance plan, or nonprofit medical plan from reducing a covered individual's cost sharing to an amount less than one hundred fifty dollars ($150) for a thirty (30)-day supply of a specialty drug.

(e) The health insurance commissioner may promulgate any rules and regulations necessary to implement and administer this section in accordance with any federal requirements and shall use the commissioner's enforcement powers to obtain compliance with the provisions of this section.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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This act would limit the copayment or coinsurance requirement on specialty drugs to one hundred fifty dollars ($150) for a thirty (30)-day supply regarding any specialty drug in any individual or health insurance contract, plan or policy issued, delivered or renewed on or after January 1, 2024. Specialty drugs would be defined as a drug prescribed to an individual with a complex or chronic medical condition or a rare medical condition.

This act would take effect upon passage.

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