

105TH CONGRESS
1ST SESSION

H. R. 1525

To assure equitable treatment in health care coverage of prescription drugs.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 1997

Mrs. LOWEY introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To assure equitable treatment in health care coverage of prescription drugs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Prescription Drug
5 Benefit Equity Act of 1997”.

6 **SEC. 2. EQUITY IN PROVISION OF PRESCRIPTION DRUG**

7 **COVERAGE.**

8 (a) **GROUP HEALTH PLANS.—**

1 “(B) no deductible or similar cost-sharing
2 is imposed with respect to benefits under the
3 non-mail-order prescription drug coverage un-
4 less such a deductible or similar cost-sharing is
5 imposed with respect to benefits under the mail-
6 order prescription drug coverage; and

7 “(C) the benefits for the non-mail-order
8 coverage assures payments consistent with ei-
9 ther (or both) of the following clauses:

10 “(i) The dollar amount of payment for
11 prescription drug coverage is not less than
12 the dollar amount of benefits provided with
13 respect to the mail-order coverage for that
14 same coverage.

15 “(ii) The cost-sharing (including
16 deductibles, copayments, or coinsurance)
17 imposed with respect to non-mail-order
18 coverage is not greater (as a percentage of
19 charges or dollar amount, as specified
20 under the coverage) than the cost-sharing
21 imposed with respect to the mail-order cov-
22 erage.

23 “(3) DEFINITIONS.—For purposes of this sub-
24 section:

1 “(A) MAIL-ORDER PRESCRIPTION DRUG
2 COVERAGE.—The term ‘mail-order prescription
3 drug coverage’ means provision of benefits for
4 prescription drugs and biologicals that are de-
5 livered directly to participants and beneficiaries
6 through the mail or similar means.

7 “(B) NON-MAIL-ORDER PRESCRIPTION
8 DRUG COVERAGE.—The term ‘non-mail-order
9 prescription drug coverage’ means the provision
10 of benefits for prescription drugs and
11 biologicals through one or more local phar-
12 macies.

13 “(C) LOCAL PHARMACY.—The term ‘local
14 pharmacy’ means, with respect to a prescription
15 drug or biological and a participant or bene-
16 ficiary, an establishment that is authorized to
17 dispense such drug or biological and that is lo-
18 cated within such distance (not to exceed 5
19 miles in the case of a participant or beneficiary
20 residing in an urban area or 10 miles in the
21 case of a participant or beneficiary residing in
22 a non-urban area) of the residence of such par-
23 ticipant or beneficiary, as the Secretary of
24 Health and Human Services shall prescribe.

1 “(b) PROHIBITIONS.—A group health plan, and a
2 health insurance issuer offering group health insurance
3 coverage in connection with a group health plan, may not
4 provide monetary payments or rebates to an individual to
5 encourage such individual to accept less than the mini-
6 mum protections available under this section.

7 “(c) CONSTRUCTION.—Nothing in this section shall
8 be construed as preventing a plan or issuer from—

9 “(1) restricting the drugs for which benefits are
10 provided under the plan or health insurance cov-
11 erage, or

12 “(2) imposing a limitation on the amount of
13 benefits provided with respect to such coverage or
14 the cost-sharing that may be imposed with respect to
15 such coverage,

16 so long as such restrictions and limitations are consistent
17 with subsection (a).

18 “(d) NOTICE.—A group health plan under this part
19 shall comply with the notice requirement under section
20 713(d) of the Employee Retirement Income Security Act
21 of 1974 with respect to the requirements of this section
22 as if such section applied to such plan.”.

23 (B) Section 2723(c) of such Act (42 U.S.C.
24 300gg-23(c)), as amended by section 604(b)(2) of

1 Public Law 104–204, is amended by striking “sec-
2 tion 2704” and inserting “sections 2704 and 2706”.

3 (2) ERISA AMENDMENTS.—(A) Subpart B of
4 part 7 of subtitle B of title I of the Employee Re-
5 tirement Income Security Act of 1974 (as added by
6 section 603(a) of the Newborns’ and Mothers’
7 Health Protection Act of 1996 and amended by sec-
8 tion 702(a) of the Mental Health Parity Act of
9 1996) is amended by adding at the end the following
10 new section:

11 **“SEC. 713. EQUITY IN PROVISION OF PRESCRIPTION DRUG**
12 **COVERAGE.**

13 “(a) EQUITY IN PROVISION OF PRESCRIPTION DRUG
14 COVERAGE.—

15 “(1) IN GENERAL.—A group health plan, and a
16 health insurance issuer offering group health insur-
17 ance coverage, that provides for mail-order prescrip-
18 tion drug coverage (as defined in paragraph (3)(A))
19 shall also provide non-mail-order prescription drug
20 coverage consistent with paragraph (2).

21 “(2) EQUITABLE COVERAGE.—A plan or cov-
22 erage provides non-mail-order prescription drug cov-
23 erage consistent with this paragraph only if—

24 “(A) benefits under the non-mail-order
25 prescription coverage are provided for in the

1 case of all drugs and all circumstances under
2 which benefits are provided under the mail-
3 order prescription drug coverage;

4 “(B) no deductible or similar cost-sharing
5 is imposed with respect to benefits under the
6 non-mail-order prescription drug coverage un-
7 less such a deductible or similar cost-sharing is
8 imposed with respect to benefits under the mail-
9 order prescription drug coverage; and

10 “(C) the benefits for the non-mail-order
11 coverage assures payments consistent with ei-
12 ther (or both) of the following clauses:

13 “(i) The dollar amount of payment for
14 prescription drug coverage is not less than
15 the dollar amount of benefits provided with
16 respect to the mail-order coverage for that
17 same coverage.

18 “(ii) The cost-sharing (including
19 deductibles, copayments, or coinsurance)
20 imposed with respect to non-mail-order
21 coverage is not greater (as a percentage of
22 charges or dollar amount, as specified
23 under the coverage) than the cost-sharing
24 imposed with respect to the mail-order cov-
25 erage.

1 “(3) DEFINITIONS.—For purposes of this sub-
2 section:

3 “(A) MAIL-ORDER PRESCRIPTION DRUG
4 COVERAGE.—The term ‘mail-order prescription
5 drug coverage’ means provision of benefits for
6 prescription drugs and biologicals that are de-
7 livered directly to participants and beneficiaries
8 through the mail or similar means.

9 “(B) NON-MAIL-ORDER PRESCRIPTION
10 DRUG COVERAGE.—The term ‘non-mail-order
11 prescription drug coverage’ means the provision
12 of benefits for prescription drugs and
13 biologicals through one or more local phar-
14 macies.

15 “(C) LOCAL PHARMACY.—The term ‘local
16 pharmacy’ means, with respect to a prescription
17 drug or biological and a participant or bene-
18 ficiary, an establishment that is authorized to
19 dispense such drug or biological and that is lo-
20 cated within such distance (not to exceed 5
21 miles in the case of a participant or beneficiary
22 residing in an urban area or 10 miles in the
23 case of a participant or beneficiary residing in
24 a non-urban area) of the residence of such par-

1 participant or beneficiary, as the Secretary of
2 Health and Human Services shall prescribe.

3 “(b) PROHIBITIONS.—A group health plan, and a
4 health insurance issuer offering group health insurance
5 coverage in connection with a group health plan, may not
6 provide monetary payments or rebates to an individual to
7 encourage such individual to accept less than the mini-
8 mum protections available under this section.

9 “(c) CONSTRUCTION.—Nothing in this section shall
10 be construed as preventing a plan or issuer from—

11 “(1) restricting the drugs for which benefits are
12 provided under the plan or health insurance cov-
13 erage, or

14 “(2) imposing a limitation on the amount of
15 benefits provided with respect to such coverage or
16 the cost-sharing that may be imposed with respect to
17 such coverage,

18 so long as such restrictions and limitations are consistent
19 with subsection (a).

20 “(d) NOTICE UNDER GROUP HEALTH PLAN.—The
21 imposition of the requirements of this section shall be
22 treated as a material modification in the terms of the plan
23 described in section 102(a)(1), for purposes of assuring
24 notice of such requirements under the plan; except that
25 the summary description required to be provided under the

1 last sentence of section 104(b)(1) with respect to such
2 modification shall be provided by not later than 60 days
3 after the first day of the first plan year in which such
4 requirements apply.”.

5 (B) Section 731(c) of such Act (29 U.S.C.
6 1191(c)), as amended by section 603(b)(1) of Public
7 Law 104–204, is amended by striking “section 711”
8 and inserting “sections 711 and 713”.

9 (C) Section 732(a) of such Act (29 U.S.C.
10 1191a(a)), as amended by section 603(b)(2) of Pub-
11 lic Law 104–204, is amended by striking “section
12 711” and inserting “sections 711 and 713”.

13 (D) The table of contents in section 1 of such
14 Act is amended by inserting after the item relating
15 to section 712 the following new item:

“Sec. 713. Equity in provision of prescription drug coverage.”.

16 (b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B
17 of title XXVII of the Public Health Service Act (as added
18 by section 605(a) of the Newborn’s and Mother’s Health
19 Protection Act of 1996) is amended by inserting after sec-
20 tion 2751 the following new section:

21 **“SEC. 2752. EQUITY IN PROVISION OF PRESCRIPTION DRUG**
22 **COVERAGE.**

23 “(a) IN GENERAL.—The provisions of section 2706
24 (other than subsection (d)) shall apply to health insurance
25 coverage offered by a health insurance issuer in the indi-

1 vidual market in the same manner as it applies to health
2 insurance coverage offered by a health insurance issuer
3 in connection with a group health plan in the small or
4 large group market.

5 “(b) NOTICE.—A health insurance issuer under this
6 part shall comply with the notice requirement under sec-
7 tion 713(d) of the Employee Retirement Income Security
8 Act of 1974 with respect to the requirements referred to
9 in subsection (a) as if such section applied to such issuer
10 and such issuer were a group health plan.”.

11 (2) Section 2762(b)(2) of such Act (42 U.S.C.
12 300gg-62(b)(2)), as added by section 605(b)(3)(B) of
13 Public Law 104-204, is amended by striking “section
14 2751” and inserting “sections 2751 and 2752”.

15 (c) APPLICATION TO MEDICARE MANAGED CARE
16 PLANS.—Subparagraph (B) of section 1876(c)(4) of the
17 Social Security Act (42 U.S.C. 1395mm(c)(4)) is amended
18 to read as follows:

19 “(B) meets the requirements of section 2752 of
20 the Public Health Service Act with respect to indi-
21 viduals enrolled with the organization under this sec-
22 tion.”.

23 (d) APPLICATION TO MEDICAID MANAGED CARE
24 PLANS.—Title XIX of such Act (42 U.S.C. 1396 et seq.)

1 is amended by inserting after section 1908 the following
2 new section:

3 “EQUITY IN PROVISION OF PRESCRIPTION DRUG
4 COVERAGE

5 “SEC. 1909. (a) IN GENERAL.—A State plan may
6 not be approved under this title, and Federal financial
7 participation not available under section 1903(a) with re-
8 spect to such a plan, unless the plan requires each health
9 insurance issuer or other entity with a contract with such
10 plan to provide coverage or benefits to individuals eligible
11 for medical assistance under the plan to comply with the
12 provisions of section 2752 of the Public Health Service
13 Act with respect to such coverage or benefits.

14 “(b) WAIVERS PROHIBITED.—The requirement of
15 subsection (a) may not be waived under section 1115 or
16 section 1915(b) of the Social Security Act.”.

17 (e) MEDIGAP AND MEDICARE SELECT POLICIES.—
18 Section 1882 of such Act (42 U.S.C. 1395ss) is amend-
19 ed—

20 (1) in subsection (s)(2), by adding at the end
21 the following new subparagraph:

22 “(D) An issuer of a medicare supplemental policy (as
23 defined in section 1882(g)) shall comply with the require-
24 ments of section 2752 of the Public Health Service Act
25 with respect to benefits offered under such policy.”; and

26 (2) in subsection (t)(1)—

1 (A) in subparagraph (B), by inserting
2 “subject to subparagraph (G),” after “(B),”

3 (B) by striking “and” at the end of sub-
4 paragraph (E),

5 (C) by striking the period at the end of
6 subparagraph (F) and inserting “; and”, and

7 (D) by adding at the end the following new
8 subparagraph:

9 “(G) the issuer of the policy complies with the
10 requirements of section 2752 of the Public Health
11 Service Act with respect to enrollees under this sub-
12 section .”.

13 (f) FEHBP.—Section 8902 of title 5, United States
14 Code, is amended by adding at the end the following new
15 subsection:

16 “(o) A contract may not be made or a plan approved
17 which excludes or does not comply with the requirements
18 of section 2752 of the Public Health Service Act.”.

19 (g) EFFECTIVE DATES.—(1)(A) Subject to subpara-
20 graph (B), the amendments made by subsection (a) shall
21 apply with respect to group health plans for plan years
22 beginning on or after January 1, 1998.

23 (B) In the case of a group health plan maintained
24 pursuant to 1 or more collective bargaining agreements
25 between employee representatives and 1 or more employ-

1 ers ratified before the date of enactment of this Act, the
2 amendments made by subsection (a) shall not apply to
3 plan years beginning before the later of—

4 (i) the date on which the last collective bargain-
5 ing agreements relating to the plan terminates (de-
6 termined without regard to any extension thereof
7 agreed to after the date of enactment of this Act),
8 or

9 (ii) January 1, 1998.

10 For purposes of clause (i), any plan amendment made pur-
11 suant to a collective bargaining agreement relating to the
12 plan which amends the plan solely to conform to any re-
13 quirement added by subsection (a) shall not be treated as
14 a termination of such collective bargaining agreement.

15 (2) The amendments made by subsection (b) shall
16 apply with respect to health insurance coverage offered,
17 sold, issued, renewed, in effect, or operated in the individ-
18 ual market on or after January 1, 1998.

19 (3) The amendment made by subsection (c) shall
20 apply to contracts for contract periods beginning on or
21 after January 1, 1998.

22 (4) The amendment made by subsection (d) shall
23 apply to Federal financial participation for State plan ex-
24 penditures made on or after January 1, 1998.

1 (5) The amendments made by subsection (e) shall
2 apply with respect to medicare supplemental policies and
3 medicare select policies offered, sold, issued, renewed, in
4 effect, or operated on and after January 1, 1998.

5 (6) The amendment made by subsection (f) shall
6 apply with respect to contracts for periods beginning on
7 and after January 1, 1998.

8 (h) COORDINATED REGULATIONS.—Section 104(1)
9 of the Health Insurance Portability and Accountability
10 Act of 1996 is amended by striking “this subtitle (and
11 the amendments made by this subtitle and section 401)”
12 and inserting “the provisions of part 7 of subtitle B of
13 title I of the Employee Retirement Income Security Act
14 of 1974, and the provisions of parts A and C of title
15 XXVII of the Public Health Service Act”.

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