109TH CONGRESS 2D SESSION

H. R. 5937

To assure equitable treatment in health care coverage of prescription drugs under group health plans, health insurance coverage, Medicare and Medicaid managed care arrangements, Medigap insurance coverage, and health plans under the Federal employees' health benefits program (FEHBP).

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2006

Mrs. LOWEY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and Government Reform, 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 under group health plans, health insurance coverage, Medicare and Medicaid managed care arrangements, Medigap insurance coverage, and health plans under the Federal employees' health benefits program (FEHBP).

Be it enacted by the Senate and House of Representa-

tives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the “Prescription Drug Benefit Equity Act of 2006”.

SEC. 2. EQUITY IN PROVISION OF PRESCRIPTION DRUG COVERAGE.

(a) Group Health Plans.—

(1) Public health service act amendments.—(A) Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

“SEC. 2707. EQUITY IN PROVISION OF PRESCRIPTION DRUG COVERAGE.

“(a) Equity in Provision of Prescription Drug Coverage.—

“(1) In general.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides for mail-order prescription drug coverage (as defined in paragraph (3)(A)) shall also provide non-mail-order prescription drug coverage consistent with paragraph (2).

“(2) Equitable coverage.—A plan or coverage provides non-mail-order prescription drug coverage consistent with this paragraph only if—

“(A) benefits under the non-mail-order prescription coverage are provided for in the case of all drugs and all circumstances under...
which benefits are provided under the mail-order prescription drug coverage;

“(B) no deductible or similar cost-sharing is imposed with respect to benefits under the non-mail-order prescription drug coverage unless such a deductible or similar cost-sharing is imposed with respect to benefits under the mail-order prescription drug coverage; and

“(C) the benefits for the non-mail-order coverage assures payments consistent with either (or both) of the following clauses:

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

“(ii) The cost-sharing (including deductibles, copayments, or coinsurance) imposed with respect to non-mail-order coverage is not greater (as a percentage of charges or dollar amount, as specified under the coverage) than the cost-sharing imposed with respect to the mail-order coverage.
"(3) DEFINITIONS.—For purposes of this sub-
section:

"(A) MAIL-ORDER PRESCRIPTION DRUG
COVERAGE.—The term ‘mail-order prescription
drug coverage’ means provision of benefits for
prescription drugs and biologicals that are de-
ivered directly to participants and beneficiaries
through the mail or similar means.

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

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

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

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

“(1) restricting the drugs for which benefits are provided under the plan or health insurance coverage, or

“(2) imposing a limitation on the amount of benefits provided with respect to such coverage or the cost-sharing that may be imposed with respect to such coverage, so long as such restrictions and limitations are consistent with subsection (a).

“(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 714(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.”.
(B) Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking “section 2704” and inserting “sections 2704 and 2707”.

(2) ERISA AMENDMENTS.—(A) Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

“SEC. 714. EQUITY IN PROVISION OF PRESCRIPTION DRUG COVERAGE.

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

“(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides for mail-order prescription drug coverage (as defined in paragraph (3)(A)) shall also provide non-mail-order prescription drug coverage consistent with paragraph (2).

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

“(A) benefits under the non-mail-order prescription coverage are provided for in the case of all drugs and all circumstances under which benefits are provided under the mail-order prescription drug coverage;
“(B) no deductible or similar cost-sharing is imposed with respect to benefits under the non-mail-order prescription drug coverage unless such a deductible or similar cost-sharing is imposed with respect to benefits under the mail-order prescription drug coverage; and

“(C) the benefits for the non-mail-order coverage assures payments consistent with either (or both) of the following clauses:

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

“(ii) The cost-sharing (including deductibles, copayments, or coinsurance) imposed with respect to non-mail-order coverage is not greater (as a percentage of charges or dollar amount, as specified under the coverage) than the cost-sharing imposed with respect to the mail-order coverage.

“(3) DEFINITIONS.—For purposes of this subsection:
“(A) Mail-order prescription drug coverage.—The term ‘mail-order prescription drug coverage’ means provision of benefits for prescription drugs and biologicals that are delivered directly to participants and beneficiaries through the mail or similar means.

“(B) Non-mail-order prescription drug coverage.—The term ‘non-mail-order prescription drug coverage’ means the provision of benefits for prescription drugs and biologicals through one or more local pharmacies.

“(C) Local pharmacy.—The term ‘local pharmacy’ means, with respect to a prescription drug or biological and a participant or beneficiary, an establishment that is authorized to dispense such drug or biological and that is located within such distance (not to exceed 5 miles in the case of a participant or beneficiary residing in an urban area or 10 miles in the case of a participant or beneficiary residing in a non-urban area) of the residence of such participant or beneficiary, as the Secretary of Health and Human Services shall prescribe.
“(b) Prohibitions.—A group health plan, and a
health insurance issuer offering group health insurance
coverage in connection with a group health plan, may not
provide monetary payments or rebates to an individual to
encourage such individual to accept less than the min-
imum protections available under this section.

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

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

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

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

“(d) Notice Under Group Health Plan.—The
imposition of the requirements of this section shall be
treated as a material modification in the terms of the plan
described in section 102(a)(1), for purposes of assuring
notice of such requirements under the plan; except that
the summary description required to be provided under the
last sentence of section 104(b)(1) with respect to such
modification shall be provided by not later than 60 days
after the first day of the first plan year in which such
requirements apply.”.

(B) Section 731(c) of such Act (29 U.S.C.
1191(c)) is amended by striking “section 711” and
inserting “sections 711 and 714”.

(C) Section 732(a) of such Act (29 U.S.C.
1191a(a)) is amended by striking “section 711” and
inserting “sections 711 and 714”.

(D) The table of contents in section 1 of such
Act is amended by inserting after the item relating
to section 713 the following new item:

“Sec. 714. Equity in provision of prescription drug coverage.”.

(3) INTERNAL REVENUE CODE AMEND-
MENTS.—Subchapter B of chapter 100 of the Inter-
nal Revenue Code of 1986 is amended—

(A) in the table of sections, by inserting
after the item relating to section 9812 the fol-
lowing new item:

“Sec. 9813. Equity in provision of prescription drug coverage.”;

and

(B) by inserting after section 9812 the fol-
lowing:

“SEC. 9813. EQUITY IN PROVISION OF PRESCRIPTION DRUG

COVERAGE.

“(a) Equity in Provision of Prescription Drug

Coverage.—
“(1) IN GENERAL.—A group health plan that
provides for mail-order prescription drug coverage
(as defined in paragraph (3)(A)) shall also provide
non-mail-order prescription drug coverage consistent
with paragraph (2).

“(2) EQUITABLE COVERAGE.—A plan provides
non-mail-order prescription drug coverage consistent
with this paragraph only if—

“(A) benefits under the non-mail-order
prescription coverage are provided for in the
case of all drugs and all circumstances under
which benefits are provided under the mail-
order prescription drug coverage;

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

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

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

“(ii) The cost-sharing (including deductibles, copayments, or coinsurance) imposed with respect to non-mail-order coverage is not greater (as a percentage of charges or dollar amount, as specified under the coverage) than the cost-sharing imposed with respect to the mail-order coverage.

“(3) DEFINITIONS.—For purposes of this subsection:

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

“(B) NON-MAIL-ORDER PRESCRIPTION DRUG COVERAGE.—The term ‘non-mail-order prescription drug coverage’ means the provision of benefits for prescription drugs and biologicals through one or more local pharmacies.
“(C) LOCAL PHARMACY.—The term ‘local pharmacy’ means, with respect to a prescription drug or biological and a participant or beneficiary, an establishment that is authorized to dispense such drug or biological and that is located within such distance (not to exceed 5 miles in the case of a participant or beneficiary residing in an urban area or 10 miles in the case of a participant or beneficiary residing in a non-urban area) of the residence of such participant or beneficiary, as the Secretary of Health and Human Services shall prescribe.

“(b) PROHIBITIONS.—A group health plan may not provide monetary payments or rebates to an individual to encourage such individual to accept less than the minimum protections available under this section.

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

“(1) restricting the drugs for which benefits are provided under the plan; or

“(2) imposing a limitation on the amount of benefits provided with respect to such coverage or the cost-sharing that may be imposed with respect to such coverage,
so long as such restrictions and limitations are consistent with subsection (a).”.

(b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

“SEC. 2753. EQUITY IN PROVISION OF PRESCRIPTION DRUG COVERAGE.

“(a) IN GENERAL.—The provisions of section 2707 (other than subsection (d)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

“(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 714(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.”.

(2) Section 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking “section 2751” and inserting “sections 2751 and 2753”.
(c) Application to Medicare Managed Care Plans.—

(1) Medicare Advantage Plans.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking “and” at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting “; and”;

(C) by adding at the end the following new subparagraph:

“(F) meets the requirements of section 2753 of the Public Health Service Act with respect to individuals enrolled with the organization under this part.”.

(2) Section 1876.—Section 1876(c)(4) of the Social Security Act (42 U.S.C. 1395mm(c)(4)) is amended—

(A) by striking “and” at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting “; and”;

(C) by adding at the end the following new subparagraph:
“(C) meets the requirements of section 2753 of the Public Health Service Act with respect to individuals enrolled with the organization under this section.”.

(d) Application to Medicaid Managed Care Plans.—Title XIX of such Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1925 the following new section:

“EQUITY IN PROVISION OF PRESCRIPTION DRUG COVERAGE

“Sec. 1926. (a) In General.—A State plan may not be approved under this title, and Federal financial participation not available under section 1903(a) with respect to such a plan, unless the plan requires each health insurance issuer or other entity with a contract with such plan to provide coverage or benefits to individuals eligible for medical assistance under the plan to comply with the provisions of section 2753 of the Public Health Service Act with respect to such coverage or benefits.

“(b) Waivers Prohibited.—The requirement of subsection (a) may not be waived under section 1115 or section 1915(b).”.

(e) Medigap and Medicare Select Policies.—Section 1882 of such Act (42 U.S.C. 1395ss) is amended—
(1) in subsection (s)(2), by adding at the end
the following new subparagraph:

“(E) An issuer of a medicare supplemental policy (as
defined in section 1882(g)) shall comply with the require-
ments of section 2753 of the Public Health Service Act
with respect to benefits offered under such policy.”; and

(2) in subsection (t)(1)—

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

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

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

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

“(G) the issuer of the policy complies with the
requirements of section 2753 of the Public Health
Service Act with respect to enrollees under this sub-
section.”.

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

“(p) A contract may not be made or a plan approved
which excludes does not comply with the requirements of
section 2753 of the Public Health Service Act.”.
(g) Effective Dates.—(1)(A) Subject to subparagraph (B), the amendments made by subsection (a) apply with respect to group health plans for plan years beginning on or after January 1, 2007.

(B) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by subsection (a) do not apply to plan years beginning before the later of—

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or


For purposes of clause (i), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

(2) The amendments made by subsection (b) apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2007.
(3) The amendment made by subsection (c) apply to contracts for contract periods beginning on or after January 1, 2007.

(4) The amendment made by subsection (d) apply to Federal financial participation for State plan expenditures made on or after January 1, 2007.

(5) The amendments made by subsection (e) apply with respect to medicare supplemental policies and medicare select policies offered, sold, issued, renewed, in effect, or operated on and after January 1, 2007.

(6) The amendment made by subsection (f) apply with respect to contracts for periods beginning on and after January 1, 2007.

(h) COORDINATION OF ADMINISTRATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and
(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.