

105TH CONGRESS  
2D SESSION

# H. R. 4559

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.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 14, 1998

Mr. BROWN of Ohio 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

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## 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.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Prescription Drug Pa-  
3 tient Choice Act of 1998”.

4 **SEC. 2. EQUITY IN PROVISION OF PRESCRIPTION DRUG**  
5 **COVERAGE.**

6 (a) GROUP HEALTH PLANS.—

7 (1) PUBLIC HEALTH SERVICE ACT AMEND-  
8 MENTS.—(A) Subpart 2 of part A of title XXVII of  
9 the Public Health Service Act is amended by adding  
10 at the end the following new section:

11 **“SEC. 2706. EQUITY IN PROVISION OF PRESCRIPTION DRUG**  
12 **COVERAGE.**

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

15 “(1) IN GENERAL.—If a group health plan or  
16 a health insurance issuer offering group health in-  
17 surance coverage provides for prescription drug cov-  
18 erage only if such drugs are furnished through pro-  
19 viders who are members of a network of providers  
20 who have entered into a contract with the plan or  
21 issuer to provide such drugs, the issuer shall also  
22 offer to enrollees the option of health insurance cov-  
23 erage which provides for coverage of such drugs  
24 which are not furnished through providers who are  
25 members of such network.

1           “(2) PREMIUMS.—A group health plan or a  
2 health insurance issuer offering group health insur-  
3 ance coverage may not charge a higher premium, co-  
4 payment, or deductible for coverage of drugs which  
5 are furnished through providers who are not mem-  
6 bers of a network of providers who have entered into  
7 a contract with the plan or issuer.

8           “(3) COST SHARING.—Under the option de-  
9 scribed in paragraph (1), the health insurance cov-  
10 erage shall provide for reimbursement rates for pre-  
11 scription coverage offered by nonparticipating pro-  
12 viders that are not less than the reimbursement  
13 rates for prescription coverage offered by participat-  
14 ing pharmacies.

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

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

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

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



1 which are not furnished through providers who are  
2 members of such network.

3 “(2) PREMIUMS.—A group health plan or a  
4 health insurance issuer offering group health insur-  
5 ance coverage may not charge a higher premium, co-  
6 payment, or deductible for coverage of drugs which  
7 are furnished through providers who are not mem-  
8 bers of a network of providers who have entered into  
9 a contract with the plan or issuer.

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11 scribed in paragraph (1), the health insurance cov-  
12 erage shall provide for reimbursement rates for pre-  
13 scription coverage offered by non participating pro-  
14 viders that are not less than the reimbursement  
15 rates for prescription coverage offered by participat-  
16 ing pharmacies.

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

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

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

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

3 “(c) NOTICE UNDER GROUP HEALTH PLAN.—The  
4 imposition of the requirements of this section shall be  
5 treated as a material modification in the terms of the plan  
6 described in section 102(a)(1), for purposes of assuring  
7 notice of such requirements under the plan; except that  
8 the summary description required to be provided under the  
9 last sentence of section 104(b)(1) with respect to such  
10 modification shall be provided by not later than 60 days  
11 after the first day of the first plan year in which such  
12 requirements apply.”.

13 (B) Section 731(c) of such Act (29 U.S.C.  
14 1191(c)) is amended by striking “section 711” and  
15 inserting “sections 711 and 713”.

16 (C) Section 732(a) of such Act (29 U.S.C.  
17 1191a(a)) is amended by striking “section 711” and  
18 inserting “sections 711 and 713”.

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

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

22 (b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B  
23 of title XXVII of the Public Health Service Act is amend-  
24 ed by inserting after section 2751 the following new sec-  
25 tion:

1 **“SEC. 2752. EQUITY IN PROVISION OF PRESCRIPTION DRUG**  
2 **COVERAGE.**

3 “(a) IN GENERAL.—The provisions of section 2706  
4 (other than subsection (c)) shall apply to health insurance  
5 coverage offered by a health insurance issuer in the indi-  
6 vidual market in the same manner as it applies to health  
7 insurance coverage offered by a health insurance issuer  
8 in connection with a group health plan in the small or  
9 large group market.

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

16 (2) Section 2762(b)(2) of such Act (42 U.S.C.  
17 300gg-62(b)(2)) is amended by striking “section 2751”  
18 and inserting “sections 2751 and 2752”.

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

23 “(B) meets the requirements of section 2752 of  
24 the Public Health Service Act with respect to indi-  
25 viduals enrolled with the organization under this sec-  
26 tion.”.

1 (d) APPLICATION TO MEDICAID MANAGED CARE  
2 PLANS.—Title XIX of such Act (42 U.S.C. 1396 et seq.)  
3 is amended by inserting after section 1908 the following  
4 new section:

5 “EQUITY IN PROVISION OF PRESCRIPTION DRUG  
6 COVERAGE

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

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

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

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

24 “(E) An issuer of a medicare supplemental policy (as  
25 defined in section 1882(g)) shall comply with the require-

1 ments of section 2752 of the Public Health Service Act  
2 with respect to benefits offered under such policy.”; and

3 (2) in subsection (t)(1)—

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

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

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

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

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

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

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

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

1 (B) In the case of a group health plan maintained  
2 pursuant to 1 or more collective bargaining agreements  
3 between employee representatives and 1 or more employ-  
4 ers that is ratified before the date of enactment of this  
5 Act, the amendments made by subsection (a) shall not  
6 apply to plan years beginning before the later of—

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

12 (ii) January 1, 1998.

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

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

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

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

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

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

11           (h) COORDINATED REGULATIONS.—Section 104(1)  
12 of Health Insurance Portability and Accountability Act of  
13 1996 is amended by striking “this subtitle (and the  
14 amendments made by this subtitle and section 401)” and  
15 inserting “the provisions of part 7 of subtitle B of title  
16 I of the Employee Retirement Income Security Act of  
17 1974, and the provisions of parts A and C of title XXVII  
18 of the Public Health Service Act”.

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