

109<sup>TH</sup> CONGRESS  
2<sup>D</sup> 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).

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  
3 Benefit Equity Act of 2006”.

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. 2707. 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  
26 case of all drugs and all circumstances under

1           which benefits are provided under the mail-  
2           order prescription drug coverage;

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

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

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

17           “(ii) The cost-sharing (including  
18           deductibles, copayments, or coinsurance)  
19           imposed with respect to non-mail-order  
20           coverage is not greater (as a percentage of  
21           charges or dollar amount, as specified  
22           under the coverage) than the cost-sharing  
23           imposed with respect to the mail-order cov-  
24           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           ticipant 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 min-  
8 imum 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.—A group health plan under this part  
21 shall comply with the notice requirement under section  
22 714(d) of the Employee Retirement Income Security Act  
23 of 1974 with respect to the requirements of this section  
24 as if such section applied to such plan.”.



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 min-  
6 imum 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 UNDER GROUP HEALTH PLAN.—The  
19 imposition of the requirements of this section shall be  
20 treated as a material modification in the terms of the plan  
21 described in section 102(a)(1), for purposes of assuring  
22 notice of such requirements under the plan; except that  
23 the summary description required to be provided under the  
24 last sentence of section 104(b)(1) with respect to such  
25 modification shall be provided by not later than 60 days

1 after the first day of the first plan year in which such  
2 requirements apply.”.

3 (B) Section 731(e) of such Act (29 U.S.C.  
4 1191(e)) is amended by striking “section 711” and  
5 inserting “sections 711 and 714”.

6 (C) Section 732(a) of such Act (29 U.S.C.  
7 1191a(a)) is amended by striking “section 711” and  
8 inserting “sections 711 and 714”.

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

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

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

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

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

18 and

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

21 **“SEC. 9813. EQUITY IN PROVISION OF PRESCRIPTION DRUG**  
22 **COVERAGE.**

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

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

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

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

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

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

23           “(i) The dollar amount of payment for  
24 prescription drug coverage is not less than  
25 the dollar amount of benefits provided with

1           respect to the mail-order coverage for that  
2           same coverage.

3           “(ii) The cost-sharing (including  
4           deductibles, copayments, or coinsurance)  
5           imposed with respect to non-mail-order  
6           coverage is not greater (as a percentage of  
7           charges or dollar amount, as specified  
8           under the coverage) than the cost-sharing  
9           imposed with respect to the mail-order cov-  
10          erage.

11          “(3) DEFINITIONS.—For purposes of this sub-  
12          section:

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

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

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

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

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

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

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

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

3 (b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B  
4 of title XXVII of the Public Health Service Act is amend-  
5 ed by inserting after section 2752 the following new sec-  
6 tion:

7 **“SEC. 2753. EQUITY IN PROVISION OF PRESCRIPTION DRUG**  
8 **COVERAGE.**

9 “(a) IN GENERAL.—The provisions of section 2707  
10 (other than subsection (d)) shall apply to health insurance  
11 coverage offered by a health insurance issuer in the indi-  
12 vidual market in the same manner as it applies to health  
13 insurance coverage offered by a health insurance issuer  
14 in connection with a group health plan in the small or  
15 large group market.

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

22 (2) Section 2762(b)(2) of such Act (42 U.S.C.  
23 300gg-62(b)(2)) is amended by striking “section 2751”  
24 and inserting “sections 2751 and 2753”.

1           (c) APPLICATION TO MEDICARE MANAGED CARE  
2 PLANS.—

3           (1) MEDICARE ADVANTAGE PLANS.—Section  
4           1852(d)(1) of the Social Security Act (42 U.S.C.  
5           1395w–22(d)(1)) is amended—

6                   (A) by striking “and” at the end of sub-  
7           paragraph (D);

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

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

12                           “(F) meets the requirements of section  
13           2753 of the Public Health Service Act with re-  
14           spect to individuals enrolled with the organiza-  
15           tion under this part.”.

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

19                   (A) by striking “and” at the end of sub-  
20           paragraph (A);

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

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



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

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

7           (2) in subsection (t)(1)—

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

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

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

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

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

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

23           “(p) A contract may not be made or a plan approved  
24 which excludes does not comply with the requirements of  
25 section 2753 of the Public Health Service Act.”.

1 (g) EFFECTIVE DATES.—(1)(A) Subject to subpara-  
2 graph (B), the amendments made by subsection (a) apply  
3 with respect to group health plans for plan years begin-  
4 ning on or after January 1, 2007.

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

11 (i) the date on which the last collective bar-  
12 gaining agreements relating to the plan terminates  
13 (determined without regard to any extension thereof  
14 agreed to after the date of enactment of this Act),  
15 or

16 (ii) January 1, 2007.

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

22 (2) The amendments made by subsection (b) apply  
23 with respect to health insurance coverage offered, sold,  
24 issued, renewed, in effect, or operated in the individual  
25 market on or after January 1, 2007.

1           (3) The amendment made by subsection (c) apply to  
2 contracts for contract periods beginning on or after Janu-  
3 ary 1, 2007.

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

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

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

14          (h) COORDINATION OF ADMINISTRATION.—The Sec-  
15 retary of Labor, the Secretary of the Treasury, and the  
16 Secretary of Health and Human Services shall ensure,  
17 through the execution of an interagency memorandum of  
18 understanding among such Secretaries, that—

19               (1) regulations, rulings, and interpretations  
20 issued by such Secretaries relating to the same mat-  
21 ter over which two or more such Secretaries have re-  
22 sponsibility under the provisions of this Act (and the  
23 amendments made thereby) are administered so as  
24 to have the same effect at all times; and

1           (2) coordination of policies relating to enforcing  
2           the same requirements through such Secretaries in  
3           order to have a coordinated enforcement strategy  
4           that avoids duplication of enforcement efforts and  
5           assigns priorities in enforcement.

○