

LB 1017

LB 1017 seeks to mandate insured Nebraskans have access to reasonable prescription drug benefits by requiring that all health plans delivered or renewed on or after Jan. 1, 2011, by meeting the following criteria:

- Insurers cannot create specialty tiers that require payment of a percentage of prescription costs.
- Insurers cannot charge prescription drug co-pays that exceed the cost of that prescription to the health care plan, nor can they charge a co-pay that exceeds by 500 percent the lowest prescription drug co-pay in the plan.
- If a health plan includes a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer must include a provision that would result in the lowest out-of-pocket prescription drug cost to the subscriber. Either out-of-pocket expenses for prescription drugs would be included under the plan's total limit for out-of-pocket expenses or prescription drugs could not exceed \$1,000 per individual or \$2,000 per family for the contract year.