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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

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A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Casey, Solomon, Ruggiero, Canario, and Shekarchi

Date Introduced: February 13, 2020

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-50 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-50. Drug coverage.**

4 (a) Any accident and sickness insurer that utilizes a formulary of medications for which
5 coverage is provided under an individual or group-plan, master contract shall require any
6 physician or other person authorized by the department of health to prescribe medication to
7 prescribe from the formulary. A physician or other person authorized by the department of health
8 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
9 accident and sickness insurer's formulary if he or she believes that the prescription of the non-
10 formulary medication is medically necessary. An accident and sickness insurer shall be required
11 to provide coverage for a non-formulary medication only when the non-formulary medication
12 meets the accident and sickness insurer's medical-exception criteria for the coverage of that
13 medication.

14 (b) An accident and sickness insurer's medical exception criteria for the coverage of non-
15 formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).

16 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
17 section may appeal the denial in accordance with the rules and regulations promulgated by the
18 department of health pursuant to chapter 17.12 of title 23.

19 (d) ~~Prior to removing a prescription drug from its plan's formulary or making any change~~

1 ~~in the preferred or tiered, cost sharing status of a covered prescription drug, an accident and~~
2 ~~sickness insurer must provide at least thirty (30) days' notice to authorized prescribers by~~
3 ~~established communication methods of policy and program updates and by updating available~~
4 ~~references on web-based publications. All adversely affected members must be provided at least~~
5 ~~thirty (30) days' notice prior to the date such change becomes effective by a direct notification:~~

6 ~~(i) The written or electronic notice must contain the following information:~~

7 ~~(A) The name of the affected prescription drug;~~

8 ~~(B) Whether the plan is removing the prescription drug from the formulary, or changing~~
9 ~~its preferred or tiered, cost sharing status; and~~

10 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~
11 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
12 ~~respectively.~~

13 ~~(ii) An accident and sickness insurer may immediately remove from its plan formularies~~
14 ~~covered prescription drugs deemed unsafe by the accident and sickness insurer or the Food and~~
15 ~~Drug Administration, or removed from the market by their manufacturer, without meeting the~~
16 ~~requirements of this section.~~

17 (e) Prescription drug formulary changes;

18 (1) Except as otherwise provided in subsection (e)(3) of this section, a health care plan
19 shall not:

20 (i) Remove a prescription drug from a formulary;

21 (ii) Move a prescription drug to a tier with a larger deductible, copayment, or coinsurance
22 if the formulary includes two (2) or more tiers of benefits providing for different deductibles,
23 copayments or coinsurance applicable to the prescription drugs in each tier; or

24 (iii) Add utilization management restrictions to a prescription drug on a formulary, unless
25 such changes occur at the time of enrollment or issuance of coverage.

26 (2) Prohibitions provided in subsection (e)(1) of this section shall apply beginning on the
27 date on which open enrollment begins for a plan year and through the end of the plan year to
28 which such open enrollment period applies.

29 (3) A health care plan with a formulary that includes two (2) or more tiers of benefits
30 providing for different deductibles, copayments or coinsurance applicable to prescription drugs in
31 each tier may move a prescription drug to a tier with a larger deductible, copayment or
32 coinsurance if an AB-rated generic equivalent or interchangeable biological product for such
33 prescription drug is added to the formulary at the same time. A health care plan may remove a
34 prescription drug from a formulary if the federal Food and Drug Administration determines that

1 such prescription drug should be removed from the market, including new utilization
2 management restrictions issued pursuant to federal Food and Drug Administration safety
3 concerns.

4 (4) A health care plan shall provide notice to policyholders of the intent to remove a
5 prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in
6 the upcoming plan year, thirty (30) days prior to the open enrollment period for the consecutive
7 plan year. Such notice of impending formulary and deductible, copayment or coinsurance
8 changes shall also be posted on the plan's online formulary and in any prescription drug finder
9 system that the plan provides to the public.

10 (5) The provisions of this subsection shall not supersede the terms of a collective
11 bargaining agreement, or the rights of a labor organization or other duly authorized representative
12 to collectively bargain changes to the formularies.

13 ~~(e)~~(f) This section shall not apply to insurance coverage providing benefits for: (1)
14 Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care;
15 (5) Medicare supplement; (6) Limited-benefit health; (7) Specified-disease indemnity; (8)
16 Sickness or bodily injury or death by accident or both; or (9) Other limited-benefit policies.

17 SECTION 2. Section 27-19-42 of the General Laws in Chapter 27-19 entitled "Nonprofit
18 Hospital Service Corporations" is hereby amended to read as follows:

19 **27-19-42. Drug coverage.**

20 (a) Any nonprofit, hospital-service corporation that utilizes a formulary of medications
21 for which coverage is provided under an individual or group-plan, master contract shall require
22 any physician or other person authorized by the department of health to prescribe medication to
23 prescribe from the formulary. A physician or other person authorized by the department of health
24 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
25 nonprofit, hospital-service corporation's formulary if he or she believes that the prescription of
26 the non-formulary medication is medically necessary. A nonprofit, hospital-service corporation
27 shall be required to provide coverage for a non-formulary medication only when the non-
28 formulary medication meets the nonprofit, hospital-service corporation's medical-exception
29 criteria for the coverage of that medication.

30 (b) A nonprofit, hospital-service corporation's medical-exception criteria for the coverage
31 of non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).

32 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
33 section may appeal the denial in accordance with the rules and regulations promulgated by the
34 department of health pursuant to chapter 17.12 of title 23.

1 ~~(d) Prior to removing a prescription drug from its plan's formulary or making any change~~
2 ~~in the preferred or tiered cost sharing status of a covered prescription drug, a nonprofit, hospital-~~
3 ~~service corporation must provide at least thirty (30) days' notice to authorized prescribers by~~
4 ~~established communication methods of policy and program updates and by updating available~~
5 ~~references on web-based publications. All adversely affected members must be provided at least~~
6 ~~thirty (30) days' notice prior to the date such change becomes effective by a direct notification:~~

7 ~~(i) The written or electronic notice must contain the following information:~~

8 ~~(A) The name of the affected prescription drug;~~

9 ~~(B) Whether the plan is removing the prescription drug from the formulary, or changing~~
10 ~~its preferred or tiered, cost sharing status; and~~

11 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~
12 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
13 ~~respectively.~~

14 ~~(ii) A nonprofit, hospital service corporation may immediately remove from its plan~~
15 ~~formularies covered prescription drugs deemed unsafe by the nonprofit, hospital service~~
16 ~~corporation or the Food and Drug Administration, or removed from the market by their~~
17 ~~manufacturer, without meeting the requirements of this section.~~

18 (e) Prescription drug formulary changes:

19 (1) Except as otherwise provided in subsection (e)(3) of this section, a health care plan
20 shall not:

21 (i) Remove a prescription drug from a formulary;

22 (ii) Move a prescription drug to a tier with a larger deductible, copayment, or coinsurance
23 if the formulary includes two (2) or more tiers of benefits providing for different deductibles,
24 copayments or coinsurance applicable to the prescription drugs in each tier; or

25 (iii) Add utilization management restrictions to a prescription drug on a formulary, unless
26 such changes occur at the time of enrollment or issuance of coverage.

27 (2) Prohibitions provided in subsection (e)(1) of this section shall apply beginning on the
28 date on which open enrollment begins for a plan year and through the end of the plan year to
29 which such open enrollment period applies.

30 (3) A health care plan with a formulary that includes two (2) or more tiers of benefits
31 providing for different deductibles, copayments or coinsurance applicable to prescription drugs in
32 each tier may move a prescription drug to a tier with a larger deductible, copayment or
33 coinsurance if an AB-rated generic equivalent or interchangeable biological product for such
34 prescription drug is added to the formulary at the same time. A health care plan may remove a

1 prescription drug from a formulary if the federal Food and Drug Administration determines that
2 such prescription drug should be removed from the market, including new utilization
3 management restrictions issued pursuant to federal Food and Drug Administration safety
4 concerns.

5 (4) A health care plan shall provide notice to policyholders of the intent to remove a
6 prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in
7 the upcoming plan year, thirty (30) days prior to the open enrollment period for the consecutive
8 plan year. Such notice of impending formulary and deductible, copayment or coinsurance
9 changes shall also be posted on the plan's online formulary and in any prescription drug finder
10 system that the plan provides to the public.

11 (5) The provisions of this subsection shall not supersede the terms of a collective
12 bargaining agreement, or the rights of a labor organization or other duly authorized representative
13 to collectively bargain changes to the formularies.

14 SECTION 3. Section 27-20-37 of the General Laws in Chapter 27-20 entitled "Nonprofit
15 Medical Service Corporations" is hereby amended to read as follows:

16 **27-20-37. Drug coverage.**

17 (a) Any nonprofit, medical-service corporation that utilizes a formulary of medications
18 for which coverage is provided under an individual or group-plan, master contract shall require
19 any physician or other person authorized by the department of health to prescribe medication to
20 prescribe from the formulary. A physician or other person authorized by the department of health
21 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
22 nonprofit, medical-service corporation's formulary if he or she believes that the prescription of
23 the non-formulary medication is medically necessary. A nonprofit, medical-service corporation
24 shall be required to provide coverage for a non-formulary medication only when the non-
25 formulary medication meets the nonprofit, medical-service corporation's medical-exception
26 criteria for the coverage of that medication.

27 (b) A nonprofit, medical-service corporation's medical-exception criteria for the coverage
28 of non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).

29 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
30 section may appeal the denial in accordance with the rules and regulations promulgated by the
31 department of health pursuant to chapter 17.12 of title 23.

32 ~~(d) Prior to removing a prescription drug from its plan's formulary or making any change~~
33 ~~in the preferred or tiered, cost-sharing status of a covered prescription drug, a nonprofit, medical-~~
34 ~~service corporation must provide at least thirty (30) days' notice to authorized prescribers by~~

1 ~~established communication methods of policy and program updates and by updating available~~
2 ~~references on web-based publications. All adversely affected members must be provided at least~~
3 ~~thirty (30) days' notice prior to the date such change becomes effective by a direct notification:~~

4 ~~(i) The written or electronic notice must contain the following information:~~

5 ~~(A) The name of the affected prescription drug;~~

6 ~~(B) Whether the plan is removing the prescription drug from the formulary, or changing~~
7 ~~its preferred or tiered, cost sharing status; and~~

8 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~
9 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
10 ~~respectively.~~

11 ~~(ii) A nonprofit, medical service corporation may immediately remove from its plan~~
12 ~~formularies covered prescription drugs deemed unsafe by the nonprofit, medical service~~
13 ~~corporation or the Food and Drug Administration, or removed from the market by their~~
14 ~~manufacturer, without meeting the requirements of this section.~~

15 (e) Prescription drug formulary changes;

16 (1) Except as otherwise provided in subsection (e)(3) of this section, a health care plan
17 shall not:

18 (i) Remove a prescription drug from a formulary;

19 (ii) Move a prescription drug to a tier with a larger deductible, copayment, or coinsurance
20 if the formulary includes two (2) or more tiers of benefits providing for different deductibles,
21 copayments or coinsurance applicable to the prescription drugs in each tier; or

22 (iii) Add utilization management restrictions to a prescription drug on a formulary, unless
23 such changes occur at the time of enrollment or issuance of coverage.

24 (2) Prohibitions provided in subsection (e)(1) of this section shall apply beginning on the
25 date on which open enrollment begins for a plan year and through the end of the plan year to
26 which such open enrollment period applies.

27 (3) A health care plan with a formulary that includes two (2) or more tiers of benefits
28 providing for different deductibles, copayments or coinsurance applicable to prescription drugs in
29 each tier may move a prescription drug to a tier with a larger deductible, copayment or
30 coinsurance if an AB-rated generic equivalent or interchangeable biological product for such
31 prescription drug is added to the formulary at the same time. A health care plan may remove a
32 prescription drug from a formulary if the federal Food and Drug Administration determines that
33 such prescription drug should be removed from the market, including new utilization
34 management restrictions issued pursuant to federal Food and Drug Administration safety

1 concerns.

2 (4) A health care plan shall provide notice to policyholders of the intent to remove a
3 prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in
4 the upcoming plan year, thirty (30) days prior to the open enrollment period for the consecutive
5 plan year. Such notice of impending formulary and deductible, copayment or coinsurance
6 changes shall also be posted on the plan's online formulary and in any prescription drug finder
7 system that the plan provides to the public.

8 (5) The provisions of this subsection shall not supersede the terms of a collective
9 bargaining agreement, or the rights of a labor organization or other duly authorized representative
10 to collectively bargain changes to the formularies.

11 SECTION 4. Section 27-41-51 of the General Laws in Chapter 27-41 entitled "Health
12 Maintenance Organizations" is hereby amended to read as follows:

13 **27-41-51. Drug coverage.**

14 (a) Any health-maintenance organization that utilizes a formulary of medications for
15 which coverage is provided under an individual or group-plan, master contract shall require any
16 physician or other person authorized by the department of health to prescribe medication to
17 prescribe from the formulary. A physician or other person authorized by the department of health
18 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
19 health-maintenance organization's formulary if he or she believes that the prescription of non-
20 formulary medication is medically necessary. A health-maintenance organization shall be
21 required to provide coverage for a non-formulary medication only when the non-formulary
22 medication meets the health-maintenance organization's medical-exception criteria for the
23 coverage of that medication.

24 (b) A health-maintenance organization's medical-exception criteria for the coverage of
25 non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).

26 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
27 section may appeal the denial in accordance with the rules and regulations promulgated by the
28 department of health pursuant to chapter 17.12 of title 23.

29 ~~(d) Prior to removing a prescription drug from its plan's formulary or making any change~~
30 ~~in the preferred or tiered, cost-sharing status of a covered prescription drug, a health-maintenance~~
31 ~~organization must provide at least thirty (30) days' notice to authorized prescribers by established~~
32 ~~communication methods of policy and program updates and by updating available references on~~
33 ~~web-based publications. All adversely affected members must be provided at least thirty (30)~~
34 ~~days' notice prior to the date such change becomes effective by a direct notification:~~

1 ~~(i) The written or electronic notice must contain the following information:~~
2 ~~(A) The name of the affected prescription drug;~~
3 ~~(B) Whether the plan is removing the prescription drug from the formulary, or changing~~
4 ~~its preferred or tiered, cost sharing status; and~~
5 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~
6 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
7 ~~respectively.~~
8 ~~(ii) A health maintenance organization may immediately remove from its plan~~
9 ~~formularies covered prescription drugs deemed unsafe by the health maintenance organization or~~
10 ~~the Food and Drug Administration, or removed from the market by their manufacturer, without~~
11 ~~meeting the requirements of this section.~~
12 (e) Prescription drug formulary changes:
13 (1) Except as otherwise provided in subsection (e)(3) of this section, a health care plan
14 shall not:
15 (i) Remove a prescription drug from a formulary;
16 (ii) Move a prescription drug to a tier with a larger deductible, copayment, or coinsurance
17 if the formulary includes two (2) or more tiers of benefits providing for different deductibles,
18 copayments or coinsurance applicable to the prescription drugs in each tier; or
19 (iii) Add utilization management restrictions to a prescription drug on a formulary, unless
20 such changes occur at the time of enrollment or issuance of coverage.
21 (2) Prohibitions provided in subsection (e)(1) of this section shall apply beginning on the
22 date on which open enrollment begins for a plan year and through the end of the plan year to
23 which such open enrollment period applies.
24 (3) A health care plan with a formulary that includes two (2) or more tiers of benefits
25 providing for different deductibles, copayments or coinsurance applicable to prescription drugs in
26 each tier may move a prescription drug to a tier with a larger deductible, copayment or
27 coinsurance if an AB-rated generic equivalent or interchangeable biological product for such
28 prescription drug is added to the formulary at the same time. A health care plan may remove a
29 prescription drug from a formulary if the federal Food and Drug Administration determines that
30 such prescription drug should be removed from the market, including new utilization
31 management restrictions issued pursuant to federal Food and Drug Administration safety
32 concerns.
33 (4) A health care plan shall provide notice to policyholders of the intent to remove a
34 prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in

1 the upcoming plan year, thirty (30) days prior to the open enrollment period for the consecutive
2 plan year. Such notice of impending formulary and deductible, copayment or coinsurance
3 changes shall also be posted on the plan's online formulary and in any prescription drug finder
4 system that the plan provides to the public.

5 (5) The provisions of this subsection shall not supersede the terms of a collective
6 bargaining agreement, or the rights of a labor organization or other duly authorized representative
7 to collectively bargain changes to the formularies.

8 SECTION 5. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T
RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

1 This act would prohibit any health insurer, nonprofit medical service corporation,
2 nonprofit hospital service corporation and health maintenance organization with an individual or
3 group-health contract, plan or policy from making prescription drug formulary changes during a
4 contract year.

5 This act would take effect upon passage.

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