

2020 -- S 2324

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

A N A C T

RELATING TO INSURANCE

Introduced By: Senators Crowley, Lombardo, Conley, and Ruggerio

Date Introduced: February 05, 2020

Referred To: Senate Health & Human Services

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(e)(3)~~ [27-18.8-3\(b\)\(5\)](#).

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~~ [commissioner](#) pursuant to ~~chapter 17.12 of title 23~~ [chapter 18.9 of title 27](#).

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 (d) A health benefit plan issuer may modify drug coverage provided under a health
14 benefit plan if:

15 (1) The modification occurs at the time of coverage renewal;

16 (2) The modification is effective uniformly among all group health benefit plan sponsors
17 covered by identical or substantially identical health benefit plans or all individuals covered by
18 identical or substantially identical individual health benefit plans, as applicable; and

19 (3) Not later than the sixtieth day before the date the modification is effective, the issuer
20 provides written notice of the modification to the commissioner, each affected group health
21 benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each
22 affected individual health benefit plan holder.

23 (e) Modifications affecting drug coverage that require written or electronic notice under
24 subsection (d) of this section, include:

25 (1) Removing a drug from a formulary;

26 (2) Adding a requirement that an enrollee receive prior authorization for a drug;

27 (3) Imposing or altering a quantity limit for a drug;

28 (4) Imposing a step-therapy restriction for a drug; and

29 (5) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the
30 drug is available.

31 ~~(f)~~ (f) An accident and sickness insurer may immediately remove from its plan
32 formularies covered prescription drugs deemed unsafe by the accident and sickness insurer or the
33 Food and Drug Administration, or removed from the market by their manufacturer, without
34 meeting the requirements of this section.

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

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

7 **27-19-42. Drug coverage.**

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

18 (b) A nonprofit, hospital-service corporation's medical-exception criteria for the coverage
19 of non-formulary medications shall be developed in accordance with § ~~23-17.13-3(e)(3)~~ 27-18.8-
20 3(b)(5).

21 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
22 section may appeal the denial in accordance with the rules and regulations promulgated by the
23 ~~department of health~~ commissioner pursuant to ~~chapter 17.12 of title 23~~ chapter 18.9 of title 27.

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

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

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

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

34 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~

1 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
2 ~~respectively.~~

3 (d) A health benefit plan issuer may modify drug coverage provided under a health
4 benefit plan if:

5 (1) The modification occurs at the time of coverage renewal;

6 (2) The modification is effective uniformly among all group health benefit plan sponsors
7 covered by identical or substantially identical health benefit plans or all individuals covered by
8 identical or substantially identical individual health benefit plans, as applicable; and

9 (3) Not later than the sixtieth day before the date the modification is effective, the issuer
10 provides written notice of the modification to the commissioner, each affected group health
11 benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each
12 affected individual health benefit plan holder.

13 (e) Modifications affecting drug coverage that require written or electronic notice under
14 subsection (d) of this section, include:

15 (1) Removing a drug from a formulary;

16 (2) Adding a requirement that an enrollee receive prior authorization for a drug;

17 (3) Imposing or altering a quantity limit for a drug;

18 (4) Imposing a step-therapy restriction for a drug; and

19 (5) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the
20 drug is available.

21 ~~(f)~~ (f) A nonprofit, hospital-service corporation may immediately remove from its plan
22 formularies covered prescription drugs deemed unsafe by the nonprofit, hospital-service
23 corporation or the Food and Drug Administration, or removed from the market by their
24 manufacturer, without meeting the requirements of this section.

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

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

28 (a) Any nonprofit, medical-service corporation that utilizes a formulary of medications
29 for which coverage is provided under an individual or group-plan, master contract shall require
30 any physician or other person authorized by the department of health to prescribe medication to
31 prescribe from the formulary. A physician or other person authorized by the department of health
32 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
33 nonprofit, medical-service corporation's formulary if he or she believes that the prescription of
34 the non-formulary medication is medically necessary. A nonprofit, medical-service corporation

1 shall be required to provide coverage for a non-formulary medication only when the non-
2 formulary medication meets the nonprofit, medical-service corporation's medical-exception
3 criteria for the coverage of that medication.

4 (b) A nonprofit, medical-service corporation's medical-exception criteria for the coverage
5 of non-formulary medications shall be developed in accordance with § ~~23-17.13-3(e)(3)~~ 27-18.8-
6 3(b)(5).

7 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
8 section may appeal the denial in accordance with the rules and regulations promulgated by the
9 ~~department of health commissioner~~ pursuant to ~~chapter 17.12 of title 23~~ chapter 18.9 of title 27.

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

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

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

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

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

23 (d) A health benefit plan issuer may modify drug coverage provided under a health
24 benefit plan if:

25 (1) The modification occurs at the time of coverage renewal;

26 (2) The modification is effective uniformly among all group health benefit plan sponsors
27 covered by identical or substantially identical health benefit plans or all individuals covered by
28 identical or substantially identical individual health benefit plans, as applicable; and

29 (3) Not later than the sixtieth day before the date the modification is effective, the issuer
30 provides written notice of the modification to the commissioner, each affected group health
31 benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each
32 affected individual health benefit plan holder.

33 (e) Modifications affecting drug coverage that require written or electronic notice under
34 subsection (d) of this section, include:

- 1 [\(1\) Removing a drug from a formulary;](#)
- 2 [\(2\) Adding a requirement that an enrollee receive prior authorization for a drug;](#)
- 3 [\(3\) Imposing or altering a quantity limit for a drug;](#)
- 4 [\(4\) Imposing a step-therapy restriction for a drug; and](#)
- 5 [\(5\) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the](#)
- 6 [drug is available.](#)

7 ~~(f)~~ (f) A nonprofit, medical-service corporation may immediately remove from its plan
8 formularies covered prescription drugs deemed unsafe by the nonprofit, medical-service
9 corporation or the Food and Drug Administration, or removed from the market by their
10 manufacturer, without meeting the requirements of this section.

11 SECTION 4. Section 27-20.1-15 of the General Laws in Chapter 27-20.1 entitled
12 "Nonprofit Dental Service Corporations" is hereby amended to read as follows:

13 **27-20.1-15. Drug coverage.**

14 (a) Any nonprofit, dental-service corporation 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 nonprofit, dental-service corporation's formulary if he or she believes that the prescription of the
20 non-formulary medication is medically necessary. A nonprofit, dental-service corporation shall be
21 required to provide coverage for a non-formulary medication only when the non-formulary
22 medication meets the nonprofit, dental-service corporation's medical-exception criteria for the
23 coverage of that medication.

24 (b) A nonprofit, dental-service corporation's medical-exception criteria for the coverage
25 of non-formulary medications shall be developed in accordance with § ~~23-17.13-3(e)(3)~~ [27-18.8-](#)
26 [3\(b\)\(5\)](#).

27 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
28 section may appeal the denial in accordance with the rules and regulations promulgated by the
29 ~~department of health~~ [commissioner](#) pursuant to ~~chapter 17.12 of title 23~~ [chapter 18.9 of title 27](#).

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

1 ~~thirty (30) days' notice prior to the date such change becomes effective by a direct notification:~~

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

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

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

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

9 (d) A health benefit plan issuer may modify drug coverage provided under a health
10 benefit plan if:

11 (1) The modification occurs at the time of coverage renewal;

12 (2) The modification is effective uniformly among all group health benefit plan sponsors
13 covered by identical or substantially identical health benefit plans or all individuals covered by
14 identical or substantially identical individual health benefit plans, as applicable; and

15 (3) Not later than the sixtieth day before the date the modification is effective, the issuer
16 provides written notice of the modification to the commissioner, each affected group health
17 benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each
18 affected individual health benefit plan holder.

19 (e) Modifications affecting drug coverage that require written or electronic notice under
20 subsection (d) of this section, include:

21 (1) Removing a drug from a formulary;

22 (2) Adding a requirement that an enrollee receive prior authorization for a drug;

23 (3) Imposing or altering a quantity limit for a drug;

24 (4) Imposing a step-therapy restriction for a drug; and

25 (5) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the
26 drug is available.

27 ~~(f)~~ (f) A nonprofit, dental-service corporation may immediately remove from its plan
28 formularies covered prescription drugs deemed unsafe by the nonprofit, dental-service
29 corporation or the Food and Drug Administration, or removed from the market by their
30 manufacturer, without meeting the requirements of this section.

31 SECTION 5. Section 27-41-51 of the General Laws in Chapter 27-41 entitled "Health
32 Maintenance Organizations" is hereby amended to read as follows:

33 **27-41-51. Drug coverage.**

34 (a) Any health-maintenance organization that utilizes a formulary of medications for

1 which coverage is provided under an individual or group-plan, master contract shall require any
2 physician or other person authorized by the department of health to prescribe medication to
3 prescribe from the formulary. A physician or other person authorized by the department of health
4 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
5 health-maintenance organization's formulary if he or she believes that the prescription of non-
6 formulary medication is medically necessary. A health-maintenance organization shall be
7 required to provide coverage for a non-formulary medication only when the non-formulary
8 medication meets the health-maintenance organization's medical-exception criteria for the
9 coverage of that medication.

10 (b) A health-maintenance organization's medical-exception criteria for the coverage of
11 non-formulary medications shall be developed in accordance with § ~~23-17.13-3(e)(3)~~ [27-18.8-](#)
12 [3\(b\)\(5\)](#).

13 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
14 section may appeal the denial in accordance with the rules and regulations promulgated by the
15 ~~department of health commissioner~~ pursuant to ~~chapter 17.12 of title 23~~ [chapter 18.9 of title 27](#).

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

- 22 ~~(i) The written or electronic notice must contain the following information:~~
- 23 ~~(A) The name of the affected prescription drug;~~
 - 24 ~~(B) Whether the plan is removing the prescription drug from the formulary, or changing~~
25 ~~its preferred or tiered, cost-sharing status; and~~
 - 26 ~~(C) The means by which subscribers may obtain a coverage determination or medical~~
27 ~~exception, in the case of drugs that will require prior authorization or are formulary exclusions~~
28 ~~respectively.~~

29 [\(d\) A health benefit plan issuer may modify drug coverage provided under a health](#)
30 [benefit plan if:](#)

- 31 [\(1\) The modification occurs at the time of coverage renewal;](#)
- 32 [\(2\) The modification is effective uniformly among all group health benefit plan sponsors](#)
33 [covered by identical or substantially identical health benefit plans or all individuals covered by](#)
34 [identical or substantially identical individual health benefit plans, as applicable; and](#)

1 (3) Not later than the sixtieth day before the date the modification is effective, the issuer
2 provides written notice of the modification to the commissioner, each affected group health
3 benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each
4 affected individual health benefit plan holder.

5 (e) Modifications affecting drug coverage that require written or electronic notice under
6 subsection (d) of this section, include:

7 (1) Removing a drug from a formulary;

8 (2) Adding a requirement that an enrollee receive prior authorization for a drug;

9 (3) Imposing or altering a quantity limit for a drug;

10 (4) Imposing a step-therapy restriction for a drug; and

11 (5) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the
12 drug is available.

13 ~~(f)~~(f) A health-maintenance organization may immediately remove from its plan
14 formularies covered prescription drugs deemed unsafe by the health-maintenance organization or
15 the Food and Drug Administration, or removed from the market by their manufacturer, without
16 meeting the requirements of this section.

17 SECTION 6. 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

1 This act would allow an issuer of a health benefit plan to modify drug coverage pursuant
2 to a health benefit plan if: (1) the modification occurs at the time of coverage renewal; (2) the
3 modification is effective among all identical or substantially identical health benefit plans; and (3)
4 written notice is provided not later than sixty (60) days before the date the modification becomes
5 effective.

6 This act would take effect upon passage.

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