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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

A N A C T

RELATING TO INSURANCE -- DRUG COVERAGE

Introduced By: Representatives Corvese, Azzinaro, Malik, Winfield, and Ucci

Date Introduced: March 11, 2016

Referred To: House Corporations

It is enacted by the General Assembly as follows:

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

27-18-50. Drug coverage. -- (a) Any accident and sickness insurer that utilizes a formulary of medications for which coverage is provided under an individual or group plan master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications previously on, or not on, the accident and sickness insurer's formulary if he or she believes that the prescription of the non-formulary medication is medically necessary. An accident and sickness insurer shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the accident and sickness insurer's medical exception criteria for the coverage of that medication.

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

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

(d) Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered prescription drug, an accident and

sickness insurer must provide at least sixty (60) days' notice to authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either:

(1) Provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or

(2) At the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as previously allowed, and written notice of the formulary change:

(i) The written notice must contain the following information:

(A) The name of the affected prescription drug;

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

(C) The reason why the plan is removing such prescription drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs; and

(E) The means by which subscribers may obtain a coverage determination under or exception;

(ii) An accident and sickness insurer may immediately remove from their plan formularies covered prescription drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of this section. Nonprofit dental service corporations must provide retrospective notice of any such formulary changes to affected subscribers, authorized prescribers, network pharmacies, and pharmacists consistent with the requirements of this section.

~~(d)~~(e) This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; or (9) other limited benefit policies.

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

27-19-42. Drug coverage. -- (a) Any nonprofit hospital service corporation that utilizes a formulary of medications for which coverage is provided under an individual or group plan master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications

previously on, or not on, the nonprofit hospital service corporation's formulary if he or she believes that the prescription of the non-formulary medication is medically necessary. A nonprofit hospital service corporation shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the nonprofit hospital service corporation's medical exception criteria for the coverage of that medication.

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

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

(d) Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered prescription drug, an accident and sickness insurer must provide at least sixty (60) days' notice to authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either:

(1) Provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or

(2) At the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as previously allowed, and written notice of the formulary change.

(i) The written notice must contain the following information:

(A) The name of the affected prescription drug;

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

(C) The reason why the plan is removing such prescription drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs; and

(E) The means by which subscribers may obtain a coverage determination under or exception;

(ii) An accident and sickness insurer may immediately remove from their plan formularies covered prescription drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of this section. Nonprofit dental service corporations must provide retrospective notice of any such formulary changes to affected subscribers, authorized prescribers, network pharmacies, and pharmacists

consistent with the requirements of this section.

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

27-20-37. Drug coverage. -- (a) Any nonprofit medical service corporation that utilizes a formulary of medications for which coverage is provided under an individual or group plan master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications previously on, or not on, the nonprofit medical service corporation's formulary if he or she believes that the prescription of the non-formulary medication is medically necessary. A nonprofit hospital service corporation shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the nonprofit medical service corporation's medical exception criteria for the coverage of that medication.

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

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

(d) Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered prescription drug, an accident and sickness insurer must provide at least sixty (60) days' notice to authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either:

(1) Provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or

(2) At the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as previously allowed, and written notice of the formulary change:

(i) The written notice must contain the following information:

(A) The name of the affected prescription drug;

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

(C) The reason why the plan is removing such prescription drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and

expected cost-sharing for those drugs; and

(E) The means by which subscribers may obtain a coverage determination under or exception;

(ii) An accident and sickness insurer may immediately remove from their plan formularies covered prescription drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of this section. Nonprofit dental service corporations must provide retrospective notice of any such formulary changes to affected subscribers, authorized prescribers, network pharmacies, and pharmacists consistent with the requirements of this section.

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

27-20.1-15. Drug coverage. -- (a) Any nonprofit dental service corporation that utilizes a formulary of medications for which coverage is provided under an individual or group plan master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications previously on, or not on, the nonprofit dental service corporation's formulary if he or she believes that the prescription of the non-formulary medication is medically necessary. A nonprofit dental service corporation shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the nonprofit dental service corporation's medical exception criteria for the coverage of that medication.

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

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

(d) Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered prescription drug, an accident and sickness insurer must provide at least sixty (60) days' notice to authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either:

(1) Provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or

(2) At the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as

previously allowed, and written notice of the formulary change:

(i) The written notice must contain the following information:

(A) The name of the affected prescription drug;

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

(C) The reason why the plan is removing such prescription drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs; and

(E) The means by which subscribers may obtain a coverage determination under or exception;

(ii) An accident and sickness insurer may immediately remove from their plan formularies covered prescription drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of this section. Nonprofit dental service corporations must provide retrospective notice of any such formulary changes to affected subscribers, authorized prescribers, network pharmacies, and pharmacists consistent with the requirements of this section.

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

27-41-51. Drug coverage. -- (a) Any health maintenance organization that utilizes a formulary of medications for which coverage is provided under an individual or group plan master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications previously on, or not on, the health maintenance organization's formulary if he or she believes that the prescription of non-formulary medication is medically necessary. A health maintenance organization shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the health maintenance organization's medical exception criteria for the coverage of that medication.

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

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

(d) Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered prescription drug, an accident and sickness insurer must provide at least sixty (60) days' notice to authorized prescribers, network pharmacies, and pharmacists prior to the date such change becomes effective, and must either:

(1) Provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or

(2) At the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as previously allowed, and written notice of the formulary change:

(i) The written notice must contain the following information:

(A) The name of the affected prescription drug;

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

(C) The reason why the plan is removing such prescription drug from the formulary, or changing its preferred or tiered cost-sharing status;

(D) Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs; and

(E) The means by which subscribers may obtain a coverage determination under or exception;

(ii) An accident and sickness insurer may immediately remove from their plan formularies covered prescription drugs deemed unsafe by the Food and Drug Administration or removed from the market by their manufacturer without meeting the requirements of this section. Nonprofit dental service corporations must provide retrospective notice of any such formulary changes to affected subscribers, authorized prescribers, network pharmacies, and pharmacists consistent with the requirements of this section.

SECTION 6. This act shall take effect on January 1, 2017.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE -- DRUG COVERAGE

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This act would require any health care insurance company to notify authorized prescribers, network pharmacies, and pharmacists at least sixty (60) days' prior to removing a prescription drug from its plan's formulary, or making any change in the preferred or tiered cost-sharing status of a covered prescription drug. Any health care insurer must provide direct written notice to affected subscribers at least sixty (60) days prior to the date the change becomes effective; or at the time an affected subscriber requests a refill of the prescription drug, provide such subscriber with a sixty (60) day supply of the prescription drug under the same terms as previously allowed, and written notice of the formulary change.

This act would take effect on January 1, 2017.

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