2021 -- S 0496

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

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A N A C T

RELATING TO INSURANCE

Introduced By: Senators Felag, Coyne, Seveney, Sosnowski, Ciccone, and Raptakis

Date Introduced: March 04, 2021

Referred To: Senate Health & Human Services

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criteria for the coverage of non-formulary medications shall be developed in accordance with § ~~23-17.13-3(c)(3) [repealed]~~ 27-18.8-3(b)(5).

(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rules and regulations promulgated by the ~~department of health~~ commissioner pursuant to ~~chapter 17.12 of title 23 [repealed]~~ chapter 18.9 of title 27.

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

~~(i) The written or electronic 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; and~~

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

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

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

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

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

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

(1) Removing a drug from a formulary;

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

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

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

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

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

~~(e)~~(g) 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) [repealed]~~ 27-18.8-3(b)(5).

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

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

~~(i) The written or electronic 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; and~~

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

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

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

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

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

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

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

(1) Removing a drug from a formulary;

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

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

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

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

~~(ii)~~(f) A nonprofit hospital-service corporation may immediately remove from its plan formularies covered prescription drugs deemed unsafe by the nonprofit hospital-service corporation or the Food and Drug Administration, or removed from the market by their manufacturer, without meeting 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 medical-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) [repealed]~~ 27-18.8-3(b)(5).

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

~~(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, a nonprofit medical service corporation must provide at least thirty (30) days' notice to authorized prescribers by established communication methods of policy and program updates and by updating available references on web based publications. All adversely affected members must be provided at least thirty (30) days' notice prior to the date such change becomes effective by a direct notification:~~

~~(i) The written or electronic 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; and~~

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

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

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

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

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

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

(1) Removing a drug from a formulary;

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

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

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

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

~~(ii)~~(f) A nonprofit medical-service corporation may immediately remove from its plan formularies covered prescription drugs deemed unsafe by the nonprofit medical-service corporation or the Food and Drug Administration, or removed from the market by their manufacturer, without meeting 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) [repealed]~~ 27-18.8-3(b)(5).

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

~~(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, a nonprofit dental-service corporation must provide at least thirty (30) days' notice to authorized prescribers by established communication methods of policy and program updates and by updating available references on web-based publications. All adversely affected members must be provided at least~~

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

~~(i) The written or electronic 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; and~~

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

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

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

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

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

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

(1) Removing a drug from a formulary;

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

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

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

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

~~(ii)~~(f) A nonprofit dental-service corporation may immediately remove from its plan formularies covered prescription drugs deemed unsafe by the nonprofit dental-service corporation or the Food and Drug Administration, or removed from the market by their manufacturer, without meeting 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) [repealed]~~ 27-18.8-3(b)(5).

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

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

~~(i) The written or electronic 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; and~~

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

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

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

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

(3) Not later than the sixtieth day before the date the modification is effective, the issuer

provides written notice of the modification to the commissioner, each affected group health benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each affected individual health benefit plan holder.

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

(1) Removing a drug from a formulary;

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

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

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

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

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

SECTION 6. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE

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

This act would take effect upon passage.

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