2016 -- S 2294 SUBSTITUTE A

========
LC003117/SUB A
========

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: Senators Crowley, Sosnowski, Metts, and Miller

Date Introduced: February 09, 2016

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).

(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 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 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.

(ii) An accident and sickness insurer may immediately remove from their 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.

~~(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, 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 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.

(ii) A nonprofit hospital service corporation may immediately remove from their 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 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, 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 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.

(ii) A nonprofit medical service corporation may immediately remove from their 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).

(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, 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 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.

(ii) A nonprofit dental service corporation may immediately remove from their 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).

(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, 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 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.

(ii) A health maintenance organization may immediately remove from their 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 on January 1, 2017.

========
LC003117/SUB A
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- DRUG COVERAGE

***

This act would require accident and sickness insurers, nonprofit hospital, medical and dental service corporations and health maintenance organizations to give thirty (30) days' notice to authorized prescribers by established communication methods and by updating available references and web-based publications before making any change in preferred or tiered cost sharing status of a covered drug. Any drug deemed unsafe by those entities or by the Food and Drug Administration may be removed immediately without prior notice.

This act would take effect on January 1, 2017.

========
LC003117/SUB A
========