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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. 2020

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:

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 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.~~

~~(ii) 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) Prescription drug formulary changes;

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

(i) Remove a prescription drug from a formulary;

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

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

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

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

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

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

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

~~(e)~~(f) 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 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.~~

~~(ii) 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.~~

(e) Prescription drug formulary changes;

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

(i) Remove a prescription drug from a formulary;

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

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

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

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

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

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

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

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).

(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 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.~~

~~(ii) 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.~~

(e) Prescription drug formulary changes;

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

(i) Remove a prescription drug from a formulary;

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

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

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

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

concerns.

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

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

SECTION 4. 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 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.~~

~~(ii) 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.~~

(e) Prescription drug formulary changes;

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

(i) Remove a prescription drug from a formulary;

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

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

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

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

(4) A health care plan shall provide notice to policyholders of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in

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

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

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

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

This act would take effect upon passage.

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