House Bill 873

By: Representatives Knight of the 130th, Hatchett of the 150th, Cooper of the 43rd, Beskin of the 54th, Frye of the 118th, and others

A BILL TO BE ENTITLED
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 provide for consumer protections and freedom of information regarding prescription drug
3 benefits; to provide for intent and applicability; to provide for definitions; to provide for
4 requirements; to provide for an advisory committee; to provide for related matters; to provide
5 for a short title; to provide for effective dates and applicability; to repeal conflicting laws;
6 and for other purposes.

7 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

8 **SECTION 1.**

9 This Act shall be known and may cited as the "Prescription Drug Benefits Freedom of
10 Information and Consumer Protection Act."

11 **SECTION 2.**

12 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
13 adding a new chapter to read as follows:

14 "CHAPTER 65

15 33-65-1.

16 It is the purpose and intent of this chapter and the policy of this state to promote
17 consistency and clarity in the disclosure of prescription drug formularies in order to aid
18 consumers in making informed choices related to their health care. Furthermore, it is the
19 purpose of this chapter to promote efficiency and consistency in prescription drug prior
20 authorization processes in order to facilitate consumers' reasonable access to
21 comprehensive health care services in this state. This chapter shall be construed liberally
22 to promote its consumer protection purposes.

23 33-65-2.
24 This chapter applies to:
25 (1) All licensed insurance carriers under this Title that provide accident and sickness
26 products whether on an individual basis, group, or blanket basis as provided in this title;
27 (2) All administrators for such products as provided for in Article 2 of Chapter 23 of this
28 title; and
29 (3) All pharmacy benefits managers as defined in Code Section 33-65-3.

30 33-65-3.
31 As used in this chapter the term:
32 (1) 'Enrollee' means a policyholder, subscriber, covered person, or other individual
33 participating in a health benefit plan.
34 (2) 'Formulary' means the preferred drug list of any insurer or pharmacy benefits
35 manager.
36 (3) 'Health benefit plan' means any accident and sickness policy, hospital or medical
37 insurance policy or certificate, health care plan contract or certificate, qualified high
38 deductible health plan, health maintenance organization subscriber contract, health
39 benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or managed care
40 plan. Health benefit plan does not include policies issued in accordance with Chapter 31
41 of this title, relating to credit life insurance and credit accident and sickness insurance,
42 policies issued in accordance with Chapter 9 of Title 34, relating to workers'
43 compensation, or to disability income policies.
44 (4) 'Insurer' means an accident and sickness insurer, fraternal benefit society, health care
45 corporation, health maintenance organization, provider sponsored health care corporation,
46 or any similar entity that provides for the financing or delivery of health care services
47 through a health benefit plan, the plan administrator of any health benefit plan established
48 pursuant to Article 1 of Chapter 18 of Title 45, or any other administrator as defined in
49 paragraph (1) of subsection (a) of Code Section 33-23-100.
50 (5) 'Pharmacy benefits manager' means a person, business entity, or other entity that
51 performs pharmacy benefits management. The term includes a person or entity acting for
52 a pharmacy benefits manager in a contractual or employment relationship in the
53 performance of pharmacy benefits management for a covered entity. The term shall not
54 include services provided by pharmacies operating under a hospital pharmacy license.
55 The term shall not include health systems while providing pharmacy services for their
56 patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for
57 outpatient procedures. The term shall not include services provided by pharmacies
58 affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model

59 health maintenance organization with an exclusive medical group contract and which
60 operates its own pharmacies which are licensed under Code Section 26-4-110.
61 (6) 'Pharmacy benefits management' means the service provided to a health benefit plan
62 or covered entity, directly or through another entity, including the procurement of
63 prescription drugs to be dispensed to patients, or the administration or management of
64 prescription drug benefits, including, but not limited to, any of the following:
65 (A) Mail order pharmacy;
66 (B) Claims processing, retail network management, or payment of claims to
67 pharmacies for dispensing prescription drugs;
68 (C) Clinical or other formulary or preferred drug list development or management;
69 (D) Negotiation or administration of rebates, discounts, payment differentials, or other
70 incentives for the inclusion of particular prescription drugs in a particular category or
71 to promote the purchase of particular prescription drugs;
72 (E) Patient compliance, therapeutic intervention, or generic substitution programs; and
73 (F) Disease management.
74 (7) 'Physician' means a person licensed to practice medicine pursuant to Article 2 of
75 Chapter 34 of Title 43.
76 (8) 'Prescriber' means the same as defined at in Code Section 16-13-21.
77 (9) 'Prior authorization' means a requirement that a prescriber obtain approval from
78 insurer or pharmacy benefits manager to prescribe a specific medication prior to
79 dispensing.
80 (10) 'Step therapy' means the process of requiring a patient to begin a prescription drug
81 therapy with the least costly formulary drug approved for treatment of patient's medical
82 condition before progressing to a more costly drug therapy for the same condition.

83 33-65-4.
84 (a) An insurer and a pharmacy benefits manager shall provide no later than October 1,
85 2018, on a public website maintained by the insurer or by the pharmacy benefits manager
86 formulary information as required by Code Section 33-65-5.
87 (b) A direct electronic link to the formulary information shall be displayed in a
88 conspicuous manner on the website home page of insurers and pharmacy benefits
89 managers. The formulary information and formulary disclosure requirements of Code
90 Section 33-65-5 shall be available to the general public without requiring the use of paid
91 software, a password, a user name, user identification, or any personally identifiable
92 information.

93 (c) An insurer and a pharmacy benefits manager shall be required to update its formulary
94 information and formulary disclosure requirements provided for in Code Section 33-65-5
95 within seven days of any change, alteration, modification or amendment to its formulary.

96 33-65-5.
97 (a) The Commissioner shall by rules and regulations develop and adopt no later than
98 October 1, 2018, requirements to promote consistency and clarity in the disclosure of
99 formularies.
100 (b) The requirements adopted under subsection (a) of this Code section shall apply to each
101 prescription drug:
102 (1) Included in a formulary and dispensed in a pharmacy; or
103 (2) Included in a formulary, covered under a health benefit plan, and typically
104 administered by a physician or health care provider.
105 (c) The formulary disclosures must:
106 (1) Use at least ten point font; and
107 (2) Be electronically searchable by drug name.
108 (d) The formulary disclosures for each drug shall:
109 (1) Clearly differentiate between drugs covered under the health benefit plan's pharmacy
110 benefits and medical benefits;
111 (2) Clearly indicate whether the drug is covered or not covered under the health benefit
112 plan;
113 (3) Clearly specify the tier under which the drug falls, if such health benefit plan uses a
114 multi-tier formulary; and
115 (4) Clearly disclose any prior authorization, step therapy, or other protocol requirements.

116 33-65-6.
117 (a) The Commissioner by rules and regulations shall:
118 (1) Prior to October 1, 2018, prescribe a single, standard form for requesting prior
119 authorization of prescription drug benefits that shall not exceed two pages in total length;
120 (2) Require that the department, insurers, and pharmacy benefits managers make such
121 form available electronically on the websites of:
122 (A) The department;
123 (B) Insurers; and
124 (C) Pharmacy benefits managers;
125 (3) Require an insurer and a pharmacy benefits manager accept the form for any
126 prescription drug prior authorization as required by a health benefit plan; and

127 (4) Require an insurer and a pharmacy benefits manager deem that a fully populated
128 standard prior authorization form a complete prior authorization request for which no
129 additional or supplemental information can be required.
130 (b) In prescribing a form pursuant to this Code section, the Commissioner shall:
131 (1) Develop the form with input from the Advisory Committee on Uniform Prior
132 Authorization established under Code Section 33-65-7; and
133 (2) Take into consideration:
134 (A) Any form for requesting prior authorization of prescription drug benefits that is
135 widely used in this state; and
136 (B) National standards, or draft standards, pertaining to electronic prior authorization
137 of prescription drug benefits.
138 (c) An insurer and a pharmacy benefits manager shall exchange prior authorization
139 requests electronically with a prescriber who has e-prescribing capability and who initiates
140 a request electronically.

141 33-65-7.
142 (a) The Commissioner shall appoint a committee, to be known as the Advisory Committee
143 on Uniform Prior Authorization, to advise the Commissioner on the technical, operational,
144 and practical aspects of developing the single, standard prescription drug prior
145 authorization form required under Code Section 33-65-6.
146 (b) The advisory committee shall be composed of the Commissioner, or the
147 Commissioner's designee, and an equal number of members from each of the following
148 groups:
149 (1) Physicians;
150 (2) Consumers experienced with prescription drug prior authorizations;
151 (3) Pharmacists;
152 (4) Independent insurance agents experienced in the sale of accident and sickness
153 policies;
154 (5) Insurers; and
155 (6) Pharmacy benefits managers.
156 (c) Members of the committee shall serve without compensation.
157 (d) The committee shall recommend to the Commissioner a single, standard form for
158 requesting prior authorization of prescription drug benefits.

159 33-65-8.

160 (a) Insurers and pharmacy benefits managers shall be required to communicate and
161 acknowledgment of receipt of the standard prescription drug prior authorization form to the
162 prescriber no later than two calendar days following receipt.

163 (b) Insurers and pharmacy benefits managers shall be required to communicate to the
164 prescriber a status of approved, denied, or incomplete no later than four calendar days
165 following receipt of the standard prescription drug prior authorization form.

166 (c) Insurers and pharmacy benefits managers shall be required to communicate to the
167 prescriber a status of approved or denied no later than two calendar days following receipt
168 of a completed and resubmitted standard prescription drug prior authorization form.

169 (d) The Commissioner shall levy a fine against all insurers or pharmacy benefits managers
170 in an amount of not less than $25,000.00 per occurrence for failure to do any of the
171 following:

172 (1) Failure to accept the standard prescription drug prior authorization form as described
173 in paragraph (3) of subsection (a) of Code Section 33-65-6;

174 (2) Failure to accept fully populated standard prior authorization form as a complete
175 prior authorization request as described in paragraph (4) of subsection (a) of Code
176 Section 33-65-6; and

177 (3) Failure to meet requirements under subsections (a), (b), and (c) of this Code section.

178 (e) Each violation of subsection (d) of this Code section shall constitute a separate and
179 distinct violation.

180 (f) Each violation of subsection (d) of this Code section shall constitute a tort under the
181 laws of this state. Any individual who has been injured by an insurer's or pharmacy
182 benefits manager's failure to comply with any portion of this chapter shall have the right
183 to bring a private action for damages.

184 33-6-9.

185 An insurer or a pharmacy benefits manager of a health benefit plan that offers prescription
186 drug benefits shall honor a prescription drug prior authorization form approved by the
187 immediately preceding insurer or pharmacy benefits manager for at least the initial 60 days
188 after a change in enrollee's health benefit plan, insurer, or pharmacy benefits manager
189 subject to receipt of a record demonstrating approval of prior authorization from the
190 prescriber, pharmacist, or enrollee."

191 **SECTION 3.**

192 (a) This Act shall become effective on July 1, 2018, except as otherwise provided in
193 subsection (b) of this section.

194 (b) Those provisions applying to public disclosure of formularies and developing
195 requirements for such public disclosure shall be effective October 1, 2018.

196 **SECTION 4.**

197 All laws and parts of laws in conflict with this Act are repealed.