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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. 2017

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A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Ackerman, Carson, Marshall, Craven, and Fogarty

Date Introduced: June 09, 2017

Referred To: House Corporations

It is enacted by the General Assembly as follows:

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

3 **27-18-50. Drug coverage. [Effective January 1, 2017.]**

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

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

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

19 (d) Prior to removing a prescription drug from its plan's formulary or making any change

1 in the preferred or tiered, cost-sharing status of a covered prescription drug, an accident and
2 sickness insurer must provide at least thirty (30) days' notice to authorized prescribers by
3 established communication methods of policy and program updates and by updating available
4 references on web-based publications. All adversely affected members must be provided at least
5 thirty (30) days' notice prior to the date such change becomes effective by a direct notification:
6 (i) The written or electronic notice must contain the following information:
7 (A) The name of the affected prescription drug;
8 (B) Whether the plan is removing the prescription drug from the formulary, or changing
9 its preferred or tiered, cost-sharing status; and
10 (C) The means by which subscribers may obtain a coverage determination or medical
11 exception, in the case of drugs that will require prior authorization or are formulary exclusions
12 respectively.
13 (ii) An accident and sickness insurer may immediately remove from its plan formularies
14 covered prescription drugs deemed unsafe by the accident and sickness insurer or the Food and
15 Drug Administration, or removed from the market by their manufacturer, without meeting the
16 requirements of this section.
17 (e) This section shall not apply to insurance coverage providing benefits for: (1) hospital
18 confinement indemnity; (2) disability income; (3) accident only; (4) long-term care; (5) Medicare
19 supplement; (6) limited-benefit health; (7) specified-disease indemnity; (8) sickness or bodily
20 injury or death by accident or both; or (9) other limited-benefit policies.
21 SECTION 2. Section 27-19-42 of the General Laws in Chapter 27-19 entitled "Nonprofit
22 Hospital Service Corporations" is hereby amended to read as follows:
23 **27-19-42. Drug coverage. [Effective January 1, 2017.]**
24 (a) Any nonprofit, hospital-service corporation that utilizes a formulary of medications
25 for which coverage is provided under an individual or group-plan, master contract shall require
26 any physician or other person authorized by the department of health to prescribe medication to
27 prescribe from the formulary. A physician or other person authorized by the department of health
28 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
29 nonprofit, hospital-service corporation's formulary if he or she believes that the prescription of
30 the non-formulary medication is medically necessary. A nonprofit hospital service corporation
31 shall be required to provide coverage for a non-formulary medication only when the non-
32 formulary medication meets the nonprofit, hospital-service corporation's medical-exception
33 criteria for the coverage of that medication.
34 (b) A nonprofit, hospital-service corporation's medical-exception criteria for the coverage

1 of non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).

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

5 (d) Prior to removing a prescription drug from its plan's formulary or making any change
6 in the preferred or tiered cost-sharing status of a covered prescription drug, a nonprofit, hospital-
7 service corporation must provide at least thirty (30) days' notice to authorized prescribers by
8 established communication methods of policy and program updates and by updating available
9 references on web-based publications. All adversely affected members must be provided at least
10 thirty (30) days' notice prior to the date such change becomes effective by a direct notification:

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

12 (A) The name of the affected prescription drug;

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

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

18 (ii) A nonprofit, hospital-service corporation may immediately remove from its plan
19 formularies covered prescription drugs deemed unsafe by the nonprofit, hospital-service
20 corporation or the Food and Drug Administration, or removed from the market by their
21 manufacturer, without meeting the requirements of this section.

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

24 **27-20-37. Drug coverage. [Effective January 1, 2017.]**

25 (a) Any nonprofit, medical-service corporation that utilizes a formulary of medications
26 for which coverage is provided under an individual or group-plan, master contract shall require
27 any physician or other person authorized by the department of health to prescribe medication to
28 prescribe from the formulary. A physician or other person authorized by the department of health
29 to prescribe medication shall be allowed to prescribe medications previously on, or not on, the
30 nonprofit, medical-service corporation's formulary if he or she believes that the prescription of
31 the non-formulary medication is medically necessary. A nonprofit, hospital-service corporation
32 shall be required to provide coverage for a non-formulary medication only when the non-
33 formulary medication meets the nonprofit, medical-service corporation's medical-exception
34 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.

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. [Effective January 1, 2017.]

(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

1 coverage of that medication.

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

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

7 (d) Prior to removing a prescription drug from its plan's formulary or making any change
8 in the preferred or tiered, cost-sharing status of a covered prescription drug, a nonprofit, dental-
9 service corporation must provide at least thirty (30) days' notice to authorized prescribers by
10 established communication methods of policy and program updates and by updating available
11 references on web-based publications. All adversely affected members must be provided at least
12 thirty (30) days' notice prior to the date such change becomes effective by a direct notification:

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

14 (A) The name of the affected prescription drug;

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

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

20 (ii) A nonprofit, dental-service corporation may immediately remove from its plan
21 formularies covered prescription drugs deemed unsafe by the nonprofit, dental-service
22 corporation or the Food and Drug Administration, or removed from the market by their
23 manufacturer, without meeting the requirements of this section.

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

26 **27-41-51. Drug coverage. [Effective January 1, 2017.]**

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

1 medication meets the health-maintenance organization's medical-exception criteria for the
2 coverage of that medication.
3 (b) A health-maintenance organization's medical-exception criteria for the coverage of
4 non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).
5 (c) Any subscriber who is aggrieved by a denial of benefits to be provided under this
6 section may appeal the denial in accordance with the rules and regulations promulgated by the
7 department of health pursuant to chapter 17.12 of title 23.
8 (d) Prior to removing a prescription drug from its plan's formulary or making any change
9 in the preferred or tiered, cost-sharing status of a covered prescription drug, a health-maintenance
10 organization must provide at least thirty (30) days' notice to authorized prescribers by established
11 communication methods of policy and program updates and by updating available references on
12 web-based publications. All adversely affected members must be provided at least thirty (30)
13 days' notice prior to the date such change becomes effective by a direct notification:
14 (i) The written or electronic notice must contain the following information:
15 (A) The name of the affected prescription drug;
16 (B) Whether the plan is removing the prescription drug from the formulary, or changing
17 its preferred or tiered, cost-sharing status; and
18 (C) The means by which subscribers may obtain a coverage determination or medical
19 exception, in the case of drugs that will require prior authorization or are formulary exclusions
20 respectively.
21 (ii) A health-maintenance organization may immediately remove from its plan
22 formularies covered prescription drugs deemed unsafe by the health-maintenance organization or
23 the Food and Drug Administration, or removed from the market by their manufacturer, without
24 meeting the requirements of this section.
25 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 - ACCIDENT AND SICKNESS INSURANCE POLICIES

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1 This act would specify that all adversely affected members of a formulary change
2 removing a covered prescription drug or making a change in the drug's preferred or tiered cost
3 sharing status receive required statutory notification.
4 This act would take effect upon passage.

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