HEALTH CARRIER PRESCRIPTION DRUG BENEFIT MANAGEMENT MODEL ACT

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own and may be cited as the Health Carrier Prescription Drug Benefit Management Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2.

Section 3. Definitions

For purposes of this Act:

A. “Authorized representative” means:

(1) A person to whom a covered person has given express written consent to represent the covered person for the purpose of filing a medical exceptions request under Section 7 of this Act;

(2) (1)An1-0.8 (i)-3e 0 Tc 0 Tw 1.109 511d ( )Tj -0.004 Tc 0.012 T3 0 -1. 0 Td [(“5.

(5) Step therapy requirements.

Drafting Note: The definition of “pharmaceutical benefit management procedure” refers to commonly used utilization management criteria. It is possible that a health benefit plan may utilize new or different utilization management criteria. States should consider whether additional utilization management criteria should be included in the definition of “pharmaceutical benefit management procedure.”

U. “Pharmacy and Therapeutics committee” or “P&T committee” means an advisory committee or committees or equivalent body or bodies that have current knowledge and expertise in:

(1) Clinically appropriate prescribing, dispensing and monitoring of outpatient prescription drugs; and

(2) Drug use review, evaluation and intervention.

Drafting Note:Although this definition is broad, states should take note of the federal rules implementing the federal Affordable Care Act (ACA) effective January 1, 2017, which will require health carriers providing essential health benefits in the individual and small group markets to use a range of requirements related to the use of a P.7 1.7 (o)--------- (d7.T-10.829)-6.3 .0.6 ())i9-9)9-9ner9-9 P1&tfo aelllR0.7 (g

Drafting Note: The provisions of Section 4 above should not be construed to have this Act: 1) apply to a health benefit plan that does not cover outpatient prescription drugs; 2) require coverage of a prescription drug for a medical condition that is not covered under the health benefit plan; or 3) require coverage of a prescription drug categorically excluded from coverage under a health benefit plan unless an express exception is made pursuant to Section 7 of this Act

Drafting Note: The reference to "designee" in Section 4 is intended to be construed broadly to apply to any person or entity the health carrier contracts with to perform, or carry out on its behalf, specified activities required under this Act or applicable regulations, such as pharmacy benefit manager (PBM). Section 10 of this Act provides that the health carrier is responsible for monitoring all of activities carried out by, or on behalf, of the health carrier by a designee that the health carrier has contracted with to perform activity and ensuring that the designee is complying with the requirements of this Act and any applicable regulations related to that activity. It is

(4) (a) Each P&T committee shall establish procedures outlining its conflict of interest standards for its members and any individuals providing expert advice to the P&T committee, which, at a minimum, are consistent with Paragraph (3).

(b) The procedures shall require the P&T committee to have a system in place to maintain the signed conflict of interest statements described in Paragraph (3)(c) and to document any P&T committee member recusals from voting.

(c) The procedures and information under Sr 0 Td [(/(&)dl (e)-6 Bud)-0.8 (e)4.9 (sg e)-6

(2) In the case of rare or ultra-rare diseases, the P&T committee process under Paragraph (1) shall include the review, as the P&T committee considers appropriate and necessary, of clinically appropriate and relevant information when there is no or limited medical and scientific evidence concerning the safety and effectiveness of prescription drugs or drug classes used to treat rare and ultra-rare diseases.

Drafting Note:

contract number.

(c) For a health benefit plan providing individual market health insurance coverage, a health carrier may not require a covered person or prospective covered person to create or access an account or enter a plan or policy number to access a plan's formulary list or other prescription drug benefit information, but may require a covered person or prospective covered person to access a plan's formulary list and other prescription drug benefit information by searching, as appropriate, by plan name.

(2) (a) (i) The health carrier's formulary list(s) shall include each prescription drug covered under the carrier's plan(s) prescription drug benefit and outpatient medical benefit, which are prescription drugs administered by a health care professional or under the professional's direct supervision in an outpatient setting.

(ii) The health carrier may provide the information pertaining to prescription drugs covered under a plan's outpatient medical benefit as an addendum or link to the formulary, if applicable, provided the information is prominently displayed.

(b) The formulary shall be electronically searchable by drug name and any other means required by the commissioner.

Drafting Note: States should be aware that organizing formularies also by major therapeutic clainapeutarica mineira d 1d [(i-6 (j)-6 r n 2-6.4(

(4) (a) The health carrier shall include in the prescription drug benefit information a description in plain language of how an individual may find the benefit-cost sharing information for the prescription drugs on a formulary list that includes:

(i) Whether the prescription drug is subject to a deductible, and if so, the amount of the deductible;

(ii) The amount of the prescription drug copayment;

(iii) The amount of the prescription drug coinsurance; and

(iv) The amount of any cost-sharing difference between the days' supply of the prescription drug.

(b) For a health benefit plan providing individual market health insurance coverage, a health carrier may meet the requirements set forth in Subparagraph (a) of this paragraph by referring the individual to a summary of the plan's benefits and coverage displayed or linked to a place elsewhere on the carrier's website, provided that a covered person or prospective covered person is not required to create or access an account or enter a policy or plan number to access this information.

Drafting Note: States may want to look at the prescription drug benefit information that is to be provided to consumers in accordance with the requirements of this paragraph to see if that information can be easily found and is clear and understandable.

(5) A health carrier shall provide, upon request, a print copy of specifically requested prescription drug benefit information of a carrier's current, accurate and complete formulary.

(6) A health carrier may make available the prescription drug benefit information required in this subsection using electronic links associated with the specific health benefit plan for which the information applies.

(7) A health carrier shall ensure a formulary list(s), whether in electronic or print format, nt,, t (0 ())]TJ 0d [((0 ())]TJ 03 (alt)-3 (h3 0 Tdd [((0 ()01 T c)-2 (uTw 2.152 0 Td [(A)10

B. Whenever the health carrier makes or approves a change in a formulary that causes a particular prescription drug not to be covered, applies a new or revised dose restriction that causes a

regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

(d) The covered person's condition and function are stable and based on the covered person's medical history a change in prescription drug would have the potential for adverse consequences or other risks

(2) (a) A health carrier may require the covered person or the covered person's authorized representative upon request to provide a written certification from the covered person's prescribing provider of the determination made under Paragraph (1).

(b) The health carrier may require the written certification to include any of, but no more than, the following information:

(i) The patient's name, group or contract number, subscriber number or

process established by the health carrier for purposes of [insert reference to state law equivalent to Section 6J of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74)].

Drafting Note: Section 6J of the NAIC *Health Benefit Plan Network Access and Adequacy Model Act* (#74) provides that a health carrier may not prohibit a participating provider from advocating on behalf of covered persons within the utilization review and grievance and appeals processes established by the carrier or a person contracting with the carrier. The medical exceptions process established under this section for the review of requests for approval for exceptions to a formulary or being subject to a dose restriction or step therapy

(iii) A health carrier shall make a decision on an expedited medical exceptions review request based on exigent circumstances made pursuant to Subsection A and notify the covered person or the covered person's authorized representative of its coverage decision no later than [24] hours following receipt of the request.

(2) (a) If the health carrier fails to make a decision on the request and provide notice of the decision within the time frame required under Paragraph (1)(a) or Paragraph (1)(b)

(i) The covered person shall be entitled to have coverage for, up to one month's supply of the prescription drug that is theuaaucief the medreuiedp A e91.217 Td ( )Tj EMC /P <</MCID 4 >6BDC -0.001 Tc

Drafting Note: States should be aware that the bracketed language above is a requirement under federal regulations implementing the ACA for plans providing essential health benefits (EHBs) in the individual and small group markets (see Title 45 CFR Subpart B – Essential Health Benefits Package Section 156.122(c) (Prescription Drug Benefits)). As such, states will need to consider whether to include the bracketed language where it could have a broader application.

(3) A health carrier shall not establish a special formulary tier or payment or other cost

Section 14. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other that those to which it is held invalid, shall not be affected.

Section 15. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].
