Fifty-sixth Legislature
Second Regular Session

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1164

(Reference to Senate engrossed bill)

Page 1, line 3, strike "section" insert "sections"; after "20-3335" insert "and 20-3336"

Line 4, strike "coverage"

Line 5, strike "exemption determination process" insert "formulary change; notice; exemption"

Line 6, strike "applicability;"

Line 18, strike "INSURER" insert "PLAN"

Line 22, after "INDIVIDUAL'S" insert "HEALTH CARE"

Strike lines 23 through 38, insert:

"B. A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER MAY NOT CHANGE A COVERED INDIVIDUAL FROM THE PREVIOUSLY COVERED PRESCRIPTION DRUG IF THE COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER PROVIDES ELECTRONIC OR WRITTEN NOTICE TO THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER NOTIFYING THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER THAT IT WILL CONTINUE ON THE CURRENT PRESCRIPTION DRUG."

Line 40, strike "DURING A PLAN YEAR" insert "THAT LIMITS OR EXCLUDES COVERAGE OF A PRESCRIPTION DRUG"

Line 41, after "PROVIDE" insert "ELECTRONIC OR"; strike "FORMULARY" insert "REMOVAL OF OR"

Page 2, line 1, after "CHANGE" insert a period strike remainder of line

Strike lines 2 through 12

Line 13, strike "APPROVE A CHANGE IN THE PRESCRIPTION DRUG." insert:

"D."

Page 2, line 14, strike "REQUEST"

Line 15, strike "A PRESCRIPTION DRUG COVERAGE EXEMPTION" insert "NOTIFY THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER"

Strike lines 16 through 43

Strike page 3

Page 4, strike lines 1 through 10, insert "NONFORMULARY PRESCRIPTION DRUGS. THE NOTICE SHALL ALSO INCLUDE NOTIFICATION TO THE PRESCRIBING HEALTH CARE PROVIDER THAT IF THE HEALTH CARE PROVIDER NOTIFIES THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER THAT THE ENROLLEE WILL CONTINUE ON THE NONFORMULARY PRESCRIPTION DRUG FOR THE REMAINDER OF THE HEALTH CARE PLAN YEAR, THE PROVIDER WILL NEED TO APPLY FOR A FORMULARY EXCEPTION PURSUANT TO SECTION 20-3336 FOR THE CONTINUED USE OF THE NONFORMULARY PRESCRIPTION DRUG ON RENEWAL OF THE HEALTH CARE PLAN.

E. THIS SECTION DOES NOT:

1. PREVENT A HEALTH CARE PROVIDER FROM PRESCRIBING ANOTHER PRESCRIPTION DRUG COVERED BY THE HEALTH CARE INSURER OF THE PHARMACY BENEFIT MANAGER IF THE HEALTH CARE PROVIDER DEEMS THE PRESCRIPTION DRUG MEDICALLY NECESSARY FOR THE COVERED INDIVIDUAL.

2. PREVENT A HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FROM:

(a) ADDING A PRESCRIPTION DRUG TO ITS FORMULARY.

(b) REMOVING A PRESCRIPTION DRUG FROM ITS FORMULARY IF THE DRUG MANUFACTURER HAS REMOVED THE PRESCRIPTION DRUG FOR SALE IN THE UNITED STATES.

(c) MAKING ANY FORMULARY CHANGES FOR PATIENTS WHO ARE NOT ON A PREVIOUSLY APPROVED PRESCRIPTION DRUG.

F. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES VIOLATES THIS SECTION, THE DIRECTOR MAY ENFORCE THIS SECTION PURSUANT TO SECTION 20-3333.

G. FOR THE PURPOSES OF THIS SECTION:

1. "HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2501.

2. "LIMIT OR EXCLUDE COVERAGE" MEANS TO:

(a) LIMIT OR REDUCE THE MAXIMUM COVERAGE OF PRESCRIPTION DRUG BENEFITS.

(b) INCREASE COST SHARING FOR A COVERED PRESCRIPTION DRUG.

(c) REQUIRE AN ADDITIONAL PRIOR AUTHORIZATION FOR A PATIENT CURRENTLY APPROVED FOR THE DRUG BASED SOLELY ON THE MOVEMENT OF A DRUG TO A MORE RESTRICTIVE FORMULARY TIER.

(d) REMOVE A PRESCRIPTION DRUG FROM A FORMULARY UNLESS EITHER OF THE FOLLOWING APPLIES:

(i) THE UNITED STATES FOOD AND DRUG ADMINISTRATION REVOKES APPROVAL FOR OR REMOVES A PRESCRIPTION DRUG FROM THE PRESCRIPTION DRUG MARKET.

(ii) THE PRESCRIPTION DRUG MANUFACTURER NOTIFIES THE UNITED STATES FOOD AND DRUG ADMINISTRATION OF A MANUFACTURING DISCONTINUATION OR A POTENTIAL DISCONTINUATION AS REQUIRED BY SECTION 506C OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT (21 UNITED STATES CODE SECTION 356c).

3. "UTILIZATION REVIEW AGENT" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2530.

20-3336. Pharmacy benefit managers; prescribing; formulary exception process requirements; exception; enforcement; definitions

A. ON RENEWAL OF A HEALTH CARE PLAN, A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FOR THE HEALTH CARE INSURER SHALL PROVIDE A COVERED INDIVIDUAL AND PRESCRIBING HEALTH CARE PROVIDER WITH ACCESS TO A CLEAR AND CONVENIENT PROCESS TO REQUEST A FORMULARY EXCEPTION PROCESS. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT MAY USE ITS EXISTING FORMULARY EXCEPTION PROCESS TO SATISFY THIS REQUIREMENT IF THE MEDICAL EXCEPTIONS PROCESS IS CONSISTENT WITH THE REQUIREMENTS PRESCRIBED IN THIS SECTION.

B. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL FOLLOW THE PROCESS AND RESPOND TO A FORMULARY EXCEPTION DETERMINATION REQUEST IN ACCORDANCE WITH 45 CODE OF FEDERAL REGULATIONS SECTION 156.122.

C. FOR A COVERED INDIVIDUAL RENEWING THE SAME HEALTH CARE PLAN, A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL APPROVE A FORMULARY EXCEPTION FOR A COVERED INDIVIDUAL WHO HAS BEEN PREVIOUSLY APPROVED TO RECEIVE THE NONFORMULARY PRESCRIPTION DRUG UNDER THE SAME HEALTH CARE PLAN IF THE PRESCRIBING HEALTH CARE PROVIDER USES THE FORMULARY EXCEPTION PROCESS AND PROVIDES RELEVANT CLINICAL DOCUMENTATION TO CERTIFY ALL OF THE FOLLOWING:

1. THE COVERED INDIVIDUAL HAS TRIED A FORMULARY EQUIVALENT PRESCRIPTION DRUG THAT WAS A PART OF THE COVERED INDIVIDUAL'S PRESCRIPTION DRUG BENEFIT AT THE TIME OF THE TRIAL, THE FORMULARY EQUIVALENT PRESCRIPTION DRUG WAS NOT EFFECTIVE IN THE TREATMENT OF THE COVERED INDIVIDUAL'S MEDICAL CONDITION AND THE HEALTH CARE PROVIDER SPECIFIES THE CONTRAINDICATION OR ADVERSE OR HARMFUL REACTION IN THE COVERED INDIVIDUAL.

2. THE COVERED INDIVIDUAL HAS EXPERIENCED A POSITIVE THERAPEUTIC OUTCOME ON THE REQUESTED DRUG FOR MORE THAN NINETY DAYS.

3. FORMULARY EQUIVALENT PRESCRIPTION DRUGS ARE CONTRAINDICATED OR WILL LIKELY CAUSE A SERIOUS ADVERSE REACTION.

D. IF A COVERED INDIVIDUAL DOES NOT QUALIFY FOR A FORMULARY EXCEPTION PURSUANT TO SUBSECTION C OF THIS SECTION, THE COVERED INDIVIDUAL MAY STILL APPLY FOR A FORMULARY EXCEPTION USING THE HEALTH CARE INSURER'S, PHARMACY BENEFIT MANAGER'S OR UTILIZATION REVIEW AGENT'S FORMULARY EXCEPTION PROCESS. WHEN EVALUATING WHETHER THE COVERED INDIVIDUAL SHOULD QUALIFY FOR A FORMULARY EXCEPTION TO CONTINUE ON A NONFORMULARY PRESCRIPTION DRUG, THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION AGENT SHALL CONSIDER THE FOLLOWING FACTORS:

1. WHETHER THE COVERED INDIVIDUAL HAS EXPERIENCED A POSITIVE THERAPEUTIC OUTCOME ON THE PREVIOUSLY APPROVED DRUG.

2. WHETHER THE FORMULARY PRESCRIPTION DRUG IS NOT IN THE BEST INTEREST OF THE COVERED INDIVIDUAL BASED ON MEDICAL NECESSITY BECAUSE THE COVERED INDIVIDUAL'S USE OF THE FORMULARY PRESCRIPTION DRUG IS EXPECTED TO CAUSE EITHER OF THE FOLLOWING:

(a) A NEGATIVE IMPACT ON THE COVERED INDIVIDUAL'S COMORBID CONDITION.

(b) A CLINICALLY PREDICTABLE NEGATIVE DRUG INTERACTION.

3. WHETHER THE FORMULARY PRESCRIPTION DRUG IS CONTRAINDICATED OR WILL LIKELY CAUSE A SERIOUS ADVERSE REACTION.

E. DENIAL OF COVERAGE FOR A HEALTH CARE INSURER'S OR PHARMACY BENEFIT MANAGER'S DENIAL OF COVERAGE FOR A NONFORMULARY PRESCRIPTION DRUG SHALL BE MADE IN WRITING BY A LICENSED PHARMACIST OR MEDICAL DIRECTOR. THE WRITTEN DENIAL SHALL CONTAIN AN EXPLANATION OF THE DENIAL THAT INCLUDES THE MEDICAL OR PHARMACOLOGICAL REASONS WHY THE AUTHORIZATION WAS DENIED AND A SIGNATURE BY THE LICENSED PHARMACIST OR MEDICAL DIRECTOR WHO MADE THE DECISION TO DENY COVERAGE. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL SEND A COPY OF THE WRITTEN DENIAL TO THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER WHO REQUESTED THE FORMULARY EXCEPTION. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL MAINTAIN COPIES OF ALL WRITTEN DENIALS AND SHALL MAKE THE COPIES AVAILABLE TO THE DEPARTMENT FOR INSPECTION. A COVERED INDIVIDUAL OR THE COVERED INDIVIDUAL'S AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DETERMINATION TO DENY A FORMULARY EXCEPTION UNDER CHAPTER 15, ARTICLE 2 OF THIS TITLE. THE WRITTEN NOTIFICATION SHALL INCLUDE THE PROCESS IN WHICH A COVERED INDIVIDUAL MAY APPEAL THE DETERMINATION.

F. IF THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT AUTHORIZES A FORMULARY EXCEPTION FOR A COVERED INDIVIDUAL PURSUANT TO THIS SECTION, THAT AUTHORIZATION SHALL BE IN EFFECT UNTIL THE END OF THE COVERED INDIVIDUAL'S PLAN YEAR. THE APPROVAL OF A FORMULARY EXCEPTION SHALL BE IN WRITING AND DELIVERED TO THE COVERED INDIVIDUAL AND THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER.

G. THIS SECTION DOES NOT:

1. PREVENT A HEALTH CARE PROVIDER FROM PRESCRIBING ANOTHER PRESCRIPTION DRUG COVERED BY THE HEALTH CARE INSURER OR THE PHARMACY BENEFIT MANAGER IF THE HEALTH CARE PROVIDER DEEMS THE PRESCRIPTION DRUG MEDICALLY NECESSARY FOR THE COVERED INDIVIDUAL.

2. PREVENT A HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FROM MANAGING ITS FORMULARY IN COMPLIANCE WITH THIS SECTION, INCLUDING:

(a) ADDING A PRESCRIPTION DRUG TO ITS FORMULARY.

(b) REMOVING A PRESCRIPTION DRUG FROM ITS FORMULARY IF THE DRUG MANUFACTURER HAS REMOVED THE PRESCRIPTION DRUG FOR SALE IN THE UNITED STATES.

(c) SETTING THE COST SHARING FOR NONFORMULARY PRESCRIPTION DRUGS.

H. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES VIOLATES THIS SECTION, THE DIRECTOR MAY ENFORCE THIS SECTION PURSUANT TO SECTION 20-3333.

I. A POLICY THAT IS ISSUED OR RENEWED BY A DISABILITY INSURER DOES NOT INCLUDE A POLICY THAT PROVIDES LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

J. FOR THE PURPOSES OF THIS SECTION:

1. "FORMULARY EXCEPTION" MEANS THAT HEALTH PLAN COVERAGE OF A HEALTH CARE PROVIDER'S SELECTED PRESCRIPTION DRUG IS GRANTED.

2. "HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2501.

3. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE THAT A HEALTH CARE INSURER ISSUES TO AN INSURED, ENROLLEE OR SUBSCRIBER.

4. "UTILIZATION REVIEW AGENT" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2530."

Page 4, line 12, after the "contracts" insert ", policies or evidences of coverage that are"

Amend title to conform

And, as so amended, it do pass

DAVID LIVINGSTON
CHAIRMAN

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