COMMITTEE ON FINANCE AND COMMERCE

SENATE AMENDMENTS TO S.B. 1164

(Reference to printed bill)

Page 1, between lines 1 and 2, insert:

"Section 1. Section 20-841.05, Arizona Revised Statutes, is amended to read:

20-841.05. Prescription drug formulary; definitions

A. A corporation with a prescription drug benefit that uses a drug formulary as a component of the subscription contract shall provide to its subscribers notice in the contract and any disclosure form regarding the applicable drug formulary. The corporation shall write the notice so that the language and format are easy to understand. The notice shall include an explanation of what a drug formulary is, how the corporation determines which prescription drugs are included or excluded and how often the corporation reviews the contents of the drug formulary.

B. A corporation described in subsection A of this section shall:

1. Develop and maintain a process by which health care professionals may request authorization for a medically necessary formulary or nonformulary prescription drug during nonbusiness hours. If the corporation does not maintain that process, the corporation shall reimburse a subscriber for the subscriber's out-of-pocket expense minus any deductible or copayment for a prescription drug that was purchased by the subscriber without preauthorization but that was later approved by the corporation.

2. Develop and maintain a process by which health care professionals may request authorization for medically necessary nonformulary prescription

drugs. The corporation shall approve an alternative prescription drug when ~~either~~ ANY of the following conditions is met:

(a) The equivalent prescription drug on the formulary has been ineffective in the treatment of the subscriber's disease or condition.

(b) The equivalent prescription drug on the formulary has caused an adverse or harmful reaction in the subscriber.

(c) THE SUBSCRIBER HAS PREVIOUSLY BEEN APPROVED TO RECEIVE THE NONFORMULARY PRESCRIPTION DRUG BY THE CURRENT OR PREVIOUS HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER AND BOTH OF THE FOLLOWING CONDITIONS APPLY:

(i) THE SUBSCRIBER IS MEDICALLY STABLE ON A PRESCRIPTION DRUG AS DETERMINED BY THE SUBSCRIBER'S PRESCRIBING HEALTH CARE PROFESSIONAL.

(ii) THE PRESCRIBING HEALTH CARE PROFESSIONAL CONTINUES TO PRESCRIBE THE DRUG FOR THE SUBSCRIBER'S COVERED MEDICAL CONDITION.

C. If the subscriber's pharmacy benefit plan does not require authorization, subsection B, paragraph 2 of this section does not apply.

D. If the subscriber's treating health care professional makes a determination that the subscriber meets any of the conditions described in subsection B of this section, any denial to cover the nonformulary prescription drug by the corporation shall be made in writing by a licensed pharmacist or medical director. The written denial shall contain an explanation of the denial, including the medical or pharmacological reasons why the authorization was denied, and INFORMATION ABOUT HOW A SUBSCRIBER MAY APPEAL THE DENIAL. The licensed pharmacist or medical director who made the denial shall sign it. The corporation shall send a copy of the written denial to the subscriber's treating health care professional who requested the authorization. The corporation shall maintain copies of all written denials and shall make the copies available to the department for inspection during regular business hours. A SUBSCRIBER OR THE SUBSCRIBER'S AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DETERMINATION TO DENY COVERAGE.

E. IF THE CORPORATION AUTHORIZES A FORMULARY EXEMPTION FOR A SUBSCRIBER PURSUANT TO SUBSECTION B, PARAGRAPH 2 OF THIS SECTION, THAT AUTHORIZATION SHALL BE IN EFFECT UNTIL THE END OF THE SUBSCRIBER'S PLAN YEAR. THE APPROVAL OF THE FORMULARY EXEMPTION SHALL BE IN WRITING AND DELIVERED TO THE SUBSCRIBER AND THE SUBSCRIBER'S TREATING HEALTH CARE PROFESSIONAL.

~~E.~~ F. Any subscription contract that is issued, amended or renewed by a corporation and that includes prescription drug benefits shall not limit or exclude coverage for at least sixty days after the corporation's notice or the pharmacy's notice pursuant to subsection ~~F~~ G of this section to the subscriber, whichever occurs first, for a prescription drug for a subscriber to refill a previously prescribed drug if the prescription drug was previously approved for coverage under the drug formulary or pharmacy benefit plan for the subscriber's medical condition and the health care professional continues to prescribe the prescription drug for the same medical condition. The limitation or exclusion prohibited by this subsection applies if the prescription drug is appropriately prescribed and is considered safe and effective for treating the subscriber's medical condition. This subsection does not prohibit the health care professional from prescribing another prescription drug that is covered by the drug formulary and that is medically appropriate for the subscriber, including generic drug substitutions.

~~F.~~ G. A corporation shall provide written notice of the removal of any prescription drug from the corporation's drug formulary to each pharmacy vendor with which the corporation has a contract. On notice from the corporation, the contracted pharmacy vendor at the point of dispensing a prescription drug that has been removed from the drug formulary shall notify the subscriber by means of a verbal consultation or other direct communication with a subscriber that the subscriber may be required to consult with a health care professional to obtain a new prescription for a replacement drug after the sixty day period prescribed in subsection ~~E~~ F of this section. The notice prescribed in this subsection is not required

if the pharmacy vendor is a pharmacy that is owned by the corporation or a corporate affiliate of that corporation.

~~G.~~ H. This section does not:

1. Prohibit a corporation from applying deductibles, coinsurance or other cost containment or quality assurance measures.

2. Apply to a corporation that provides a multitiered benefit plan that allows access to prescription drugs without authorization by the corporation.

3. Apply to any corporation that holds a certificate of authority to operate either as a dental service corporation or an optometric service corporation.

~~H.~~ I. For the purposes of this section:

1. "Health care professional" means a person who has an active nonrestricted license pursuant to title 32 and is authorized to write drug prescriptions to treat medical conditions.

2. "Prescription drug" means any prescription medication as defined in section 32-1901 that is prescribed by a health care professional to a subscriber to treat the subscriber's condition.

Sec. 2. Section 20-846, Arizona Revised Statutes, is amended to read:

20-846. Individual health insurance policies; mandatory coverage exemption; definitions

A. A hospital service corporation, medical service corporation or hospital and medical service corporation may issue a subscription contract to an uninsured individual that is not subject to the requirements of any of the following:

1. Section 20-461, subsection A, paragraph 17 and subsection B.

2. Section 20-826, subsections F, J, K, U, V, W and X.

3. Section 20-841, subsections A and C.

4. Sections 20-841.01, 20-841.02, 20-841.03, 20-841.04, 20-841.06, 20-841.07 and 20-841.08.

5. Section 20-841.05, subsections B and ~~E~~ F.

B. For the purposes of this section:

1. "Health insurance coverage":

(a) Means a health care plan or arrangement that pays for or furnishes medical or health services and that is issued by a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or medical, hospital, dental and optometric service corporation or a similar entity in another state.

(b) Includes a self-insured or self-funded employee benefit plan or multiemployer employee benefit plan created pursuant to 29 United States Code section 186(c) if the regulation of that plan is preempted by section 514(b) of the employee retirement ~~insurance~~ INCOME security act of 1974 (29 United States Code section 1144(b)).

(c) Does not include limited benefit coverage as defined in section 20-1137.

2. "Uninsured individual" means a person who has either:

(a) Not had health insurance coverage for the ninety days immediately before the effective date of coverage issued pursuant to this section, except that this requirement does not apply at the renewal of coverage pursuant to this section.

(b) Lost health insurance coverage in one of the following ways within ninety days immediately before the effective date of coverage issued pursuant to this section:

(i) The individual left a job that provided health insurance coverage.

(ii) The individual's employer discontinued offering health insurance coverage.

(iii) The individual exhausted continuation coverage under a COBRA continuation provision as defined in section 20-2301.

(iv) The individual's family health insurance coverage was discontinued due to the death of a spouse or a divorce.

(v) The individual attained the maximum age for dependent coverage under a health insurance policy.

(vi) The individual's participation in a public health care program was discontinued."

Renumber to conform

Page 1, line 23, after "INDIVIDUAL'S" strike remainder of line

Strike line 24, insert "PLAN YEAR."

Line 25, strike ", PARAGRAPH 1"

Between lines 39 and 40, insert:

"C. A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER SHALL PROVIDE WRITTEN NOTICE OF THE REMOVAL FROM OR AN INCREASE IN THE COST SHARING FOR ANY PRESCRIPTION DRUG ON THE DRUG FORMULARY TO EACH IMPACTED COVERED INDIVIDUAL AT LEAST SIXTY DAYS BEFORE THE PLAN YEAR ENDS. THE NOTICE SHALL SET FORTH THE PROCESS BY WHICH THE COVERED INDIVIDUAL'S HEALTH CARE PROFESSIONAL MAY REQUEST AUTHORIZATION FOR THE CONTINUED USE OF THE NONFORMULARY PRESCRIPTION DRUG IF THE MEDICAL PRESCRIBER DETERMINES THAT THE COVERED INDIVIDUAL:

1. HAS PREVIOUSLY BEEN APPROVED BY THE COVERED INDIVIDUAL'S PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER TO BE TREATED BY THE CURRENT SPECIFIC PRESCRIPTION DRUG OR DRUG REGIMEN.

2. IS MEDICALLY STABLE ON THE CURRENT NONFORMULARY DRUG."

Reletter to conform

Page 2, line 10, after "WITHIN" strike remainder of line

Strike lines 11 through 38, insert "THE TIMELINES OUTLINED IN 45 CODE OF FEDERAL REGULATIONS SECTION 156.122."

Renumber to conform

Line 39, strike "EXPEDITIOUSLY"

Line 40, after "INDIVIDUAL" strike remainder of line

Strike lines 41 through 44

Page 3, strike lines 1 through 32, insert "PURSUANT TO SECTION 20-841.05."

Line 39, strike "EITHER" insert "ANY OF THE FOLLOWING"

Between lines 42 and 43, insert:

"(c) MAKING ANY FORMULARY CHANGES FOR PATIENTS THAT ARE NOT CURRENTLY STABLE ON A PREVIOUSLY APPROVED PRESCRIPTION DRUG."

Page 4, strike lines 9 through 13

Renumber to conform

Strike lines 19 through 27

Renumber to conform

Between lines 29 and 30, insert:

"Sec. 4. Section 20-2341, Arizona Revised Statutes, is amended to read:

20-2341. Uninsured small business health insurance plans; mandatory coverage exemption; definitions

A. A policy, subscription contract, contract, plan or evidence of coverage issued to an uninsured small business by a health care insurer is not subject to the requirements of any of the following:

1. Section 20-461, subsection A, paragraph 17 and subsection B.

2. Section 20-826, subsection C, paragraph 1.

3. Section 20-826, subsections F, J, K, U, V, W, X and Y.

4. Sections 20-841, 20-841.01, 20-841.02, 20-841.03, 20-841.04, 20-841.06, 20-841.07 and 20-841.08.

5. Section 20-841.05, subsections B and ~~E~~ F.

6. Section 20-1057, subsections C, K, L, Y, Z, AA and BB.

7. Sections 20-1057.01, 20-1057.03, 20-1057.04, 20-1057.05 and 20-1057.08.

8. Section 20-1057.02, subsection B.

9. Section 20-1342, subsection A, paragraph 8, subdivision (a).

10. Section 20-1342, subsection A, paragraphs 11 and 12.

11. Section 20-1342, subsections H, I, J and K.

12. Section 20-1342.01.

13. Sections 20-1376, 20-1376.01, 20-1376.02, 20-1376.03 and 20-1376.04.

14. Section 20-1402, subsection A, paragraph 4, subdivision (a).

15. Section 20-1402, subsection A, paragraphs 7 and 8.

16. Section 20-1402, subsections H, I, J, K and L.

17. Section 20-1404, subsection F, paragraph 1.

18. Section 20-1404, subsections I, Q, R, S, T and U.

19. Section 20-1406.

20. Sections 20-1406.01, 20-1406.02, 20-1406.03 and 20-1406.04.

21. Section 20-1407.

22. Section 20-2321.

23. Section 20-2327.

24. Section 20-2329.

B. Section 20-2304, subsection B does not apply to a policy, subscription contract, contract, plan or evidence of coverage issued to an uninsured small business pursuant to subsection A of this section.

C. In this article, unless the context otherwise requires:

1. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation.

2. "Uninsured small business" means a small employer that did not provide a health benefits plan for at least ninety days immediately before the effective date of coverage provided pursuant to this section, except that this requirement does not apply at the renewal of coverage pursuant to this section."

Renumber to conform

Amend title to conform

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