Senate Engrossed

~~pharmacy benefits; coverage; exemptions~~
(now: pharmacy benefits; coverage)

State of Arizona
Senate
Fifty-sixth Legislature
Second Regular Session
2024

SENATE BILL 1164

AN ACT

AMENDING TITLE 20, CHAPTER 25, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3335; RELATING TO PHARMACY BENEFIT MANAGERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, chapter 25, article 2, Arizona Revised Statutes, is amended by adding section 20-3335, to read:

20-3335. Pharmacy benefit managers; prescribing; coverage exemption determination process; enforcement; applicability; definitions

A. IF A PHARMACY BENEFIT MANAGER ENTERS INTO AN AGREEMENT WITH A HEALTH CARE INSURER TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES TO COVERED INDIVIDUALS, THE PHARMACY BENEFIT MANAGER, ON BEHALF OF THE PHARMACY BENEFIT MANAGER OR A HEALTH CARE INSURER:

1. MAY NOT LIMIT OR EXCLUDE COVERAGE OF A PRESCRIPTION DRUG FOR ANY COVERED INDIVIDUAL WHO IS ON A SPECIFIC PRESCRIPTION DRUG IF BOTH OF THE FOLLOWING APPLY:

(a) THE PRESCRIPTION DRUG WAS PREVIOUSLY APPROVED BY THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER FOR COVERAGE FOR THE COVERED INDIVIDUAL.

(b) THE COVERED INDIVIDUAL CONTINUES TO BE AN ENROLLEE OF THE HEALTH CARE INSURER THAT THE PHARMACY BENEFIT MANAGER HAS CONTRACTED WITH TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES.

2. IF PARAGRAPH 1 OF THIS SUBSECTION APPLIES, SHALL CONTINUE COVERAGE OF A COVERED INDIVIDUAL'S SPECIFIC PRESCRIPTION DRUG THROUGH THE LAST DAY OF THE COVERED INDIVIDUAL'S PLAN YEAR.

B. FOR THE PURPOSES OF SUBSECTION A OF THIS SECTION, A PHARMACY BENEFIT MANAGER, ON BEHALF OF THE PHARMACY BENEFIT MANAGER OR A HEALTH CARE INSURER, MAY NOT DO ANY OF THE FOLLOWING FOR A COVERED INDIVIDUAL IDENTIFIED UNDER SUBSECTION A OF THIS SECTION:

1. LIMIT OR REDUCE THE MAXIMUM COVERAGE OF PRESCRIPTION DRUG BENEFITS.

2. INCREASE COST SHARING FOR A COVERED PRESCRIPTION DRUG.

3. MOVE A PRESCRIPTION DRUG TO A MORE RESTRICTIVE FORMULARY TIER.

4. REMOVE A PRESCRIPTION DRUG FROM A FORMULARY UNLESS EITHER OF THE FOLLOWING APPLIES:

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

(b) 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.

C. IF A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER MAKES ANY FORMULARY CHANGE DURING A PLAN YEAR, THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER SHALL PROVIDE WRITTEN NOTICE OF THE FORMULARY CHANGE FOR ANY PRESCRIPTION DRUG ON THE DRUG FORMULARY TO EACH IMPACTED COVERED INDIVIDUAL AND THE IMPACTED COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE

PROVIDER AT LEAST SIXTY DAYS BEFORE THE FORMULARY CHANGE DURING THE PLAN YEAR. THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER MAY ONLY CHANGE A COVERED INDIVIDUAL FROM THE PREVIOUSLY COVERED PRESCRIPTION DRUG IF THE COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER PROVIDES WRITTEN AUTHORIZATION TO THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER FOR THE CHANGE IN THE PRESCRIPTION DRUG.

D. A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER SHALL PROVIDE WRITTEN NOTICE OF THE REMOVAL FROM OR AN INCREASE IN COST SHARING FOR ANY PRESCRIPTION DRUG ON THE DRUG FORMULARY TO EACH IMPACTED COVERED INDIVIDUAL AND THE IMPACTED COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER AT LEAST SIXTY DAYS BEFORE THE END OF THE PLAN YEAR, IF THE COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER DID NOT PREVIOUSLY APPROVE A CHANGE IN THE PRESCRIPTION DRUG. THE NOTICE SHALL SET FORTH THE PROCESS BY WHICH THE COVERED INDIVIDUAL'S HEALTH CARE PROVIDER MAY REQUEST A PRESCRIPTION DRUG COVERAGE EXEMPTION FOR THE CONTINUED USE OF THE NONFORMULARY PRESCRIPTION DRUG AND THE EXEMPTION PROCESS SHALL COMPLY WITH SUBSECTION E OF THIS SECTION.

E. A PRESCRIPTION DRUG COVERAGE EXEMPTION DETERMINATION PROCESS IS AVAILABLE TO COVERED INDIVIDUALS AND THE PRESCRIBING HEALTH CARE PROVIDER TO ENSURE CONTINUITY OF CARE AFTER A COVERED INDIVIDUAL'S RENEWAL IN THE FOLLOWING MANNER:

1. 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 COVERAGE EXEMPTION DETERMINATION. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT MAY USE ITS EXISTING MEDICAL EXCEPTIONS PROCESS TO SATISFY THIS REQUIREMENT IF THE MEDICAL EXCEPTIONS PROCESS IS CONSISTENT WITH THE REQUIREMENTS PRESCRIBED IN THIS SECTION.

2. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL RESPOND TO A COVERAGE EXEMPTION DETERMINATION REQUEST WITHIN THE TIMELINES OUTLINED IN 45 CODE OF FEDERAL REGULATIONS SECTION 156.122.

3. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL APPROVE A PRESCRIPTION DRUG COVERAGE EXEMPTION FOR A COVERED INDIVIDUAL WHO HAS BEEN PREVIOUSLY APPROVED TO RECEIVE THE NONFORMULARY PRESCRIPTION DRUG BY THE COVERED INDIVIDUAL'S CURRENT HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER AND THE PRESCRIBING HEALTH CARE PROVIDER CONTINUES TO PRESCRIBE THE PRESCRIPTION DRUG FOR THE COVERED INDIVIDUAL'S MEDICAL CONDITION.

4. 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 CORPORATION SHALL SEND A COPY OF THE WRITTEN DENIAL TO THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER 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 COVERED INDIVIDUAL OR THE COVERED INDIVIDUAL'S AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DETERMINATION TO DENY A COVERAGE EXEMPTION. THE WRITTEN NOTIFICATION SHALL INCLUDE THE PROCESS IN WHICH A COVERED INDIVIDUAL MAY APPEAL THE DETERMINATION.

5. IF THE CORPORATION AUTHORIZES A COVERAGE EXEMPTION 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 COVERAGE EXEMPTION SHALL BE IN WRITING AND DELIVERED TO THE COVERED INDIVIDUAL AND THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER.

F. THIS SECTION DOES NOT:

1. PREVENT A HEALTH CARE PROVIDER FROM PRESCRIBING ANOTHER PRESCRIPTION DRUG COVERED BY THE CARRIER, THE HEALTH CARE INSURER OR THE PHARMACY BENEFIT MANAGER, IF THE CARRIER, HEALTH CARE INSURER OR THE PHARMACY BENEFIT MANAGER IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES AND 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.

G. 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 IMPOSE A CIVIL PENALTY AGAINST THAT HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT.

H. 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.

I. FOR THE PURPOSES OF THIS SECTION:

1. "COVERAGE EXEMPTION" MEANS THAT IMMEDIATE 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.

Sec. 2. Applicability

This act applies to contracts entered into, amended, extended or renewed on or after December 31, 2024.