

8863

2009-2010 Regular Sessions

I N A S S E M B L Y

June 11, 2009

Introduced by M. of A. ESPAILLAT -- read once and referred to the
Committee on Insurance

AN ACT to amend the insurance law, in relation to group health insurance
policies and prescription drug coverage

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEM-
BLY, DO ENACT AS FOLLOWS:

1 Section 1. Section 3221 of the insurance law is amended by adding
2 three new subsections (r), (s) and (t) to read as follows:
3 (R)(1) NO INSURANCE SHALL PROVIDE INCENTIVES (MONEY OR OTHERWISE) TO A
4 PRESCRIBING PHYSICIAN OF DRUGS THAT DISCRIMINATE ON THE BASIS OF THE
5 DRUG PRESCRIBED.
6 (2) AN INSURER SHALL BE LIABLE FOR ANY INJURIES OR DAMAGE SUSTAINED BY
7 A MEMBER INSURED BY A GROUP HEALTH POLICY ISSUED UNDER THIS SECTION AS A
8 RESULT OF A MEMBER'S DRUG SUBSTITUTION OCCASIONED BY CHANGES TO EXISTING
9 FORMULARY OR CO-PAYMENT OR CO-INSURANCE PAYMENT STRUCTURES.
10 (3) WHEN AN INSURER HAS CHANGED THE DRUG MEDICATION OF A MEMBER
11 INSURED BY A GROUP HEALTH POLICY ISSUED UNDER THIS SECTION TO A GENERIC
12 ALTERNATIVE WHICH ALTERNATIVE AS ATTESTED TO BY THE MEMBER'S PRESCRIBING
13 PHYSICIAN IS NOT THE EQUIVALENT OF THE ORIGINAL PRESCRIBED DRUG THE
14 INSURER SHALL CONTINUE TO COVER AND PAY FOR THE ORIGINAL DRUG AND MAKE
15 SAID DRUG AVAILABLE TO THE MEMBER AS ORIGINALLY PRESCRIBED.
16 (S)(1) THE FOLLOWING SHALL APPLY TO DEDUCTIBLE CO-PAYMENT AND CO-INSU-
17 RANCE AMOUNTS ESTABLISHED BY INSURERS OF HEALTH PLANS ISSUED UNDER THIS
18 SECTION.
19 (2) THE CO-PAYMENT AND CO-INSURANCE AMOUNT WITH RESPECT TO ANY COVERED
20 DRUG SHALL NOT EXCEED THE COST OF THE DRUG TO THE HEALTH PLAN.
21 (3) SHOULD A HEALTH PLAN INCLUDE AN OUT OF POCKET LIMIT ON NON-PHARMA-
22 CY BENEFITS IT SHALL ALSO PROVIDE THAT OUT OF POCKET EXPENSES FOR
23 COVERED PRESCRIPTION DRUGS SHALL BE INCLUDED AS MEDICAL BENEFIT EXPENSES
24 UNDER THE PLAN'S GENERAL OUT OF POCKET EXPENSE CAP.

EXPLANATION--Matter in *ITALICS* (underscored) is new; matter in brackets
[] is old law to be omitted.

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1 (4) SHOULD AN INSURER PROVIDE FOR TIERED CO-PAYMENT AND CO-INSURANCE
2 AMOUNTS, IT SHALL ALSO PROVIDE THAT THE MAXIMUM CO-PAYMENT AND CO-INSU-
3 RANCE AMOUNT SHALL NOT EXCEED THREE HUNDRED PERCENT OF THE LOWEST
4 CO-PAYMENT AND CO-INSURANCE AMOUNT.
5 (T) EVERY GROUP OR BLANKET POLICY WHICH PROVIDES COVERAGE FOR
6 PRESCRIPTION DRUGS SHALL BE SUBJECT TO THE FOLLOWING REQUIREMENTS:
7 (1) IF LESS EXPENSIVE DRUGS ARE REQUIRED TO BE TAKEN BY THE PATIENT
8 INITIALLY, THE SINGLE SOURCE MEDICATION MUST BE AVAILABLE FOLLOWING
9 COMPLIANCE WITH THE STEP THERAPY AND A DETERMINATION BY THE PATIENT'S
10 PHYSICIAN THAT THE DRUG REMAINS MEDICALLY NECESSARY.
11 (2) THE INSURERS MUST SUBMIT THEIR PRESCRIPTION DRUG FORMULARIES TO
12 THE DEPARTMENT ON AN ANNUAL BASIS AND WHENEVER THEY ARE ALTERED. THE
13 DEPARTMENT SHALL ISSUE GUIDELINES FOR INSURERS TO FOLLOW IN MAKING
14 DETERMINATIONS OF MEDICAL NECESSITY WITH RESPECT TO PRESCRIPTION DRUG
15 COVERAGE.
16 (3) AN INSURER CAN AMEND THE FORMULARY ONCE A YEAR OR WHEN AN AMEND-
17 MENT IS TO INCLUDE A NEW DRUG OR A NEW GENERIC VERSION OF A CURRENT
18 DRUG.
19 (4) A PATIENT RECEIVING COVERAGE FOR A DRUG ON AN INSURER'S EXISTING
20 FORMULARY SHALL NOT BE DENIED COVERAGE UPON A CHANGE IN THE FORMULARY IF
21 HIS OR HER PHYSICIAN DETERMINES THAT DRUG TO BE MEDICALLY NECESSARY.
22 S 2. This act shall take effect immediately.