S T A T E O F N E W Y O R K

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I N S E N A T E

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Introduced by Sens. KLEIN, ADAMS, HASSELL-THOMPSON, C. JOHNSON, ONORATO, OPPENHEIMER, STAVISKY -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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

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

Section 1. Section 3221 of the insurance law is amended by adding two new subsections (s) and (t) to read as follows:

(S) EVERY GROUP OR BLANKET POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL:

(1) LIMIT THE CO-PAYMENT AND CO-INSURANCE AMOUNTS WITH RESPECT TO ANY COVERED DRUG SO THAT IT SHALL NOT EXCEED THE COST OF THE DRUG TO THE HEALTH PLAN.

(2) PROVIDE AN OUT-OF-POCKET CAP ON PHARMACY BENEFITS FOR COVERED PRESCRIPTION DRUGS.

(3) LIMIT THE MAXIMUM CO-PAYMENT AND CO-INSURANCE AMOUNTS SO THEY SHALL NOT EXCEED TEN TIMES THE DOLLAR VALUE OF THE LOWEST CO-PAYMENT AND CO-INSURANCE AMOUNT WHOSE COST IS ABOVE ZERO DOLLARS.

(T) EVERY GROUP OR BLANKET POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS:

(1) WHEN AN INSURER HAS REQUIRED THAT A MEMBER INSURED BY A HEALTH POLICY ISSUED UNDER THIS SECTION TAKE A GENERIC ALTERNATIVE TO A BRAND-NAME PATENTED DRUG PRESCRIBED BY THEIR DOCTOR, AND THE ALTERNATIVE IS NOT DEEMED AS HAVING AN EQUIVALENT IMPACT ON THE MEMBER BY THE MEMBER'S PRESCRIBING PHYSICIAN AND IS NOT DEEMED AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA, THE INSURER

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

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SHALL PAY FOR AND MAKE AVAILABLE THE BRAND-NAME PATENTED DRUG ORIGINALLY PRESCRIBED BY THE MEMBER'S DOCTOR.

(2) IN CASES WHERE STEP THERAPY IS REQUIRED PRIOR TO A PATIENT ACCESSING A BRAND-NAME PATENTED PRESCRIPTION DRUG, THE PATIENT CAN RECEIVE THE BRAND-NAME PATENTED PRESCRIPTION DRUG PRESCRIBED BY THEIR DOCTOR IF THE PATIENT TRIES ONE ALTERNATIVE MEDICATION AND THE PATIENT'S DOCTOR DETERMINES THAT THE SINGLE SOURCE THERAPY REMAINS MEDICALLY NECESSARY.

(3) INSURERS MUST SUBMIT THEIR PRESCRIPTION DRUG FORMULARIES TO THE DEPARTMENT AND ON AN ANNUAL BASIS, WHICH THE DEPARTMENT SHALL PUBLICLY POST ON THEIR WEBSITE TO ENABLE CONSUMERS TO COMPARE DRUG FORMULARIES DURING OPEN ENROLLMENT PERIODS. ONCE SUBMITTED, PLANS MAY NOT REMOVE OR MAKE CHANGES TO THE DRUG FORMULARY MID-YEAR EXCEPT IN INSTANCES WHERE AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA BECOMES AVAILABLE, THE DRUG IS RECALLED BY THE FOOD AND DRUG ADMINISTRATION, OR SIGNIFICANT NEW SAFETY INFORMATION BECOMES AVAILABLE.

(4) A PATIENT RECEIVING COVERAGE FOR A DRUG ON AN INSURER'S EXISTING FORMULARY SHALL NOT BE DENIED COVERAGE UPON A CHANGE IN THE FORMULARY IF HIS OR HER PHYSICIAN DETERMINES THAT DRUG TO BE MEDICALLY NECESSARY.

S 2. Section 3216 of the insurance law is amended by adding two new subsections (j-1) and (j-2) to read as follows:

(J-1) EVERY POLICY OF ACCIDENT AND HEALTH INSURANCE DELIVERED OR ISSUED FOR DELIVERY TO ANY PERSON IN THIS STATE WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL:

(1) LIMIT THE CO-PAYMENT AND CO-INSURANCE AMOUNTS WITH RESPECT TO ANY COVERED DRUG SO THAT IT SHALL NOT EXCEED THE COST OF THE DRUG TO THE HEALTH PLAN.

(2) PROVIDE AN OUT-OF-POCKET CAP ON PHARMACY BENEFITS FOR COVERED PRESCRIPTION DRUGS.

(3) LIMIT THE MAXIMUM CO-PAYMENT AND CO-INSURANCE AMOUNTS SO THEY SHALL NOT EXCEED TEN TIMES THE DOLLAR VALUE OF THE LOWEST CO-PAYMENT AND CO-INSURANCE AMOUNT WHOSE COST IS ABOVE ZERO DOLLARS.

(J-2) EVERY POLICY OF ACCIDENT AND HEALTH INSURANCE DELIVERED OR ISSUED FOR DELIVERY TO ANY PERSON IN THIS STATE WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS:

(1) WHEN AN INSURER HAS REQUIRED THAT A MEMBER INSURED BY A HEALTH POLICY ISSUED UNDER THIS SECTION TAKE A GENERIC ALTERNATIVE TO A BRAND-NAME PATENTED DRUG PRESCRIBED BY THEIR DOCTOR, AND THE ALTERNATIVE IS NOT DEEMED AS HAVING AN EQUIVALENT IMPACT ON THE MEMBER BY THE MEMBER'S PRESCRIBING PHYSICIAN AND IS NOT DEEMED AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA, THE INSURER SHALL PAY FOR AND MAKE AVAILABLE THE BRAND-NAME PATENTED DRUG ORIGINALLY PRESCRIBED BY THE MEMBER'S DOCTOR.

(2) IN CASES WHERE STEP THERAPY IS REQUIRED PRIOR TO A PATIENT ACCESSING A BRAND-NAME PATENTED PRESCRIPTION DRUG, THE PATIENT CAN RECEIVE THE BRAND-NAME PATENTED PRESCRIPTION DRUG PRESCRIBED BY THEIR DOCTOR IF THE PATIENT TRIES ONE ALTERNATIVE MEDICATION AND THE PATIENT'S DOCTOR DETERMINES THAT THE SINGLE SOURCE THERAPY REMAINS MEDICALLY NECESSARY.

(3) INSURERS MUST SUBMIT THEIR PRESCRIPTION DRUG FORMULARIES TO THE DEPARTMENT AND ON AN ANNUAL BASIS, WHICH THE DEPARTMENT SHALL PUBLICLY POST ON THEIR WEBSITE TO ENABLE CONSUMERS TO COMPARE DRUG FORMULARIES DURING OPEN ENROLLMENT PERIODS. ONCE SUBMITTED, PLANS MAY NOT REMOVE OR MAKE CHANGES TO THE DRUG FORMULARY MID-YEAR EXCEPT IN INSTANCES WHERE AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA BECOMES AVAILABLE, THE DRUG IS RECALLED BY THE FOOD AND DRUG ADMINISTRATION, OR SIGNIFICANT NEW SAFETY INFORMATION BECOMES AVAILABLE.

(4) A PATIENT RECEIVING COVERAGE FOR A DRUG ON AN INSURER'S EXISTING FORMULARY SHALL NOT BE DENIED COVERAGE UPON A CHANGE IN THE FORMULARY IF HIS OR HER PHYSICIAN DETERMINES THAT DRUG TO BE MEDICALLY NECESSARY.

S 3. Section 4303 of the insurance law is amended by adding two new subsections (gg) and (hh) to read as follows:

(GG) EVERY CONTRACT ISSUED BY A HOSPITAL SERVICE CORPORATION OR HEALTH SERVICE CORPORATION WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL:

(1) LIMIT THE CO-PAYMENT AND CO-INSURANCE AMOUNTS WITH RESPECT TO ANY COVERED DRUG SO THAT IT SHALL NOT EXCEED THE COST OF THE DRUG TO THE HEALTH CONTRACT.

(2) PROVIDE AN OUT-OF-POCKET CAP ON PHARMACY BENEFITS FOR COVERED PRESCRIPTION DRUGS.

(3) LIMIT THE MAXIMUM CO-PAYMENT AND CO-INSURANCE AMOUNTS SO THEY SHALL NOT EXCEED TEN TIMES THE DOLLAR VALUE OF THE LOWEST CO-PAYMENT AND CO-INSURANCE AMOUNT WHOSE COST IS ABOVE ZERO DOLLARS.

(HH) EVERY CONTRACT ISSUED BY A HOSPITAL SERVICE CORPORATION OR HEALTH SERVICE CORPORATION WHICH PROVIDES PRESCRIPTION DRUG COVERAGE SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS:

(1) WHEN AN INSURER HAS REQUIRED THAT A MEMBER INSURED BY A HEALTH CONTRACT ISSUED UNDER THIS SECTION TAKE A GENERIC ALTERNATIVE TO A BRAND-NAME PATENTED DRUG PRESCRIBED BY THEIR DOCTOR, AND THE ALTERNATIVE IS NOT DEEMED AS HAVING AN EQUIVALENT IMPACT ON THE MEMBER BY THE MEMBER'S PRESCRIBING PHYSICIAN AND IS NOT DEEMED AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA, THE INSURER SHALL PAY FOR AND MAKE AVAILABLE THE BRAND-NAME PATENTED DRUG ORIGINALLY PRESCRIBED BY THE MEMBER'S DOCTOR.

(2) IN CASES WHERE STEP THERAPY IS REQUIRED PRIOR TO A PATIENT ACCESSING A BRAND-NAME PATENTED PRESCRIPTION DRUG, THE PATIENT CAN RECEIVE THE BRAND-NAME PATENTED PRESCRIPTION DRUG PRESCRIBED BY THEIR DOCTOR IF THE PATIENT TRIES ONE ALTERNATIVE MEDICATION AND THE PATIENT'S DOCTOR DETERMINES THAT THE SINGLE SOURCE THERAPY REMAINS MEDICALLY NECESSARY.

(3) INSURERS MUST SUBMIT THEIR PRESCRIPTION DRUG FORMULARIES TO THE DEPARTMENT AND ON AN ANNUAL BASIS, WHICH THE DEPARTMENT SHALL PUBLICLY POST ON THEIR WEBSITE TO ENABLE CONSUMERS TO COMPARE DRUG FORMULARIES DURING OPEN ENROLLMENT PERIODS. ONCE SUBMITTED, PLANS MAY NOT REMOVE OR MAKE CHANGES TO THE DRUG FORMULARY MID-YEAR EXCEPT IN INSTANCES WHERE AN A-RATED GENERICALLY AND THERAPEUTICALLY EQUIVALENT PRODUCT AS DETERMINED BY THE FDA BECOMES AVAILABLE, THE DRUG IS RECALLED BY THE FOOD AND DRUG ADMINISTRATION, OR SIGNIFICANT NEW SAFETY INFORMATION BECOMES AVAILABLE.

(4) A PATIENT RECEIVING COVERAGE FOR A DRUG ON AN INSURER'S EXISTING FORMULARY SHALL NOT BE DENIED COVERAGE UPON A CHANGE IN THE FORMULARY IF HIS OR HER PHYSICIAN DETERMINES THAT DRUG TO BE MEDICALLY NECESSARY.

S 4. This act shall take effect one year after the date on which this act shall have become a law.