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

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 ASSEMBLY, DO ENACT AS FOLLOWS:

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

(R)(1) NO INSURANCE SHALL PROVIDE INCENTIVES (MONEY OR OTHERWISE) TO A PRESCRIBING PHYSICIAN OF DRUGS THAT DISCRIMINATE ON THE BASIS OF THE DRUG PRESCRIBED.

(2) AN INSURER SHALL BE LIABLE FOR ANY INJURIES OR DAMAGE SUSTAINED BY A MEMBER INSURED BY A GROUP HEALTH POLICY ISSUED UNDER THIS SECTION AS A RESULT OF A MEMBER'S DRUG SUBSTITUTION OCCASIONED BY CHANGES TO EXISTING FORMULARY OR CO-PAYMENT OR CO-INSURANCE PAYMENT STRUCTURES.

(3) WHEN AN INSURER HAS CHANGED THE DRUG MEDICATION OF A MEMBER INSURED BY A GROUP HEALTH POLICY ISSUED UNDER THIS SECTION TO A GENERIC ALTERNATIVE WHICH ALTERNATIVE AS ATTESTED TO BY THE MEMBER'S PRESCRIBING PHYSICIAN IS NOT THE EQUIVALENT OF THE ORIGINAL PRESCRIBED DRUG THE INSURER SHALL CONTINUE TO COVER AND PAY FOR THE ORIGINAL DRUG AND MAKE SAID DRUG AVAILABLE TO THE MEMBER AS ORIGINALLY PRESCRIBED.

(S)(1) THE FOLLOWING SHALL APPLY TO DEDUCTIBLE CO-PAYMENT AND CO-INSURANCE AMOUNTS ESTABLISHED BY INSURERS OF HEALTH PLANS ISSUED UNDER THIS SECTION.

(2) THE CO-PAYMENT AND CO-INSURANCE AMOUNT WITH RESPECT TO ANY COVERED DRUG SHALL NOT EXCEED THE COST OF THE DRUG TO THE HEALTH PLAN.

(3) SHOULD A HEALTH PLAN INCLUDE AN OUT OF POCKET LIMIT ON NON-PHARMACY BENEFITS IT SHALL ALSO PROVIDE THAT OUT OF POCKET EXPENSES FOR COVERED PRESCRIPTION DRUGS SHALL BE INCLUDED AS MEDICAL BENEFIT EXPENSES 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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(4) SHOULD AN INSURER PROVIDE FOR TIERED CO-PAYMENT AND CO-INSURANCE AMOUNTS, IT SHALL ALSO PROVIDE THAT THE MAXIMUM CO-PAYMENT AND CO-INSURANCE AMOUNT SHALL NOT EXCEED THREE HUNDRED PERCENT OF THE LOWEST CO-PAYMENT AND CO-INSURANCE AMOUNT.

(T) EVERY GROUP OR BLANKET POLICY WHICH PROVIDES COVERAGE FOR PRESCRIPTION DRUGS SHALL BE SUBJECT TO THE FOLLOWING REQUIREMENTS:

(1) IF LESS EXPENSIVE DRUGS ARE REQUIRED TO BE TAKEN BY THE PATIENT INITIALLY, THE SINGLE SOURCE MEDICATION MUST BE AVAILABLE FOLLOWING COMPLIANCE WITH THE STEP THERAPY AND A DETERMINATION BY THE PATIENT'S PHYSICIAN THAT THE DRUG REMAINS MEDICALLY NECESSARY.

(2) THE INSURERS MUST SUBMIT THEIR PRESCRIPTION DRUG FORMULARIES TO THE DEPARTMENT ON AN ANNUAL BASIS AND WHENEVER THEY ARE ALTERED. THE DEPARTMENT SHALL ISSUE GUIDELINES FOR INSURERS TO FOLLOW IN MAKING DETERMINATIONS OF MEDICAL NECESSITY WITH RESPECT TO PRESCRIPTION DRUG COVERAGE.

(3) AN INSURER CAN AMEND THE FORMULARY ONCE A YEAR OR WHEN AN AMENDMENT IS TO INCLUDE A NEW DRUG OR A NEW GENERIC VERSION OF A CURRENT DRUG.

(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. This act shall take effect immediately.