STATE OF NEW YORK

5022--C

2017-2018 Regular Sessions

IN SENATE

March 6, 2017

Introduced by Sens. SERINO, ALCANTARA, AVELLA, BRESLIN, CARLUCCI, CROCI, GOLDEN, GRIFFO, HAMILTON, HANNON, HELMING, KAMINSKY, KENNEDY, KRUEGER, MARCHIONE, MURPHY, ORTT, RITCHIE, SANDERS, SAVINO, VALESKY -- 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 -- recommitted to the Committee on Insurance in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to prescription drug formulary changes during a contract year

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The insurance law is amended by adding a new section 4909 to read as follows:

§ 4909. Prescription drug formulary changes. (a) Except as otherwise provided in subsection (c) of this section, a health care plan shall not:

(i) remove a prescription drug from a formulary;

(ii) move a prescription drug to a tier with a larger deductible, copayment, or coinsurance if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier; or

(iii) add utilization management restrictions to a prescription drug on a formulary, unless such changes occur at the time of enrollment or issuance of coverage.

(b) Prohibitions provided in subsection (a) of this section shall apply beginning on the date on which open enrollment begins for a plan

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

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year and through the end of the plan year to which such open enrollment period applies.

(c) (i) A health care plan with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deductible, copayment or coinsurance if an AB-rated generic equivalent or interchangeable biological product for such prescription drug is added to the formulary at the same time.

(ii) A health care plan may remove a prescription drug from a formulary if the federal Food and Drug Administration determines that such prescription drug should be removed from the market, including new utilization management restrictions issued pursuant to federal Food and Drug Administration safety concerns.

(d) A health care plan shall provide notice to policyholders of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in the upcoming plan year, thirty days prior to the open enrollment period for the consecutive plan year. Such notice of impending formulary and deductible, copayment or coinsurance changes shall also be posted on the plan's online formulary and in any prescription drug finder system that the plan provides to the public.

§ 2. The public health law is amended by adding a new section 4909 to read as follows:

§ 4909. Prescription drug formulary changes. 1. Except as otherwise provided in subdivision three of this section, a health care plan shall not:

(a) remove a prescription drug from a formulary;

(b) move a prescription drug to a tier with a larger deductible, copayment, or coinsurance if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier; or

(c) add utilization management restrictions to a prescription drug on a formulary, unless such changes occur at the time of enrollment or issuance of coverage.

2. Prohibitions provided in subdivision one of this section shall apply beginning on the date on which open enrollment begins for a plan year and through the end of the plan year to which such open enrollment period applies.

3. (a) A health care plan with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deductible, copayment or coinsurance if an AB-rated generic equivalent or interchangeable biological product for such prescription drug is added to the formulary at the same time.

(b) A health care plan may remove a prescription drug from a formulary if the federal Food and Drug Administration determines that such prescription drug should be removed from the market, including new utilization management restrictions issued pursuant to federal Food and Drug Administration safety concerns.

4. A health care plan shall provide notice to policyholders of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in the upcoming plan year, thirty days prior to the open enrollment period for the consecutive plan year. Such notice of impending formulary and deductible, copayment or

coinsurance changes shall also be posted on the plan's online formulary and in any prescription drug finder system that the plan provides to the public.

§ 3. This act shall take effect on the sixtieth day after it shall have become a law; provided, however, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed by the superintendent of financial services on or before such date.