

STATE OF NEW YORK

6244

2019-2020 Regular Sessions

IN SENATE

May 29, 2019

Introduced by Sen. GOUNARDES -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to access to appropriate drugs at reasonable prices, formulary exceptions, standing prior authorizations and external appeals; to amend the insurance law, in relation to access to retail pharmacies, prescription synchronization, limits on patient drug costs, explanations of benefits and rebates; to amend the social services law, in relation to prescription drug synchronization; and to amend the education law, in relation to limits on copayments and drug substitutions

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 4806 to read as follows:

§ 4806. Access to appropriate drugs at reasonable prices; formulary exceptions; standing prior authorization requirement. (a) An insurer offering a prescription drug benefit with a formulary of approved or preferred drugs shall establish a procedure by which it determines whether a formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an insured. If the insurer determines that no formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an insured, the insurer shall cover the cost of an off-formulary drug for that insured, at no additional cost to the insured beyond what the insured would otherwise pay for a preferred brand name drug on the formulary. The determinations whether a drug provides appropriate therapeutic benefits and whether a non-formulary drug is necessary to meet the particular health care needs of the insured are utilization review decisions and are reviewable in accordance with article forty-nine of this chapter, including external appeal.

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

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(b) (1) For purposes of this section, "prior authorization requirement" means any practice implemented by an insurer in which coverage of a prescription drug or device is dependent upon a covered person or a health care practitioner obtaining approval from the insurer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a drug or device.

(2) An insurer which requires prior authorizations for particular prescription drugs shall have a procedure by which an insured who is being prescribed such drug for a chronic condition may obtain a standing prior authorization for a drug for the lesser of the following from the date of the approval: (i) twelve months; or (ii) the last day of the covered person's eligibility under the policy or plan.

(3) As a condition of such standing prior authorization, if according to the available medical and scientific evidence the patient's chronic condition is likely to change during the standing referral period, the insurer or health plan may require the prescribing health care practitioner to certify to the insurer, not more frequently than on a quarterly basis, that the patient's chronic condition has not changed materially with respect to the need for the prescription.

(4) A twelve-month standing prior authorization provided under paragraph two of this subsection does not apply to and is not required for any of the following:

(i) medications that have a typical course of administration of less than one year or for which available medical or scientific evidence does not support a twelve-month period of use, in which case the standing prior authorization period shall be the typical course of administration or the period of use supported by the available medical or scientific evidence;

(ii) medications that require an initial trial period to determine effectiveness and tolerability, except that after such trial period a one-year, or greater, prior authorization period will be given; and

(iii) medications that are schedule II controlled substance or a schedule III controlled substance containing hydrocodone.

(5) For drugs used to treat acute conditions, insurers shall grant standing prior authorizations for the period that the medical and scientific evidence shows to be the anticipated period for the course of treatment to have its intended effect.

(6) The standing prior authorizations provided for in this section are no longer valid and automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information finding that the drug in question is no longer approved or safe for the prescribed purpose.

(7) If an AB-rated generic drug that is therapeutically equivalent to the drug subject to a standing prior authorization becomes available, the insurer may substitute such newly released drug for the drug subject to the standing prior authorization, provided advance notice is given to the insured.

(8) The determination whether the drug is being prescribed to treat a chronic condition and the period over which the course of treatment for an acute condition is anticipated to have its intended effect are utilization review decisions and are reviewable in accordance with article forty-nine of this chapter, including external appeal.

(c) (1) If a formulary drug being prescribed for an insured is removed by the insurer from its formulary for reasons other than a determination that the approval for the use of that drug has been withdrawn by the

1 U.S. Food and Drug Administration, the insurer shall continue to cover
2 that drug for that insured for a transitional period to the end of the
3 plan year at the same copayment as charged when the drug was on formu-
4 lary. Thereafter, the insured may seek continued coverage of the drug,
5 if appropriate, pursuant to the provisions of subsection (a) of this
6 section.

7 (2) If a formulary drug being prescribed for an insured is moved by
8 the insurer to a higher cost sharing tier in its formulary for reasons
9 other than release of an AB-rated generic drug, the insurer shall
10 continue to cover that drug for that insured for a transitional period
11 to the end of the plan year at the same copayment as charged when the
12 drug was on formulary. Thereafter, the insured may seek continued cover-
13 age of the drug, if appropriate, pursuant to the provisions of
14 subsection (a) of this section.

15 (3) If an insurer that provides prescription drug coverage enrolls a
16 new insured who is currently being prescribed a drug for a chronic
17 health condition, or as part of an ongoing course of treatment for an
18 acute condition, and that drug is not on the insurer's formulary, the
19 insurer shall cover that drug for that insured at no additional cost to
20 the insured beyond what the insured would otherwise pay for a preferred
21 brand name drug on the formulary, for a transitional period of ninety
22 (90) days from the effective date of enrollment. The insured must adhere
23 to the insurer's quality assurance requirements and provide to the
24 insurer necessary medical information related to the prescription and
25 otherwise adhere to the insurer's policies and procedures including, but
26 not limited to procedures regarding obtaining pre-authorization and a
27 treatment plan approved by the insurer. In no event shall this
28 subsection be construed to require an insurer to provide coverage for
29 benefits not otherwise covered. The transitional period does not
30 preclude the insured from seeking continued coverage of the drug, if
31 appropriate, pursuant to the provisions of subsection (a) of this
32 section.

33 § 2. The public health law is amended by adding a new section 4406-h
34 to read as follows:

35 § 4406-h. Access to appropriate drugs at reasonable prices; formulary
36 exceptions; standing prior authorization requirement. 1. A health main-
37 tenance organization offering a prescription drug benefit with a formu-
38 lary of approved or preferred drugs shall have a procedure by which it
39 determines whether a formulary drug provides appropriate therapeutic
40 benefits to meet the particular health care needs of an enrollee. If the
41 health maintenance organization determines that no formulary drug
42 provides appropriate therapeutic benefits to meet the particular health
43 care needs of an enrollee, the health maintenance organization shall
44 cover the cost of an off-formulary drug for that enrollee, at no addi-
45 tional cost to the enrollee beyond what the enrollee would otherwise pay
46 for a preferred brand name drug on the formulary. The determinations
47 whether a drug provides appropriate therapeutic benefits and whether a
48 non-formulary drug is necessary to meet the particular health care needs
49 of the insured are utilization review decisions and are reviewable in
50 accordance with article forty-nine of this chapter, including external
51 appeal.

52 2. (a) For purposes of this section, "prior authorization requirement"
53 means any practice implemented by a health maintenance organization in
54 which coverage of a prescription drug or device is dependent upon a
55 covered person or a health care practitioner obtaining approval from the
56 health maintenance organization prior to the service, device, or drug

1 being performed, received, or prescribed, as applicable. "Prior authori-
2 zation" includes prospective or utilization review procedures conducted
3 prior to providing a drug or device.

4 (b) A health maintenance organization which requires prior authori-
5 zations for particular prescription drugs shall have a procedure by
6 which an enrollee who is being prescribed such drug for a chronic condi-
7 tion may obtain a standing prior authorization for a drug for the lesser
8 of the following from the date of the approval: (i) twelve months; (ii)
9 the last day of the enrollee's eligibility under the policy or plan.

10 (c) As a condition of such standing prior authorization, if according
11 to the available medical and scientific evidence the enrollee's chronic
12 condition is likely to change during the standing referral period, the
13 insurer or health plan may require the prescribing health care practi-
14 tioner to certify to the health maintenance organization, not more
15 frequently than on a quarterly basis, that the enrollee's chronic condi-
16 tion has not changed materially with respect to the need for the
17 prescription.

18 (d) A twelve-month standing prior authorization provided under subpar-
19 agraph (i) of paragraph (b) of this subdivision does not apply to and is
20 not required for any of the following:

21 (i) medications that have a typical course of administration of less
22 than one year or for which available medical or scientific evidence does
23 not support a twelve-month period of use, in which case the standing
24 prior authorization period shall be the typical course of administration
25 or the period of use supported by the available medical or scientific
26 evidence;

27 (ii) medications that require an initial trial period to determine
28 effectiveness and tolerability, except that after such trial period a
29 one-year, or greater, prior authorization period will be given; and

30 (iii) medications that are schedule II controlled substance or a sche-
31 dule III controlled substance containing hydrocodone.

32 (e) For drugs used to treat acute conditions, insurers shall grant
33 standing prior authorizations for the period that the medical and scien-
34 tific evidence shows to be the anticipated period for the course of
35 treatment to have its intended effect.

36 (f) The standing prior authorizations provided for in this section are
37 no longer valid and automatically terminate if there are changes to
38 federal or state laws or federal regulatory guidance or compliance
39 information finding that the drug in question is no longer approved or
40 safe for the prescribed purpose.

41 (g) If an AB-rated generic drug that is therapeutically equivalent to
42 the drug subject to a standing prior authorization becomes available,
43 the health maintenance organization may substitute such newly released
44 drug for the drug subject to the standing prior authorization, provided
45 advance notice is given to the enrollee.

46 (h) The determination whether the drug is being prescribed to treat a
47 chronic condition and the period over which the course of treatment for
48 an acute condition is anticipated to have its intended effect are utili-
49 zation review decisions and are reviewable in accordance with article
50 forty-nine of this chapter, including external appeal.

51 3. (a) If a formulary drug being prescribed for an enrollee is removed
52 by the health maintenance organization from its formulary for reasons
53 other than a determination that the approval for the use of that drug
54 has been withdrawn by the U.S. Food and Drug Administration, the health
55 maintenance organization shall continue to cover that drug for that
56 enrollee for a transitional period to the end of the plan year at the

1 same copayment as charged when the drug was on formulary. Thereafter,
2 the enrollee may seek continued coverage of the drug, if appropriate,
3 pursuant to the provisions of subdivision one of this section.

4 (b) If a formulary drug being prescribed for an insured is moved by
5 the health maintenance organization to a higher cost sharing tier in its
6 formulary for reasons other than release of an AB-rated generic drug,
7 the health maintenance organization shall continue to cover that drug
8 for that enrollee for a transitional period to the end of the plan year
9 at the same copayment as charged when the drug was on formulary. There-
10 after, the enrollee may seek continued coverage of the drug, if appro-
11 priate, pursuant to the provisions of subdivision one of this section.

12 (c) If a health maintenance organization that provides prescription
13 drug coverage enrolls a new enrollee who is currently being prescribed a
14 drug for a chronic health condition, or as part of an ongoing course of
15 treatment for an acute condition, and that drug is not on the health
16 maintenance organization's formulary, the health maintenance organiza-
17 tion shall cover that drug for that enrollee at no additional cost to
18 the enrollee beyond what the enrollee would otherwise pay for a
19 preferred brand name drug on the formulary, for a transitional period of
20 ninety (90) days from the effective date of enrollment. The enrollee
21 must adhere to the health maintenance organization's quality assurance
22 requirements and provide to the health maintenance organization neces-
23 sary medical information related to the prescription and otherwise
24 adhere to the health maintenance organization's policies and procedures
25 including, but not limited to procedures regarding obtaining pre-author-
26 ization and a treatment plan approved by the health maintenance organ-
27 ization. In no event shall this subdivision be construed to require a
28 health maintenance organization to provide coverage for benefits not
29 otherwise covered. The transitional period does not preclude the enrol-
30 lee from seeking continued coverage of the drug, if appropriate, pursu-
31 ant to the provisions of subdivision one of this section.

32 § 3. Section 4903 of the insurance law is amended by adding a new
33 subsection (i) to read as follows:

34 (i) (1) Each health plan shall make available to all participating
35 health care providers on its web site or provider portal a listing of
36 its prior authorization requirements, including specific information or
37 documentation that a provider must submit in order for the prior author-
38 ization request to be considered complete.

39 (2) Each health plan shall make available on its web site information
40 about the policies, contracts, or agreements offered by it that clearly
41 identifies specific services, drugs, or devices to which a prior author-
42 ization requirement exists.

43 (3) Each health plan shall give thirty (30) days advance written
44 notice to participating providers of any changes in prior authorization
45 requirements. Each health plan shall also give thirty (30) days advance
46 written notice to plan participants of any changes in prior authori-
47 zation requirements with respect to any services, drugs or devices which
48 such participant is currently being prescribed or has been prescribed in
49 the preceding year.

50 § 4. Section 4903 of the public health law is amended by adding a new
51 subdivision 9 to read as follows:

52 9. (a) Each health plan shall make available to all participating
53 health care providers on its web site or provider portal a listing of
54 its prior authorization requirements, including specific information or
55 documentation that a provider must submit in order for the prior author-
56 ization request to be considered complete.

(b) Each health plan shall make available on its web site information about the policies, contracts, or agreements offered by it that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(c) Each health plan shall give thirty (30) days advance written notice to participating providers of any changes in prior authorization requirements. Each health plan shall also give thirty (30) days advance written notice to plan participants of any changes in prior authorization requirements with respect to any services, drugs or devices which such participant is currently being prescribed or has been prescribed in the preceding year.

§ 5. Subsection (b) of section 4910 of the insurance law is amended by adding a new paragraph 5 to read as follows:

(5) (A) The insured has had a drug prescription denied on the ground that it is not on the health care plan's formulary, and that the health care plan has a covered drug on the formulary which is effective to meet the particular health care needs of an insured; and

(B) The insured's attending physician, who shall be a licensed physician or other health care provider qualified to prescribe drugs to treat the insured for the health service sought, certifies that available formulary drugs are not sufficiently effective to meet the insured's health needs, or are otherwise contraindicated for the insured, and recommends an off-formulary drug that will be effective to treat the insured.

§ 6. Subdivision 2 of section 4910 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e) (i) The enrollee has had a drug prescription denied on the ground that it is not on the health maintenance organization's formulary, and that the health maintenance organization has a covered drug on the formulary which is effective to meet the particular health care needs of an enrollee; and

(ii) The enrollee's attending physician, who shall be a licensed physician or other health care provider qualified to prescribe drugs to treat the insured for the health service sought, certifies that available formulary drugs are not sufficiently effective to meet the enrollee's health needs, or are otherwise contraindicated for the enrollee, and recommends an off-formulary drug that will be effective to treat the enrollee.

§ 7. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (E) to read as as follows:

(E) For external appeals requested pursuant to paragraph five of subsection (b) of section four thousand nine hundred ten of this title relating to an off-formulary drug denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the non-formulary drug shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(I) that the off-formulary drug prescription shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the available medical and scientific evidence, the formulary drug deemed sufficient by the health plan will not be as effective in addressing the insured's health problem for which a drug has been prescribed as the off-formulary drug prescribed by

1 the treating physician or otherwise be appropriate to meet the partic-
2 ular health care needs of the insured, which is more likely to provide a
3 beneficial clinical outcome; or

4 (II) upholding the health plan's denial of coverage.

5 § 8. Subdivision 2 of section 4914 of the public health law is amended
6 by adding a new paragraph (e) to read as follows:

7 (e) For external appeals requested pursuant to paragraph (e) of subdi-
8 vision two of section forty-nine hundred ten of this title relating to
9 an off-formulary drug denial, the external appeal agent shall review the
10 utilization review agent's final adverse determination and, in accord-
11 ance with the provisions of this title, shall make a determination as to
12 whether the non-formulary drug shall be covered by the health mainte-
13 nance organization; provided that such determination shall:

14 (i) be conducted only by one or a greater odd number of clinical peer
15 reviewers;

16 (ii) be accompanied by a written statement:

17 (1) that the off-formulary drug prescription shall be covered by the
18 health maintenance organization either when the reviewer or a majority
19 of the panel of reviewers determines, upon review of the available
20 medical and scientific evidence, the formulary drug deemed sufficient by
21 the health maintenance organization will not be as effective in address-
22 ing the enrollee's health problem for which a drug has been prescribed
23 as the off-formulary drug prescribed by the treating physician or other-
24 wise be appropriate to meet the particular health care needs of the
25 enrollee, which is more likely to provide a beneficial clinical outcome;
26 or

27 (2) upholding the health maintenance organization's denial of cover-
28 age.

29 § 9. The opening paragraph of paragraph 28 of subsection (i) of
30 section 3216 of the insurance law, as added by chapter 589 of the laws
31 of 2011, is designated subparagraph (A) and a new subparagraph (B) is
32 added to read as follows:

33 (B) Notwithstanding any other provision of this paragraph, if a pres-
34 criber, after consulting with the insurer regarding the appropriateness
35 of mail order delivery given: (i) the residence or delivery location of
36 the insured; (ii) the medical condition of the insured; (iii) the stor-
37 age requirements of the drug; (iv) the availability of the insured to
38 receive the prescription; or (v) the insured's ability to comprehend
39 pharmaceutical guidance and support over the telephone, determines that
40 a drug as prescribed on an individual basis is most appropriately filled
41 at a retail location, provided that an in-network retail pharmacy of the
42 patient's choosing agrees to the same reimbursement amount and is able
43 to fill the prescription, the prescriber's determination shall be final.

44 § 10. The opening paragraph of paragraph 18 of subsection (1) of
45 section 3221 of the insurance law is designated subparagraph (A) and a
46 new subparagraph (B) is added to read as follows:

47 (B) Notwithstanding any other provision of this paragraph, if a pres-
48 criber, after consulting with the insurer regarding the appropriateness
49 of mail order delivery given: (i) the residence or delivery location of
50 the insured; (ii) the medical condition of the insured; (iii) the stor-
51 age requirements of the drug; (iv) the availability of the insured to
52 receive the prescription; or (v) the insured's ability to comprehend
53 pharmaceutical guidance and support over the telephone, determines that
54 a drug as prescribed on an individual basis is most appropriately filled
55 at a retail location, provided that an in-network retail pharmacy of the

patient's choosing agrees to the same reimbursement amount and is able to fill the prescription, the prescriber's determination shall be final.

§ 11. The opening paragraph of subsection (kk) of section 4303 of the insurance law is designated paragraph 1 and a new paragraph 2 is added to read as follows:

(2) Notwithstanding any other provision of this subsection, if a prescriber, after consulting with the insurer regarding the appropriateness of mail order delivery given: (A) the residence or delivery location of the covered person; (B) the medical condition of the covered person; (C) the storage requirements of the drug; (D) the availability of the covered person to receive the prescription; or (E) the covered person's ability to comprehend pharmaceutical guidance and support over the telephone, determines that a drug as prescribed on an individual basis is most appropriately filled at a retail location, provided that an in-network retail pharmacy of the patient's choosing agrees to the same reimbursement amount and is able to fill the prescription, the prescriber's determination shall be final.

§ 12. The insurance law is amended by adding a new section 3224-d to read as follows:

§ 3224-d. Prescription synchronization. (a) Every individual or group health insurance policy providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily prorated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

- (1) the medications are covered by the policy or plan;
- (2) the medications are used for treatment and management of chronic conditions that are subject to refills;
- (3) the medications are not a schedule II controlled substance or a schedule III controlled substance containing hydrocodone;
- (4) the medications meet all prior authorization criteria specific to medications at the time of the synchronization request;
- (5) the medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization; and
- (6) the medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) No individual or group health insurance policy providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every individual or group health insurance policy must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this section shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(1) the prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(2) the prescriber prescribes a different drug.

§ 13. The insurance law is amended by adding a new section 4303-a to read as follows:

§ 4303-a. Prescription synchronization. (a) Every hospital service corporation and health service corporation providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily prorated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

(1) the medications are covered by the policy or plan;

(2) the medications are used for treatment and management of chronic conditions that are subject to refills;

(3) the medications are not a schedule II controlled substance or a schedule III controlled substance containing hydrocodone;

(4) the medications meet all prior authorization criteria specific to medications at the time of the synchronization request;

(5) the medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization; and

(6) the medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) No hospital service corporation or health service corporation providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every hospital service corporation or health service corporation providing prescription drug coverage must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this section shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(1) The prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(2) The prescriber prescribes a different drug.

§ 14. Subdivision 9 of section 367-a of the social services law is amended by adding a new paragraph (i) to read as follows:

(i) (i) The department of health shall establish a program for synchronization of medications when it is agreed among the recipient, a provider and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the

1 patient for the management or treatment of a chronic illness provided
2 that the medications:

3 (A) are covered by the department of health pursuant to this title;

4 (B) are used for treatment and management of chronic conditions that
5 are subject to refills;

6 (C) are not a schedule II controlled substance or a schedule III
7 controlled substance containing hydrocodone;

8 (D) meet all prior authorization criteria specific to the medications
9 at the time of the synchronization request;

10 (E) are of a formulation that can be effectively split over required
11 short fill periods to achieve synchronization; and

12 (F) do not have quantity limits or dose optimization criteria or
13 requirements that would be violated in fulfilling synchronization.

14 (ii) The department of health shall not deny coverage for the dispens-
15 ing of a medication by a network pharmacy for a partial supply when it
16 is for the purpose of synchronizing the patient's medications. When
17 applicable to permit synchronization, the department of health shall
18 allow a pharmacy to override any denial codes indicating that a
19 prescription is being refilled too soon for the purposes of medication
20 synchronization.

21 (iii) To permit synchronization, the department of health shall apply
22 a prorated daily cost-sharing rate to any medication dispensed by a
23 network pharmacy pursuant to this section.

24 (iv) The dispensing fee paid to a network pharmacy contracted to
25 provide services pursuant to this section for a partial supply associ-
26 ated with a medication synchronization shall be paid in full and shall
27 not be prorated.

28 (v) The requirements of this paragraph applies only once for each
29 prescription drug subject to medication synchronization except when
30 either of the following occurs:

31 (A) the prescriber changes the dosage or frequency of administration
32 of the prescription drug subject to a medication synchronization; or

33 (B) the prescriber prescribes a different drug.

34 (vi) Nothing in this paragraph shall be deemed to require health care
35 practitioners and pharmacists to synchronize the refilling of multiple
36 prescriptions for a recipient.

37 § 15. Subdivision 4 of section 364-j of the social services law is
38 amended by adding a new paragraph (w) to read as follows:

39 (w) (i) The department of health or a managed care organization
40 contracted to provide services pursuant to this section shall establish
41 a program for synchronization of medications when it is agreed among the
42 recipient, a provider and a pharmacist that synchronization of multiple
43 prescriptions for the treatment of a chronic illness is in the best
44 interest of the patient for the management or treatment of a chronic
45 illness provided that the medications:

46 (A) are covered by Medicaid services or a managed care organization
47 contracted to provide services pursuant to this chapter;

48 (B) are used for treatment and management of chronic conditions that
49 are subject to refills;

50 (C) are not a schedule II controlled substance or a schedule III
51 controlled substance containing hydrocodone;

52 (D) meet all prior authorization criteria specific to the medications
53 at the time of the synchronization request;

54 (E) are of a formulation that can be effectively split over required
55 short fill periods to achieve synchronization; and

1 (F) do not have quantity limits or dose optimization criteria or
2 requirements that would be violated in fulfilling synchronization.

3 (ii) The department of health or a managed care organization
4 contracted to provide services under this section shall not deny cover-
5 age for the dispensing of a medication by a network pharmacy for a
6 partial supply when it is for the purpose of synchronizing the patient's
7 medications. When applicable to permit synchronization, the department
8 of health or a managed care organization contracted to provide services
9 under this title shall allow a pharmacy to override any denial code
10 indicating that a prescription is being refilled too soon for the
11 purposes of medication synchronization.

12 (iii) To permit synchronization, the department of health or a managed
13 care organization contracted to provide services pursuant to this title
14 shall apply a prorated daily cost-sharing rate to any medication
15 dispensed by a network pharmacy pursuant to this section.

16 (iv) The dispensing fee paid to a network pharmacy contracted to
17 provide services pursuant to this section for a partial supply associ-
18 ated with a medication synchronization shall be paid in full and shall
19 not be prorated.

20 (v) The requirements of this paragraph applies only once for each
21 prescription drug subject to medication synchronization except when
22 either of the following occurs:

23 (A) the prescriber changes the dosage or frequency of administration
24 of the prescription drug subject to a medication synchronization; or

25 (B) the prescriber prescribes a different drug.

26 (vi) Nothing in this paragraph shall be deemed to require health care
27 practitioners and pharmacists to synchronize the refilling of multiple
28 prescriptions for a covered individual.

29 § 16. Subsection (h) of section 4325 of the insurance law, as added by
30 chapter 487 of the laws of 2010, is amended to read as follows:

31 (h) (i) No corporation or insurer organized or licensed under this
32 chapter which provides coverage for prescription drugs shall require, or
33 enter into a contract which permits, a copayment which exceeds the usual
34 and customary cost of such prescribed drug or which exceeds the total
35 price paid to the pharmacy for such prescribed drug after the insured
36 has met the annual deductible requirement.

37 (ii) In determining any coinsurance amount required to be paid for a
38 prescription drug, no insurer or corporation organized under this chap-
39 ter shall base its computation on a price higher than the actual price
40 paid by the pharmacy for the drug, taking into account any rebates
41 specific to the drug. The department of financial services shall issue
42 regulations setting forth the method each insurer or corporation organ-
43 ized under this chapter must use to determine the actual price paid by
44 the pharmacy.

45 (iii) Each insurer or corporation licensed under this article which
46 offers prescription drug coverage must itself or through its pharmacy
47 benefit manager issue a written explanation of benefit form to its
48 enrollees with respect to each prescription filled, containing all cate-
49 gories of information required of explanation of benefits forms for
50 medical benefits.

51 § 17. Subdivision 6 of section 6810 of the education law is amended by
52 adding a new paragraph (b-1) to read as follows:

53 (b-1) The prescriber or pharmacist shall inform the patient whether he
54 or she has prescribed or substituted a different generic drug product
55 from the generic drug product the patient has previously received.
56 Notification required pursuant to this paragraph shall be provided both

1 written and orally, contemporaneously with the filling of the
2 prescription.

3 § 18. Section 6826-a of the education law is amended by adding a new
4 subdivision 3 to read as follows:

5 3. The copayment amount shall not exceed the total price paid to the
6 pharmacy for the prescribed drug, except in cases where the insured has
7 not met the annual deductible requirement. The copayment charged to a
8 consumer for a prescription drug shall not exceed the amount which would
9 be charged if the drug were purchased without insurance coverage.

10 § 19. Paragraph 1 of subsection (e) of section 3231 of the insurance
11 law is amended by adding a new subparagraph (C) to read as follows:

12 (C) an insurer shall annually certify to the department that, during
13 the prior benefit year, the insurer made available to enrollees at the
14 point of sale at least a majority (i.e., greater than fifty percent) of
15 the rebates.

16 (i) For purposes of this subparagraph, "rebate" means:

17 (1) negotiated price concessions including but not limited to base
18 rebates and reasonable estimates of any price protection rebates and
19 performance-based rebates that may accrue directly or indirectly to the
20 issuer during the coverage year from a manufacturer, dispensing pharma-
21 cy, or other party to the transaction; and

22 (2) reasonable estimates of any fees and other administrative costs
23 that are passed through to the issuer and serve to reduce the issuer's
24 prescription drug liabilities for the coverage year.

25 (ii) In providing the certification required under this section, an
26 issuer shall not publish or otherwise reveal information regarding the
27 actual amount of rebates the issuer received on a product-, manufactur-
28 er-, or pharmacy-specific basis. Such information is protected as a
29 trade secret, is not a public record as defined in the public officers
30 law and shall not be disclosed directly or indirectly. An insurer shall
31 impose the confidentiality protections of this section on any third
32 parties or vendors with which it contracts that may receive or have
33 access to rebate information.

34 § 20. Subsection (b) of section 3221 of the insurance law is amended
35 to read as follows:

36 (b) (1) No such policy shall be delivered or issued for delivery in
37 this state unless a schedule of the premium rates pertaining to such
38 form shall have been filed with the superintendent.

39 (2) An insurer shall annually certify to the department that, during
40 the prior benefit year, the insurer made available to enrollees at the
41 point of sale at least a majority (i.e., greater than fifty percent) of
42 the rebates.

43 (A) For purposes of this paragraph, "rebate" means:

44 (i) Negotiated price concessions including but not limited to base
45 rebates and reasonable estimates of any price protection rebates and
46 performance-based rebates that may accrue directly or indirectly to the
47 issuer during the coverage year from a manufacturer, dispensing pharma-
48 cy, or other party to the transaction; and

49 (ii) Reasonable estimates of any fees and other administrative costs
50 that are passed through to the issuer and serve to reduce the issuer's
51 prescription drug liabilities for the coverage year.

52 (B) In providing the certification required under this section, an
53 issuer shall not publish or otherwise reveal information regarding the
54 actual amount of rebates the issuer received on a product-, manufactur-
55 er-, or pharmacy-specific basis. Such information is protected as a
56 trade secret, is not a public record as defined in the public officers

1 law and shall not be disclosed directly or indirectly. An insurer shall
2 impose the confidentiality protections of this section on any third
3 parties or vendors with which it contracts that may receive or have
4 access to rebate information.

5 § 21. Severability. If any item, clause, sentence, subparagraph,
6 subdivision or other part of this act, or the application thereof to any
7 person or circumstances shall be held to be invalid, such holding shall
8 not affect, impair or invalidate the remainder of this act but it shall
9 be confined in its operation to the item, clause, sentence, subpara-
10 graph, subdivision or other part of this act directly involved in such
11 holding, or to the person and circumstances therein involved.

12 § 22. This act shall take effect immediately and shall apply to insur-
13 ance policies issued, amended, or renewed on or after January 1, 2020;
14 provided, however, that the amendments to subdivision 9 of section 367-a
15 of the social services law made by section fourteen of this act shall
16 not affect the expiration of such subdivision pursuant to section 4 of
17 chapter 19 of the laws of 1998, as amended, and shall expire therewith;
18 and provided, further, that the amendments to section 364-j of the
19 social services law made by section fifteen of this act shall not affect
20 the repeal of such section and shall be deemed repealed therewith.
21 Effective immediately the addition, amendment or repeal of any rule or
22 regulation necessary for the implementation of this act on its effective
23 date are authorized to be made and completed on or before such date.