§ 3242. Prescription drug coverage. * (a) Every insurer that delivers or issues for delivery in this state a policy that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.

* NB Effective until January 1, 2027

* (a) Every insurer that delivers or issues for delivery in this state a policy that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds, prospective insureds, health care providers, and other interested parties. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments. A formulary drug list shall only be considered easily accessible if:

(1) it can be viewed on the insurer's public website without requiring an individual to create or access an account or enter a password or to be covered under an insurance policy issued by the insurer; and

(2) an individual can easily discern which formulary drug list applies to which plan, if an insurer offers more than one plan.

* NB Effective January 1, 2027

(b) (1) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, an insurer shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health

law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

(2) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on a standard exception request that is not based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than seventy-two hours following receipt of the request.

(C) An insurer that grants a standard exception request that is not based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills.

(D) For the purpose of this subsection, "exigent circumstances" means when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary prescription drug.

(3) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request an expedited review based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on an expedited review request based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than twenty-four hours following receipt of the request.

(C) An insurer that grants an exception based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

(4) An insurer that denies an exception request under paragraph two or three of this subsection shall provide written notice of its determination to the insured or the insured's designee and the insured's prescribing health care provider within three business days of receipt

of the exception request. The written notice shall be considered a final adverse determination under section four thousand nine hundred four of this chapter or section four thousand nine hundred four of the public health law. Written notice shall also include the name or names of clinically appropriate prescription drugs covered by the insurer to treat the insured.

(5) (A) If an insurer denies a request for an exception under paragraph two or three of this subsection, the insured, the insured's designee, or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal agent certified by the superintendent pursuant to section four thousand nine hundred eleven of this chapter in accordance with article forty-nine of this chapter or article forty-nine of the public health law.

(B) An external appeal agent shall make a determination on the external appeal and notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than seventy-two hours following the external appeal agent's receipt of the request, if the original request was a standard exception request under paragraph two of this subsection. The external appeal agent shall notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider in writing of the external appeal determination within two business days of rendering such determination.

(C) An external appeal agent shall make a determination on the external appeal and notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than twenty-four hours following the external appeal agent's receipt of the request, if the original request was an expedited exception request under paragraph three of this subsection and the insured's prescribing health care provider attests that exigent circumstances exist. The external appeal agent shall notify the insurer, the insured or the insured's designee, and the insured's prescribing health care provider in writing of the external appeal determination within seventy-two hours of the external appeal agent's receipt of the external appeal.

(D) An external appeal agent shall make a determination in accordance

with subparagraph (A) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter or subparagraph (A) of paragraph (d) of subdivision two of section four thousand nine hundred fourteen of the public health law. When making a determination, the external appeal agent shall consider whether the formulary prescription drug covered by the insurer will be or has been ineffective, would not be as effective as the non-formulary prescription drug, or would have adverse effects.

(E) If an external appeal agent overturns the insurer's denial of a standard exception request under paragraph two of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills. If an external appeal agent overturns the insurer's denial of an expedited exception request under paragraph three of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

* (c)(1) Except as otherwise provided in paragraph three of this subsection, an insurer 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, issuance or renewal of coverage.

(2) Prohibitions provided in paragraph one of this subsection shall apply beginning on the date on which a plan year begins and through the end of such plan year.

(3) (A) An insurer 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) An insurer 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.

(C) An insurer with a formulary that includes two or more tiers of benefits providing for different copayments applicable to prescription drugs may move a prescription drug to a tier with a larger copayment during the plan year, provided the change is not applicable to an insured who is already receiving such prescription drug or has been diagnosed with or presented with a condition on or prior to the start of the plan year that is treated by such prescription drug or is a prescription drug that is or would be part of the insured's treatment regimen for such condition.

(4) An insurer shall provide notice to insureds of the intent to remove a prescription drug from a formulary or alter deductible, copayment or coinsurance requirements in the upcoming plan year, ninety days prior to the start of the plan year. Such notice of impending formulary and deductible, copayment or coinsurance changes shall also be posted on the insurer's online formulary and in any prescription drug finder system that the insurer provides to the public.

(5) The provisions of this subsection shall not supersede the terms of a collective bargaining agreement, or the rights of labor representation groups to collectively bargain changes to the formularies.

* NB There are 2 sb (c)'s

* (c) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to immediately obtain, on the insured's behalf, an additional thirty-day supply of any current prescription of the insured, except as provided in section two hundred seventy-eight-a of the public health law, at the same level of coverage as a normal refill of such prescription drug upon the declaration of a state disaster emergency pursuant to section twenty-eight of the executive law.

* NB There are 2 sb (c)'s