House Bill 644

By: Representatives Taylor of the 79th and Brockway of the 102nd

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 20 of Title 33 of the Official Code of Georgia Annotated, relating to health care plans, so as to require issuers of health benefits plans which utilize drug formularies to make certain disclosures to enrollees; to provide for definitions; to require notice to an enrollee of a modification affecting drug coverage; to provide that certain copayment or cost-sharing amounts continue to apply for a certain duration; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 20 of Title 33 of the Official Code of Georgia Annotated, relating to health care plans, is amended by adding a new Code section to read as follows:

"33-20-35.

(a) As used in this Code section, the term:

(1) 'Commissioner' means the Commissioner of Insurance.

(2) 'Drug formulary' or 'formulary' means a list of prescription drugs:

(A) For which a health benefits plan provides coverage;

(B) For which a health benefits plan approves payment; or

(C) That a health insurance issuer encourages or offers incentives for physicians or other authorized prescribers to prescribe.

(3) 'Enrollee' shall have the same meaning as in paragraph (2) of Code Section 33-21-1.

(4) 'Health benefits plan' or 'plan' shall have the same meaning as in paragraph (4) of Code Section 33-21-1.

(5) 'Health care services' shall have the same meaning as in paragraph (5) of Code Section 33-21-1.

(6) 'Insurer' shall have the same meaning as in paragraph (7) of Code Section 33-21-1.

(7) 'Physician' shall have the same meaning as in paragraph (2) of Code Section 43-34-1.

(8) 'Prescription drug' or 'drug' shall have the same meaning as in paragraph (35) of Code Section 26-4-5.

(9) 'Prior authorization' means the requirement that the physician of an enrollee in a health benefits plan ensure that the intended use of the drug to be prescribed is covered under such enrollee's health benefits plan.

(10) 'Provider' shall have the same meaning as in paragraph (9) of Code Section 33-21-1.

(11) 'Step therapy' means the process whereby an enrollee in a health benefits plan offering prescription drugs is required to attempt utilization of less expensive drugs. Under a step therapy plan, the enrollee must show that less expensive drugs are ineffective before the provider will authorize the prescribed drug.

(b) An issuer of a health benefits plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) Provide in plain language in the coverage documentation provided to each enrollee at the time of enrollment the following:

(A) Notice that the plan uses one or more drug formularies;

(B) An explanation of a drug formulary;

(C) A statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

(D) A statement of how often the issuer reviews the contents of each drug formulary; and

(E) Notice, on a form approved by the Commissioner, that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

(2) Upon request, disclose within three business days to an individual whether a specific drug is included in a particular drug formulary;

(3) Inform an enrollee or, upon request, a prospective enrollee, that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's physician or other person authorized to prescribe prescription drugs will prescribe the drug for a particular medical condition or mental illness; and

(4) Provide notice to an enrollee of a modification affecting drug coverage not later than the ninetieth day before the date any such modification takes effect. A modification affecting drug coverage occurs upon any of the following:

(A) Removing a drug from a formulary;

(B) Adding a requirement that an enrollee receive prior authorization for a drug;

(C) Imposing or altering a quantity limit for a drug;

(D) Imposing a step therapy restriction for a drug; or

(E) Moving a drug to a higher cost-sharing tier.

A modification affecting drug coverage shall not become effective until the subsequent contract term negotiated by the insurer and enrollee.

(c) An enrollee who has been prescribed a drug as of February 15, 2013, shall continue to receive that drug for the same copayment or cost-sharing amount in effect on February 15, 2013, for the earlier of the remainder of the term of the plan, the course of drug treatment, or June 30, 2014.″

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.