The Senate Committee on Health and Human Services offered the following substitute to SB 195:

A BILL TO BE ENTITLED
AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for consumer protections and freedom of information regarding prescription drug benefits; to provide for intent and applicability; to provide for definitions; to provide for requirements; to provide for an advisory committee; to provide for related matters; to provide for a short title; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be cited as the "Prescription Drug Benefits Freedom of Information and Consumer Protection Act."

SECTION 2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

″CHAPTER 65

33-65-1.

It is the purpose and intent of this chapter and the policy of this state to promote consistency and clarity in the disclosure of prescription drug formularies in order to aid consumers in making informed choices related to their health care. Furthermore, it is the purpose of this chapter to promote efficiency and consistency in prescription drug prior authorization processes in order to facilitate consumers' reasonable access to comprehensive health care services in this state. This chapter shall be construed liberally to promote its consumer protection purposes.

33-65-2.

This chapter applies to:

(1) All licensed insurance carriers under this Title that provide accident and sickness products whether on an individual, group, or blanket basis as provided in this title;

(2) All administrators for such products as provided for in Article 2 of Chapter 23 of this title; and

(3) All pharmacy benefits managers as defined in Code Section 33-65-3.

33-65-3.

As used in this chapter the term:

(1) 'Enrollee' means a policyholder, subscriber, covered person, or other individual participating in a health benefit plan.

(2) 'Formulary' means the preferred drug list of any insurer or pharmacy benefits manager.

(3) 'Health benefit plan' means any accident and sickness policy, hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified high deductible health plan, health maintenance organization subscriber contract, health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or managed care plan. Health benefit plan does not include policies issued in accordance with Chapter 31 of this title, relating to credit life insurance and credit accident and sickness insurance, policies issued in accordance with Chapter 9 of Title 34, relating to workers' compensation, or to disability income policies.

(4) 'Insurer' means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity that provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(5) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term shall not include services provided by pharmacies operating under a hospital pharmacy license. The term shall not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. The term shall not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model

health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(6) 'Pharmacy benefits management' means the service provided to a health benefit plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:

(A) Mail order pharmacy;

(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(C) Clinical or other formulary or preferred drug list development or management;

(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(E) Patient compliance, therapeutic intervention, or generic substitution programs; and

(F) Disease management.

(7) 'Physician' means a person licensed to practice medicine pursuant to Article 2 of Chapter 34 of Title 43.

(8) 'Prescriber' means the same as defined at in Code Section 16-13-21.

(9) 'Prior authorization' means a requirement that a prescriber obtain approval from an insurer or pharmacy benefits manager to prescribe a specific medication prior to dispensing.

(10) 'Step therapy' means the process of requiring a patient to begin a prescription drug therapy with the least costly formulary drug approved for treatment of patient's medical condition before progressing to a more costly drug therapy for the same condition.

33-65-4.

(a) An insurer and a pharmacy benefits manager shall provide no later than January 1, 2020, on a public website maintained by the insurer or by the pharmacy benefits manager, formulary information as required by Code Section 33-65-5.

(b) A direct electronic link to the formulary information shall be displayed in a conspicuous manner on the website home page of insurers and pharmacy benefits managers. The formulary information and formulary disclosure requirements of Code Section 33-65-5 shall be available to the general public without requiring the use of paid software, a password, a user name, user identification, or any personally identifiable information.

(c) An insurer and a pharmacy benefits manager shall be required to update their formulary information and formulary disclosure requirements provided for in Code Section 33-65-5 within seven days of any change, alteration, modification, or amendment to its formulary.

33-65-5.

(a) The Commissioner shall by rules and regulations develop and adopt no later than January 1, 2020, requirements to promote consistency and clarity in the disclosure of formularies.

(b) The requirements adopted pursuant to subsection (a) of this Code section shall apply to each prescription drug:

(1) Included in a formulary and dispensed in a pharmacy; or

(2) Included in a formulary, covered under a health benefit plan, and typically administered by a physician or health care provider.

(c) The formulary disclosures shall:

(1) Use at least 10 point font; and

(2) Be electronically searchable by drug name.

(d) The formulary disclosures for each drug shall:

(1) Clearly differentiate between drugs covered under the health benefit plan's pharmacy benefits and medical benefits;

(2) Clearly indicate whether the drug is covered or not covered under the health benefit plan;

(3) Clearly specify the tier under which the drug falls, if such health benefit plan uses a multi-tier formulary; and

(4) Clearly disclose any prior authorization, step therapy, or other protocol requirements.

33-65-6.

(a) The Commissioner by rules and regulations shall:

(1) Prior to January 1, 2020, prescribe a single, standard form for requesting prior authorization of prescription drug benefits that shall not exceed two pages in total length;

(2) Require that the department, insurers, and pharmacy benefits managers make such form available electronically on the websites of:

(A) The department;

(B) Insurers; and

(C) Pharmacy benefits managers;

(3) Require that an insurer and a pharmacy benefits manager accept the prior authorization form for any prescription drug as required by a health benefit plan; and

(4) Require that an insurer and a pharmacy benefits manager deem a fully populated standard prescription drug prior authorization form as a complete prior authorization request, for which no additional or supplemental information is required.

(b) In prescribing a form pursuant to this Code section, the Commissioner shall:

(1) Develop the form with input from the Advisory Committee on Uniform Prior Authorization established under Code Section 33-65-7; and

(2) Take into consideration:

(A) Any form for requesting prior authorization of prescription drug benefits that is widely used in this state; and

(B) National standards, or draft standards, pertaining to electronic prior authorization of prescription drug benefits.

(c) An insurer and a pharmacy benefits manager shall exchange prior authorization requests electronically with a prescriber who has e-prescribing capability and who initiates a request electronically.

33-65-7.

(a) The Commissioner shall appoint a committee, to be known as the Advisory Committee on Uniform Prior Authorization, to advise the Commissioner on the technical, operational, and practical aspects of developing the single, standard prescription drug prior authorization form required under Code Section 33-65-6.

(b) The advisory committee shall be composed of the Commissioner, or the Commissioner's designee, and an equal number of members from each of the following groups:

(1) Physicians;

(2) Consumers experienced with prescription drug prior authorizations;

(3) Pharmacists;

(4) Independent insurance agents experienced in the sale of accident and sickness policies;

(5) Insurers; and

(6) Pharmacy benefits managers.

(c) Members of the committee shall serve without compensation.

(d) The committee shall recommend to the Commissioner a single, standard form for requesting prior authorization of prescription drug benefits.

33-65-8.

(a) Insurers and pharmacy benefits managers shall be required to communicate and acknowledge receipt of the standard prescription drug prior authorization form to the prescriber no later than two calendar days following receipt.

(b) Insurers and pharmacy benefits managers shall be required to communicate to the prescriber a status of approved, denied, or incomplete no later than four calendar days following receipt of the standard prescription drug prior authorization form.

(c) Insurers and pharmacy benefits managers shall be required to communicate to the prescriber a status of approved or denied no later than two calendar days following receipt of a completed and resubmitted standard prescription drug prior authorization form.

(d) The Commissioner shall levy a fine against all insurers or pharmacy benefits managers in an amount of not less than $1,000.00 per occurrence for failure to do any of the following:

(1) Failure to accept the standard prescription drug prior authorization form as required in paragraph (3) of subsection (a) of Code Section 33-65-6;

(2) Failure to accept a fully populated standard prescription drug prior authorization form as a complete prior authorization request as required in paragraph (4) of subsection (a) of Code Section 33-65-6; or

(3) Failure to meet requirements under subsections (a), (b), and (c) of this Code section.

(e) Each violation of subsection (d) of this Code section shall constitute a separate and distinct violation.

(f) Each violation of subsection (d) of this Code section shall constitute a tort under the laws of this state. Any individual who has been injured by an insurer's or pharmacy benefits manager's failure to comply with any portion of this chapter shall have the right to bring a private action for damages.

33-65-9.

An insurer or a pharmacy benefits manager of a health benefit plan that offers prescription drug benefits shall honor a prescription drug prior authorization form approved by the immediately preceding insurer or pharmacy benefits manager for at least the initial 60 days after a change in enrollee's health benefit plan, insurer, or pharmacy benefits manager subject to receipt of a record demonstrating approval of prior authorization from the prescriber, pharmacist, or enrollee.″

SECTION 3.

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