

Senate Bill 195

By: Senators Hufstetler of the 52nd, Burke of the 11th and Kirkpatrick of the 32nd

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

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

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

7 **SECTION 1.**

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

10 **SECTION 2.**

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

13 "CHAPTER 65

14 33-65-1.

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

22 33-65-2.

23 This chapter applies to:

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

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

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

29 33-65-3.

30 As used in this chapter the term:

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

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

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

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

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

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

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

64 (A) Mail order pharmacy;

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

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

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

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

72 (F) Disease management.

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

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

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

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

82 33-65-4.

83 (a) An insurer and a pharmacy benefits manager shall provide no later than January 1,
84 2020, on a public website maintained by the insurer or by the pharmacy benefits manager,
85 formulary information as required by Code Section 33-65-5.

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

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

95 33-65-5.

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

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

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

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

104 (c) The formulary disclosures shall:

105 (1) Use at least 10 point font; and

106 (2) Be electronically searchable by drug name.

107 (d) The formulary disclosures for each drug shall:

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

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

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

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

115 33-65-6.

116 (a) The Commissioner by rules and regulations shall:

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

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

121 (A) The department;

122 (B) Insurers; and

123 (C) Pharmacy benefits managers;

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

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

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

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

132 (2) Take into consideration:

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

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

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

140 33-65-7.

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

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

148 (1) Physicians;

149 (2) Consumers experienced with prescription drug prior authorizations;

150 (3) Pharmacists;

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

153 (5) Insurers; and

154 (6) Pharmacy benefits managers.

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

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

158 33-65-8.

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

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

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

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

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

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

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

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

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

183 33-65-9.

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

190 **SECTION 3.**

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