House Bill 875

By: Representatives Hawkins of the 27th, Cooper of the 43rd, Fludd of the 64th, Rogers of the 29th, Maxwell of the 17th, and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to require issuers of health benefit policies to provide certain information to enrollees and establish certain processes and limits relating to specialty drugs; to provide for a short title; to define terms; to provide specific requirements for issuers; 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 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, is amended by adding a new Code section to read as follows:

"33-24-59.20.

(a) This Code section shall be known and may be cited as the 'Patient Access to Specialty Tier Drugs Act.'

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

(1) 'Health benefit policy' means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization, subscriber contract or agreement, preferred provider organization, accident and sickness insurance benefit plan, or other insurance contract under any other name. The term includes any health insurance plan established under Article 1 of Chapter 18 of Title 45 or under Chapter 4 of Title 49.

(2) 'Specialty drug' means any generic or brand name drug which may be identified by an issuer of a health benefit policy as a high cost drug used to treat complex or rare medical conditions.

(c) An issuer of a health benefit policy shall:

(1) Ensure that any copayment, coinsurance, or any other form of cost sharing for a covered specialty drug for an individual prescription does not exceed $200.00 per 30 day supply; $1,000.00 per insured; and $2,000.00 per insured family per plan year;

(2) Make available standardized definitions of drug tiers; post on its website all prescription drug formularies, drug costs, prior authorization information, and other key resources in plain language for consumers, prospective consumers, advocates, and physicians; and establish a dedicated pharmacy consumer service phone line for advocates, physicians, and prospective consumers to call for any prescription specialty tier drug clarification, exception process, or prior authorization inquiries;

(3) Establish an exception approval process which would allow a physician to request a specialty drug not included on the issuer's formulary and post such process on its website so that a nonformulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the issuer's internal review process and any applicable state review process; and

(4) Ensure that prior authorization approvals for specialty drugs shall not be changed for the duration of the plan year and, effective January 1, 2017, accept any previous prior authorizations for 90 days for any person taking medication for a chronic condition after such person acquires a new health benefit policy from the issuer.″

SECTION 2.

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