

REFERENCE TITLE: prescription drugs; maximum expense limitation

State of Arizona
Senate
Fiftieth Legislature
Second Regular Session
2012

SB 1401

Introduced by
Senators Murphy: Barto, McComish

AN ACT

AMENDING SECTION 20-841.05, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-848; AMENDING SECTION 20-1057.02, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.13; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1342.07 AND 20-1342.08; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1402.05, 20-1402.06, 20-1404.05 AND 20-1404.06; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-841.05, Arizona Revised Statutes, is amended to
3 read:

4 20-841.05. Prescription drug formulary; definitions

5 A. A corporation with a prescription drug benefit that uses a drug
6 formulary as a component of the subscription contract shall provide to its
7 subscribers notice in the contract and any disclosure form regarding the
8 applicable drug formulary. The corporation shall write the notice so that
9 the language and format are easy to understand. The notice shall include an
10 explanation of what a drug formulary is, how the corporation determines which
11 prescription drugs are included or excluded and how often the corporation
12 reviews the contents of the drug formulary.

13 B. A corporation described in subsection A of this section shall:

14 1. Develop and maintain a process by which health care professionals
15 may request authorization for a medically necessary formulary or nonformulary
16 prescription drug during nonbusiness hours. If the corporation does not
17 maintain that process, the corporation shall reimburse a subscriber for the
18 subscriber's out-of-pocket expense minus any deductible or copayment for a
19 prescription drug that was purchased by the subscriber without
20 preauthorization but that was later approved by the corporation.

21 2. Develop and maintain a process by which health care professionals
22 may request authorization for medically necessary nonformulary prescription
23 drugs. The corporation shall approve an alternative prescription drug when
24 either of the following conditions is met:

25 (a) The equivalent prescription drug on the formulary has been
26 ineffective in the treatment of the subscriber's disease or condition.

27 (b) The equivalent prescription drug on the formulary has caused an
28 adverse or harmful reaction in the subscriber.

29 C. If the subscriber's pharmacy benefit plan does not require
30 authorization, subsection B, paragraph 2 of this section does not apply.

31 D. If the subscriber's treating health care professional makes a
32 determination that the subscriber meets any of the conditions described in
33 subsection B of this section, any denial to cover the nonformulary
34 prescription drug by the corporation shall be made in writing by a licensed
35 pharmacist or medical director. The written denial shall contain an
36 explanation of the denial, including the medical or pharmacological reasons
37 why the authorization was denied, and the licensed pharmacist or medical
38 director who made the denial shall sign it. The corporation shall send a
39 copy of the written denial to the subscriber's treating health care
40 professional who requested the authorization. The corporation shall maintain
41 copies of all written denials and shall make the copies available to the
42 department for inspection during regular business hours.

43 E. Any subscription contract that is issued, amended or renewed by a
44 corporation and that includes prescription drug benefits shall not limit or
45 exclude coverage for at least sixty days after the corporation's notice or

1 the pharmacy's notice pursuant to subsection F of this section to the
2 subscriber, whichever occurs first, for a prescription drug for a subscriber
3 to refill a previously prescribed drug if the prescription drug was
4 previously approved for coverage under the drug formulary or pharmacy benefit
5 plan for the subscriber's medical condition and the health care professional
6 continues to prescribe the prescription drug for the same medical condition.
7 The limitation or exclusion prohibited by this subsection applies if the
8 prescription drug is appropriately prescribed and is considered safe and
9 effective for treating the subscriber's medical condition. This subsection
10 does not prohibit the health care professional from prescribing another
11 prescription drug that is covered by the drug formulary and that is medically
12 appropriate for the subscriber, including generic drug substitutions.

13 F. A corporation shall provide written notice of the removal of any
14 prescription drug from the corporation's drug formulary to each pharmacy
15 vendor with which the corporation has a contract. On notice from the
16 corporation, the contracted pharmacy vendor at the point of dispensing a
17 prescription drug that has been removed from the drug formulary shall notify
18 the subscriber by means of a verbal consultation or other direct
19 communication with a subscriber that the subscriber may be required to
20 consult with a health care professional to obtain a new prescription for a
21 replacement drug after the sixty day period prescribed in subsection E of
22 this section. The notice prescribed in this subsection is not required if
23 the pharmacy vendor is a pharmacy that is owned by the corporation or a
24 corporate affiliate of that corporation.

25 G. A CORPORATION WITH A PRESCRIPTION DRUG BENEFIT THAT USES A
26 MULTITIERED DRUG FORMULARY AS A COMPONENT OF A SUBSCRIPTION CONTRACT SHALL
27 NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A HIGHER
28 COST TIER OF THE FORMULARY DURING THE TERM OF THE SUBSCRIPTION CONTRACT. IF
29 A CORPORATION PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION
30 DRUG TO A LOWER OR HIGHER COST TIER OF THE FORMULARY IN A SUBSEQUENT TERM OF
31 THE SUBSCRIPTION CONTRACT, THE CORPORATION SHALL GIVE THE SUBSCRIBER SIXTY
32 DAYS' NOTICE REGARDING THE IMPENDING CHANGE AND PUBLISH THE IMPENDING CHANGE
33 ON THE CORPORATION'S WEBSITE IN A MANNER THAT IS ACCESSIBLE TO AND SEARCHABLE
34 BY SUBSCRIBERS AND PROVIDERS.

35 H. IF A SUBSCRIPTION CONTRACT FOR HOSPITAL AND MEDICAL COVERAGE
36 INCLUDES A PRESCRIPTION DRUG BENEFIT THAT REQUIRES DEDUCTIBLES, COPAYMENTS,
37 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES TO BE PAID BY A SUBSCRIBER, THE
38 CUMULATIVE COSTS PAID BY A SUBSCRIBER FOR DEDUCTIBLES, COPAYMENTS,
39 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS DURING THE
40 TERM OF THE SUBSCRIPTION CONTRACT SHALL BE APPLIED TOWARD ANY ANNUAL
41 OUT-OF-POCKET MAXIMUM AMOUNT CONTAINED IN THE SUBSCRIPTION CONTRACT.

42 ~~G.~~ I. This section does not:

43 1. Prohibit a corporation from applying deductibles, coinsurance or
44 other cost containment or quality assurance measures.

1 2. Apply to a corporation that provides a multitiered benefit plan
2 that allows access to prescription drugs without authorization by the
3 corporation.

4 3. Apply to any corporation that holds a certificate of authority to
5 operate either as a dental service corporation or an optometric service
6 corporation.

7 ~~H.~~ J. For the purposes of this section:

8 1. "Health care Professional" means a person who has an active
9 nonrestricted license pursuant to title 32 and WHO is authorized to write
10 drug prescriptions to treat medical conditions.

11 2. "Prescription drug" means any prescription medication as defined in
12 section 32-1901 that is prescribed by a health care professional to a
13 subscriber to treat the subscriber's condition.

14 Sec. 2. Title 20, chapter 4, article 3, Arizona Revised Statutes, is
15 amended by adding section 20-848, to read:

16 20-848. Out-of-pocket expenses; limitation

17 NOTWITHSTANDING ANY OTHER LAW, THE MAXIMUM AMOUNT OF ANNUAL
18 OUT-OF-POCKET EXPENSES THAT MAY BE CHARGED BY A CORPORATION TO A SUBSCRIBER
19 DURING THE TERM OF A SUBSCRIPTION CONTRACT MAY NOT EXCEED _____.

20 Sec. 3. Section 20-1057.02, Arizona Revised Statutes, is amended to
21 read:

22 20-1057.02. Prescription drug formulary; definitions

23 A. A health care services organization with a prescription drug
24 benefit that uses a drug formulary as a component of the evidence of coverage
25 shall provide to its enrollees notice in the evidence of coverage and the
26 disclosure form prescribed in section 20-1076 regarding the applicable drug
27 formulary. The health care services organization shall write the notice so
28 that the language and format are easy to understand. The notice shall
29 include an explanation of what a drug formulary is, how the health care
30 services organization determines which prescription drugs are included or
31 excluded and how often the health care services organization reviews the
32 contents of the drug formulary.

33 B. A health care services organization described in subsection A of
34 this section shall:

35 1. Develop and maintain a process by which health care professionals
36 may request authorization for a medically necessary formulary or nonformulary
37 prescription drug during nonbusiness hours. If the health care services
38 organization does not maintain that process, the health care services
39 organization shall reimburse an enrollee for the enrollee's out-of-pocket
40 expense minus any deductible or copayment for a prescription drug that was
41 purchased by the enrollee without preauthorization but that was later
42 approved by the health care services organization.

43 2. Develop and maintain a process by which health care professionals
44 may request authorization for medically necessary nonformulary prescription

1 drugs. The health care services organization shall approve an alternative
2 prescription drug when either of the following conditions is met:

3 (a) The equivalent prescription drug on the formulary has been
4 ineffective in the treatment of the enrollee's disease or condition.

5 (b) The equivalent prescription drug on the formulary has caused an
6 adverse or harmful reaction in the enrollee.

7 C. If the health care services organization's pharmacy benefit plan
8 does not require authorization, subsection B, paragraph 2 of this section
9 does not apply.

10 D. If the enrollee's treating health care professional makes a
11 determination that the enrollee meets any of the conditions described in
12 subsection B of this section, any denial to cover the nonformulary
13 prescription drug by the health care services organization shall be made in
14 writing by a licensed pharmacist or medical director. The written denial
15 shall contain an explanation of the denial, including the medical or
16 pharmacological reasons why the authorization was denied, and the licensed
17 pharmacist or medical director who made the denial shall sign it. The health
18 care services organization shall send a copy of the written denial to the
19 enrollee's treating health care professional who requested the authorization.
20 The health care services organization shall maintain copies of all written
21 denials and shall make the copies available to the department for inspection
22 during regular business hours.

23 E. Any evidence of coverage that is issued, amended or renewed by a
24 health care services organization and that includes prescription drug
25 benefits shall not limit or exclude coverage for at least sixty days after
26 the health care services organization's notice or the pharmacy's notice
27 pursuant to subsection F of this section to the enrollee, whichever occurs
28 first, for a prescription drug for an enrollee to refill a previously
29 prescribed drug if the prescription drug was previously approved for coverage
30 under the drug formulary or pharmacy benefit plan for the enrollee's medical
31 condition and the health care professional continues to prescribe the
32 prescription drug for the same medical condition. The limitation or
33 exclusion prohibited by this subsection applies if the prescription drug is
34 appropriately prescribed and is considered safe and effective for treating
35 the enrollee's medical condition. This subsection does not prohibit the
36 health care professional from prescribing another prescription drug that is
37 covered by the drug formulary and that is medically appropriate for the
38 enrollee, including generic drug substitutions.

39 F. A health care services organization shall provide written notice of
40 the removal of any prescription drug from the health care services
41 organization's drug formulary to each pharmacy vendor with which the health
42 care services organization has a contract. On notice from the health care
43 services organization, the contracted pharmacy vendor at the point of
44 dispensing a prescription drug that has been removed from the drug formulary
45 shall notify the enrollee by means of a verbal consultation or other direct

1 communication with an enrollee that the enrollee may be required to consult
2 with a health care professional to obtain a new prescription for a
3 replacement drug after the sixty day period prescribed in subsection E of
4 this section. The notice prescribed in this subsection is not required if
5 the pharmacy vendor is a pharmacy that is owned by a health care services
6 organization or a corporate affiliate of that health care services
7 organization.

8 G. A HEALTH CARE SERVICES ORGANIZATION WITH A PRESCRIPTION DRUG
9 BENEFIT THAT USES A MULTITIERED DRUG FORMULARY AS A COMPONENT OF AN EVIDENCE
10 OF COVERAGE SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION
11 DRUG TO A HIGHER COST TIER OF THE FORMULARY DURING THE TERM OF THE EVIDENCE
12 OF COVERAGE. IF A HEALTH CARE SERVICES ORGANIZATION PLANS TO RECLASSIFY
13 BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A LOWER OR HIGHER COST
14 TIER OF THE FORMULARY IN A SUBSEQUENT TERM OF THE EVIDENCE OF COVERAGE, THE
15 HEALTH CARE SERVICES ORGANIZATION SHALL GIVE THE ENROLLEE SIXTY DAYS' NOTICE
16 REGARDING THE IMPENDING CHANGE AND PUBLISH THE IMPENDING CHANGE ON THE HEALTH
17 CARE SERVICES ORGANIZATION'S WEBSITE IN A MANNER THAT IS ACCESSIBLE TO AND
18 SEARCHABLE BY ENROLLEES AND PROVIDERS.

19 H. IF AN EVIDENCE OF COVERAGE FOR HOSPITAL AND MEDICAL COVERAGE
20 INCLUDES A PRESCRIPTION DRUG BENEFIT THAT REQUIRES DEDUCTIBLES, COPAYMENTS,
21 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES TO BE PAID BY AN ENROLLEE, THE
22 CUMULATIVE COSTS PAID BY AN ENROLLEE FOR DEDUCTIBLES, COPAYMENTS, COINSURANCE
23 OR OTHER OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS DURING THE TERM OF THE
24 EVIDENCE OF COVERAGE SHALL BE APPLIED TOWARD ANY ANNUAL OUT-OF-POCKET MAXIMUM
25 AMOUNT CONTAINED IN THE EVIDENCE OF COVERAGE.

26 ~~G.~~ I. This section does not:

27 1. Prohibit a health care services organization from applying
28 deductibles, coinsurance or other cost containment or quality assurance
29 measures.

30 2. Apply to a health care services organization that provides a
31 multitiered benefit plan that allows access to prescription drugs without
32 authorization by the health care services organization.

33 ~~H.~~ J. For the purposes of this section:

34 1. "Health care professional" means a person who has an active
35 nonrestricted license pursuant to title 32 and WHO is authorized to write
36 drug prescriptions to treat medical conditions.

37 2. "Prescription drug" means any prescription medication as defined in
38 section 32-1901 that is prescribed by a health care professional to an
39 enrollee to treat the enrollee's condition.

40 Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
41 amended by adding section 20-1057.13, to read:

42 20-1057.13. Out-of-pocket expenses; limitation

43 NOTWITHSTANDING ANY OTHER LAW, THE MAXIMUM AMOUNT OF ANNUAL
44 OUT-OF-POCKET EXPENSES THAT MAY BE CHARGED BY A HEALTH CARE SERVICES

1 ORGANIZATION TO AN ENROLLEE DURING THE TERM OF AN EVIDENCE OF COVERAGE MAY
2 NOT EXCEED _____.

3 Sec. 5. Title 20, chapter 6, article 4, Arizona Revised Statutes, is
4 amended by adding sections 20-1342.07 and 20-1342.08, to read:

5 20-1342.07. Prescription medications; formularies; notice;
6 out-of-pocket expenses

7 A. A DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT USES A
8 MULTITIERED DRUG FORMULARY AS A COMPONENT OF A DISABILITY INSURANCE POLICY
9 SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A
10 HIGHER COST TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A
11 DISABILITY INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED
12 PRESCRIPTION DRUG TO A LOWER OR HIGHER COST TIER OF THE FORMULARY IN A
13 SUBSEQUENT TERM OF THE DISABILITY INSURANCE POLICY, THE DISABILITY INSURER
14 SHALL GIVE THE INSURED SIXTY DAYS' NOTICE REGARDING THE IMPENDING CHANGE AND
15 PUBLISH THE IMPENDING CHANGE ON THE DISABILITY INSURER'S WEBSITE IN A MANNER
16 THAT IS ACCESSIBLE TO AND SEARCHABLE BY INSUREDS AND PROVIDERS.

17 B. IF A DISABILITY INSURANCE POLICY FOR HOSPITAL AND MEDICAL COVERAGE
18 INCLUDES A PRESCRIPTION DRUG BENEFIT THAT REQUIRES DEDUCTIBLES, COPAYMENTS,
19 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES TO BE PAID BY AN INSURED, THE
20 CUMULATIVE COSTS PAID BY AN INSURED FOR DEDUCTIBLES, COPAYMENTS, COINSURANCE
21 OR OTHER OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS DURING THE TERM OF THE
22 DISABILITY INSURANCE POLICY SHALL BE APPLIED TOWARD ANY ANNUAL OUT-OF-POCKET
23 MAXIMUM AMOUNT CONTAINED IN THE DISABILITY INSURANCE POLICY.

24 20-1342.08. Out-of-pocket expenses; limitation

25 NOTWITHSTANDING ANY OTHER LAW, THE MAXIMUM AMOUNT OF ANNUAL
26 OUT-OF-POCKET EXPENSES THAT MAY BE CHARGED BY A DISABILITY INSURER TO AN
27 INSURED DURING THE TERM OF A DISABILITY INSURANCE POLICY MAY NOT EXCEED
28 _____.

29 Sec. 6. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
30 amended by adding sections 20-1402.05, 20-1402.06, 20-1404.05 and 20-1404.06,
31 to read:

32 20-1402.05. Prescription medications; formularies; notice;
33 out-of-pocket expenses

34 A. A GROUP DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT
35 USES A MULTITIERED DRUG FORMULARY AS A COMPONENT OF A GROUP DISABILITY POLICY
36 SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A
37 HIGHER COST TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A GROUP
38 DISABILITY INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED
39 PRESCRIPTION DRUG TO A LOWER OR HIGHER COST TIER OF THE FORMULARY IN A
40 SUBSEQUENT TERM OF THE GROUP DISABILITY POLICY, THE DISABILITY INSURER SHALL
41 GIVE THE INSURED SIXTY DAYS' NOTICE REGARDING THE IMPENDING CHANGE AND
42 PUBLISH THE IMPENDING CHANGE ON THE DISABILITY INSURER'S WEBSITE IN A MANNER
43 THAT IS ACCESSIBLE TO AND SEARCHABLE BY INSUREDS AND PROVIDERS.

1 B. IF A GROUP DISABILITY POLICY FOR HOSPITAL AND MEDICAL COVERAGE
2 INCLUDES A PRESCRIPTION DRUG BENEFIT THAT REQUIRES DEDUCTIBLES, COPAYMENTS,
3 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES TO BE PAID BY AN INSURED, THE
4 CUMULATIVE COSTS PAID BY AN INSURED FOR DEDUCTIBLES, COPAYMENTS, COINSURANCE
5 OR OTHER OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS DURING THE TERM OF THE
6 GROUP DISABILITY POLICY SHALL BE APPLIED TOWARD ANY ANNUAL OUT-OF-POCKET
7 MAXIMUM AMOUNT CONTAINED IN THE GROUP DISABILITY POLICY.

8 20-1402.06. Out-of-pocket expenses; limitation

9 NOTWITHSTANDING ANY OTHER LAW, THE MAXIMUM AMOUNT OF ANNUAL
10 OUT-OF-POCKET EXPENSES THAT MAY BE CHARGED BY A GROUP DISABILITY INSURER TO
11 AN INSURED DURING THE TERM OF A GROUP DISABILITY POLICY MAY NOT EXCEED
12 _____.

13 20-1404.05. Prescription medications; formularies; notice;
14 out-of-pocket expenses

15 A. A BLANKET DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT
16 USES A MULTITIERED DRUG FORMULARY AS A COMPONENT OF A BLANKET DISABILITY
17 POLICY SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG
18 TO A HIGHER COST TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A
19 BLANKET DISABILITY INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED
20 PRESCRIPTION DRUG TO A LOWER OR HIGHER COST TIER OF THE FORMULARY IN A
21 SUBSEQUENT TERM OF THE BLANKET DISABILITY POLICY, THE BLANKET DISABILITY
22 INSURER SHALL GIVE THE INSURED SIXTY DAYS' NOTICE REGARDING THE IMPENDING
23 CHANGE AND PUBLISH THE IMPENDING CHANGE ON THE BLANKET DISABILITY INSURER'S
24 WEBSITE IN A MANNER THAT IS ACCESSIBLE TO AND SEARCHABLE BY INSUREDS AND
25 PROVIDERS.

26 B. IF A BLANKET DISABILITY POLICY FOR HOSPITAL AND MEDICAL COVERAGE
27 INCLUDES A PRESCRIPTION DRUG BENEFIT THAT REQUIRES DEDUCTIBLES, COPAYMENTS,
28 COINSURANCE OR OTHER OUT-OF-POCKET EXPENSES TO BE PAID BY AN INSURED, THE
29 CUMULATIVE COSTS PAID BY AN INSURED FOR DEDUCTIBLES, COPAYMENTS, COINSURANCE
30 OR OTHER OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS DURING THE TERM OF THE
31 BLANKET DISABILITY POLICY SHALL BE APPLIED TOWARD ANY ANNUAL OUT-OF-POCKET
32 MAXIMUM AMOUNT CONTAINED IN THE BLANKET DISABILITY POLICY.

33 20-1404.06. Out-of-pocket expenses; limitation

34 NOTWITHSTANDING ANY OTHER LAW, THE MAXIMUM AMOUNT OF ANNUAL
35 OUT-OF-POCKET EXPENSES THAT MAY BE CHARGED BY A BLANKET DISABILITY INSURER TO
36 AN INSURED DURING THE TERM OF A BLANKET DISABILITY POLICY MAY NOT EXCEED
37 _____.