ARIZONA HOUSE OF REPRESENTATIVES

Fifty-sixth Legislature
Second Regular Session

Senate: FICO DPA 7-0-0-0 | APPROP DPA S/E 7-2-0-0 | 3rd Read 27-1-2-0
House: RA DPA 7-0-0-0

SB 1164: pharmacy benefits; coverage
Sponsor: Senator Shamp, LD 29
Committee on Appropriations

Overview

Effective December 31, 2024, outlines the prohibitions, limitations and permissive actions for a health care provider (provider), health care insurer (insurer), Pharmacy Benefits Manager (PBM) and the covered individual. Establishes a process to review and determine a prescription drug coverage exemption.

History

Statute outlines the procedures for in-person and desktop audits performed by an auditing entity working on behalf of an insurer or PBM for the purposes of auditing drug claims adjudicated by pharmacies. The auditing entity must deliver a preliminary audit report to the pharmacy within 60 days after the conclusion of the audit. A pharmacy is allowed at least 30 days after receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. Unless otherwise required by state or federal law, audit information may not be shared with any entity other than the insurer on whose behalf the audit was conducted (A.R.S. §§ 20-3322, 20-3323).

The Department of Insurance and Financial Institutions (DIFI) regulates and monitors insurance companies and professionals operating in Arizona to protect the public and help ensure that these entities follow state and federal laws (Ariz. Const., Art. 15 § 5). Beginning January 1, 2025, PBMs must apply and pay a fee to DIFI for a valid certificate of authority to operate as a PBM who performs services for a health plan subject to state jurisdiction (A.R.S. § 20-3333). A PBM is a person, business or entity that manages the prescription drug coverage provided by a contracted insurer or other third-party payor. Responsibilities include the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals related to prescription drug coverage, contracting with network pharmacies and controlling the cost of covered prescription drugs (A.R.S. § 20-3321).

Provisions

1. States that if a PBM enters into an agreement with a health care insurer (insurer) to provide pharmacy benefit management services (services), the PBM:
   a) cannot limit or exclude prescription drug coverage for a covered individual who takes a specific prescription drug that was previously approved by the PBM or insurer and the covered individual continues to be enrolled by the insurer; and
   b) requires coverage of the specific prescription drug through the last day of the covered individual's plan year. (Sec. 1)

☐ Prop 105 (45 votes) ☐ Prop 108 (40 votes) ☐ Emergency (40 votes) ☐ Fiscal Note

2. Stipulates that a PBM or insurer cannot:
   a) limit or reduce the maximum coverage of prescription drug benefits;
   b) increase cost sharing for a covered prescription drug;
   c) move a prescription drug to a more restrictive formulary tier; or
   d) remove a prescription drug from a formulary, except as noted. (Sec. 1)
3. Requires the PBM or insurer to give written notice of a formulary change for the prescription drug on the drug formulary to each impacted individual and health care provider (provider) at least 60 days before the change during the plan year. (Sec. 1)
4. Permits the PBM or insurer to only change a covered individual from the previously prescribed drug if the covered individual's provider gives written authorization to the PBM or insurer for the change in the prescription drug. (Sec. 1)
5. Requires a PBM or insurer provide written notice of the removal from, or an increase in cost sharing for any prescription drug on the drug formulary to each impacted covered individual and the prescribing provider at least 60 days before the plan year ends if the covered individual's prescribing provider did not previously approve a change. (Sec. 1)
6. States that the notice sets the process for the covered individual's provider to request a prescription drug coverage exemption for the continued use of the nonformulary prescription drug as outlined. (Sec. 1)
7. Creates a prescription drug coverage exemption determination process to ensure continuity of care after a covered individual's renewal as follows:
   a) an insurer, PBM or utilization review agent (agent) that is contracted for services for the insurer must provide a covered individual and prescribing provider with access to a clear and convenient process to request a coverage exemption;
   b) an insurer, PBM or agent may use their existing medical exceptions process to satisfy the stated requirements;
   c) an insurer, PBM or agent must respond to a coverage exemption determination request within the timelines detailed in federal law;
   d) an insurer, PBM or agent must approve an exemption for a covered individual who was previously approved to receive the nonformulary prescription drug by the covered individual's current Insurer or PBM and the provider continues to prescribe the medication for the medical condition;
   e) a denial must be in writing and state the reasons for the denial, signed by either the licensed pharmacist or medical director as outlined in the bill;
   f) notice of a denial must be sent to the covered individual's provider that made the request and maintain copies for inspection during regular business hours;
   g) the covered individual or the person's representative may appeal a denial determination and the process must be included in the notification; and
   h) an approved authorization for a coverage exemption must be in writing, delivered to the covered person and the provider and valid until the end of the covered person's plan year. (Sec. 1)
8. States the provider is not prevented from prescribing another prescription drug as outlined. (Sec. 1)
9. Stipulates the insurer or PBM may contract to provide services. (Sec. 1)
10. Authorizes the director to assess a civil penalty for violations against the insurer, PBM or agent as outlined. (Sec. 1)

11. States that a policy that is issued or renewed by a disability insurer does not include a policy that provides limited benefit coverage. (Sec. 1)

12. Defines pertinent terms. (Sec. 1)

13. Applies these requirements and prohibitions to contracts entered into, amended, extended or renewed on December 31, 2024. (Sec. 2)