ENGROSSED HOUSE
BILL NO. 1672 By: Blackwell of the House

and

Holt of the Senate

[ insurance - Continuity of Care Act of 2013 - prescription medication notice requirements - codification - effective date ]

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 8 of this act shall be known and may be cited as the "Continuity of Care Act of 2013".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Continuity of Care Act of 2013:

1. "Drug formulary" means a list of drugs:

a. for which a health benefit plan provides coverage,

b. for which a health benefit plan issuer approves payment, or

c. that a health benefit plan issuer encourages or offers incentives for physicians to prescribe;

2. "Enrollee" means an individual who is covered under a group health benefit plan, including a covered dependent;

3. "Physician" means a person licensed as a physician by the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners; and

4. "Prescription drug" means:

a. a substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public,

b. a drug or device that under federal law is required, before being dispensed or delivered, to be labeled with the statement:

(1) "Caution: federal law prohibits dispensing without prescription" or "Rx only" or another legend that complies with federal law, or

(2) "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian", or

c. a drug or device that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a practitioner only.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.3 of Title 36 unless there is created a duplication in numbering, reads as follows:

The Continuity of Care Act of 2013 applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

1. An insurance company;
2. A group hospital service corporation;
3. A fraternal benefit society;
4. A stipulated premium company;
5. A reciprocal exchange;
6. A health maintenance organization;
7. A multiple employer welfare arrangement; or
8. An approved nonprofit health corporation.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Continuity of Care Act of 2013 shall not apply to:

1. A health benefit plan that provides coverage:

a. only for a specified disease or for another single benefit,

b. only for accidental death or dismemberment,

c. for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury,

d. as a supplement to a liability insurance policy,

e. for credit insurance,

f. only for dental or vision care,

g. only for hospital expenses, or

h. only for indemnity for hospital confinement;

2. A Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act, 42 U.S.C., Section 1395ss, as amended;

3. A workers' compensation insurance policy;

4. Medical payment insurance coverage provided under a motor vehicle insurance policy;

5. A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the Insurance Commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan; or

6. A Medicaid managed care program.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

An issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

1. Provide in plain language in the coverage documentation provided to each enrollee:

a. notice that the plan uses one or more drug formularies,

b. an explanation of what a drug formulary is,

c. a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary,

d. a statement of how often the issuer reviews the contents of each drug formulary, and

e. notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

2. Disclose to an individual on request, not later than three (3) business days after the date of the request, whether a specific drug is included in a particular drug formulary; and

3. Notify an enrollee and any other individual who requests information under this section that the inclusion of a drug in a

drug formulary does not guarantee that the health care provider of an enrollee will prescribe that drug for a particular medical condition or mental illness.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan issuer may modify drug coverage provided under a health benefit plan if:

1. The modification occurs at the time of coverage renewal;

2. The modification is effective uniformly among all group health benefit plan sponsors covered by identical or substantially identical health benefit plans or all individuals covered by identical or substantially identical individual health benefit plans, as applicable; and

3. No later than sixty (60) days before the date the modification is effective, the issuer provides written notice of the modification to the Insurance Commissioner, each affected group health benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each affected individual health benefit plan holder.

B. Modifications affecting drug coverage that require notice under subsection A of this section include:

1. Removing a drug from a formulary;

2. Adding a requirement that an enrollee receive prior authorization for a drug;

3. Imposing or altering a quantity limit for a drug;

4. Imposing a step-therapy restriction for a drug; and

5. Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available.

C. A health benefit plan issuer may elect to offer an enrollee in the plan the option of receiving notifications required by this section by e-mail.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

B. This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under subsection A of this section if the alternative drug is:

1. Covered under the health benefit plan; and

2. Medically appropriate for the enrollee.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6850.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination as defined in the Uniform Health Carrier External Review Act if:

1. The drug is not included in a drug formulary used by the health benefit plan; and

2. The enrollee's physician has determined that the drug is medically necessary.

B. The enrollee may appeal the adverse determination pursuant to the requirements of the Uniform Health Carrier External Review Act.

SECTION 9. This act shall become effective November 1, 2013.

Passed the House of Representatives the 13th day of March, 2013.

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Presiding Officer of the House
of Representatives

Passed the Senate the ___ day of _____, 2013.

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Presiding Officer of the Senate