AIMED ALLIANCE
Alliance for the Adoption of Innovations in Medicine

MODEL NONMEDICAL SWITCHING LEGISLATION

(A) Short Title. This Act shall be known and may be cited as the "Preserving Patient Stability Act of 2017."

(B) Purpose. The purpose of this Act is to ensure that covered persons who are stable on their prescription drug regimens, as determined by the prescribing provider, have continuous care and that third-party payers cannot make restrictive changes to their formularies after a plan year has begun or has been renewed, resulting in increased cost-sharing or loss of access to a medication—a practice referred to as "nonmedical switching."

(C) Definitions.

(1) "Commissioner" shall mean the Commissioner of the Department of Insurance.

(2) "Cost-sharing" shall mean any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(3) "Coverage Exemption Determination" shall mean a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(4) "Covered person" shall mean a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(5) "Formulary" shall mean a complete list of drugs eligible for coverage under a health insurance plan.

(6) "Health care provider" shall mean a physician or other health care practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with his or her scope of practice under state law.

(7) "Health insurance plan" shall mean a policy, contract, certificate, or agreement entered into, offered, or issued by a third-party payer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(8) "Renewal period" shall mean the term in which a covered person has been continuously enrolled in a health insurance plan after the termination date of a prior year in which the covered person was enrolled.

(9) "Third-party payer" shall mean a health insurer; third-party administrator; carrier; plan sponsor; prescription drug benefit manager; nonprofit hospital service corporation; medical service corporation; prepaid limited health service

organization; health maintenance organization; preferred provider organization; provider-sponsored network; state government payer, including, but not limited to, Medicaid and the public employees insurance agency; or any other party that administers a fully-insured plan and is contractually obligated to provide coverage or a health insurance plan to pay for covered health care services or prescription drug benefits rendered to covered persons.

(D) Nonmedical switching. For each third-party payer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Third-party payers shall not limit or exclude coverage of a drug, for any covered person who is medically stable on such drug as determined by the prescribing provider, if

(a) The drug previously had been approved for coverage by the third-party payer for the covered person;

(b) The covered person's prescribing provider continues to prescribe the drug for the medical condition; and

(c) The covered person continues to be an enrollee of the health insurance plan.

(2) Coverage of covered person's medication, as described in paragraph (D), subparagraph (1), shall continue through the last day of the covered person's eligibility under the health insurance plan, inclusive of any renewal period.

(3) Prohibited limitations and exclusions referred to in paragraph (D), subparagraph (1) include, but are not limited to:

(a) Limiting or reducing the maximum coverage of prescription drug benefits;

(b) Increasing out-of-pocket costs for a covered drug;

(c) Moving a prescription drug to a more restrictive tier, if the third-party payer uses a formulary with tiers; or

(d) Removing a prescription drug from a formulary.

(4) This Act does not preclude the prescribing provider from prescribing another drug covered by the third-party payer that the prescribing provider deems medically necessary for the covered person.

(5) This Act does not prohibit a third-party payer from:

(a) Adding a drug to its formulary; or

(b) Removing a drug from its formulary if the drug's manufacturer has removed the drug for sale in the United States.

(E) Exemption Process.

(1) To ensure continuity of care, the third-party payer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a Coverage Exemption Determination.

(2) A Coverage Exemption Determination shall expeditiously grant the exemption determination request if the third-party payer discontinues the covered person's previous health care plan ("Discontinued Health Insurance Plan") during open enrollment, the covered person enrolls in a comparable plan offered by the same third-party payer, and the following conditions are met:

(a) The covered person is medically stable on a drug as determined by the prescribing provider; and

(b) The prescribing provider continues to prescribe the drug to the covered person for the medical condition; and

(c) In comparison to the Discontinued Health Insurance Plan, the new health insurance plan:

(i) Limits or reduces the maximum coverage of prescription drug benefits;

(ii) Increases out-of-pocket costs for the drug;

(iii) Moves the drug to a more restrictive tier, if the third-party payer uses a formulary with tiers; or

(iv) Excludes the drug from a formulary.

(3) Upon the granting of a Coverage Exemption Determination request, the third-party payer shall authorize coverage no more restrictive than that offered in the Discontinued Health Insurance Plan for the drug prescribed by the covered person's prescribing provider.

(4) The third-party payer shall respond to a Coverage Exemption Determination request or an appeal within seventy-two hours of receipt. In cases where exigent circumstances exist, a third-party payer shall respond within twenty-four hours of receipt. Should a response by a third-party payer not be received within this time allotted, the appeal shall be deemed granted.

(F) Enforcement. If the Commissioner suspects that a third-party payer has violated any section of this Act, the Commissioner may take any enforcement action under his or her authority that is necessary to obtain compliance with this Act, including conducting a hearing and imposing a penalty.