WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Committee Substitute

for

Senate Bill 762

SENATORS MARONEY, TAKUBO, LINDSAY, BALDWIN,

STOLLINGS, WOELFEL, AND RUCKER, *original sponsors*

[Originating in the Committee on Health and Human

Resources; reported on February 24, 2020]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §5-16-7g; to amend said code by adding thereto a new section, designated §33-15-4u; to amend said code by adding thereto a new section, designated §33-16-3ff; to amend said code by adding thereto a new section, designated §33-24-7u; to amend said code by adding thereto a new section, designated §33-25-8r; and to amend said code by adding thereto a new section, designated §33-25A-8u, all relating to creating the Preserving Patient Stability Act of 2020; setting forth definitions; prohibiting nonmedical switching of biological products; recognizing exemptions; providing effective date; and providing for enforcement.

Be it enacted by the Legislature of West Virginia:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7g. Definitions.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicates otherwise:

(1) "Agency" means the Public Employees Insurance Agency created by this article.

(2) "Director" means the Director of the Public Employees Insurance Agency created by this article.

(3) "Biological product" means the same as the term is defined in 42 U.S.C. § 262.

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

(5) “Coverage exemption determination” means a determination made by the agency to cover a medication that would otherwise be excluded from coverage.

(6) “Covered person” means an employee covered under the health insurance plan created by this article.

(7) “Formulary” means a complete list of drugs eligible for coverage under a health insurance plan.

(8) “Health care provider” means 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.

(9) “Health insurance plan”, unless the context indicates otherwise, means the medical indemnity plan, the managed care plan option, or the group life insurance plan offered by the agency.

(10) “Renewal period” means 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.

(b) For each covered person under a health insurance plan contract with the agency that covers prescription drug benefits:

(1) The agency shall not limit or exclude coverage of a biological product for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the agency for the covered person;

(B)The covered person’s prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person’s medication, as described in subsection (b) of this section, shall continue through the last day of the covered person’s eligibility under the health

insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the agency uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the agency that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit the agency from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the agency shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the agency discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the agency, and the following conditions are met:

(1) The covered person is medically stable on a biological product as determined by the prescribing provider;

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition;

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the agency uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the agency shall authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The agency shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, the agency shall respond within 24 hours of receipt. Should a response by the agency not be received within this time allotted, the appeal shall be deemed granted.

(k) A covered person has rights of appeal of any adverse decision pursuant to the provisions of this article and the rules promulgated thereunder.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4u.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicate otherwise:

(1) "Biological product" means the same as the term is defined in 42 U.S.C. § 262.

(2) “Commissioner” means the Insurance Commissioner of West Virginia.

(3) “Cost-sharing” means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(4) “Coverage exemption determination” means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(5) “Covered person” means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(6) “Formulary” means a complete list of drugs eligible for coverage under a health insurance plan.

(7) “Health care provider” means 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.

(8) “Health insurance plan” means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(9) “Insurer” means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(10) “Renewal period” means 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.

(b) For each insurer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Insurers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the insurer for

the covered person;

(B)The covered person's prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person's medication, as described in subsection (b) of this section, shall continue through the last day of the covered person's eligibility under the health insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the insurer that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit an insurer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the insurer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the insurer discontinues the covered person's previous health care plan

during open enrollment, the covered person enrolls in a comparable plan offered by the same insurer, and the following conditions are met:

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

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the insurer shall authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The insurer shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within 24 hours of receipt. Should a response by the insurer not be received within this time allotted, the appeal shall be deemed granted.

(k) If the commissioner suspects that an insurer has violated any provision of this section, the commissioner may take any enforcement action pursuant to the provisions of article 34 of this chapter.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3ff.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicate otherwise:

(1) "Biological product" means the same as the term is defined in 42 U.S.C. § 262.

(2) "Commissioner" means the Insurance Commissioner of West Virginia.

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

(4) "Coverage exemption determination" means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(5) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(6) "Formulary" means a complete list of drugs eligible for coverage under a health insurance plan.

(7) "Health care provider" means 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.

(8) "Health insurance plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(9) "Insurer" means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(10) "Renewal period" means 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.

(b) For each insurer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Insurers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the insurer for the covered person;

(B)The covered person's prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person's medication, as described in subsection (b) of this section, shall continue through the last day of the covered person's eligibility under the health insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the insurer that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit an insurer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the insurer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the insurer discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the same insurer, and the following conditions are met:

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

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the insurer shall authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The insurer shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within 24 hours of receipt. Should a response by the insurer not be received within this time allotted, the appeal shall be deemed granted.

(k) If the commissioner suspects that an insurer has violated any provision of this section, the commissioner may take any enforcement action pursuant to the provisions of article 34 of this

chapter.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7u.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicate otherwise:

(1) “Biological product” means the same as the term is defined in 42 U.S.C. § 262.

(2) “Commissioner” means the Insurance Commissioner of West Virginia.

(3) “Cost-sharing” means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense requirement.

(4) “Coverage exemption determination” means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(5) “Covered person” means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(6) “Formulary” means a complete list of drugs eligible for coverage under a health insurance plan.

(7) “Health care provider” means 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.

(8) “Health insurance plan” means a policy, contract, certificate, or agreement entered

into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(9) “Insurer” means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(10) “Renewal period” means 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.

(b) For each insurer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Insurers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the insurer for the covered person;

(B)The covered person’s prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person’s medication, as described in subsection (b) of this section, shall continue through the last day of the covered person’s eligibility under the health insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the insurer that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit an insurer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the insurer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the insurer discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the same insurer, and the following conditions are met:

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

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the insurer shall

authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The insurer shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within 24 hours of receipt. Should a response by the insurer not be received within this time allotted, the appeal shall be deemed granted.

(k) If the commissioner suspects that an insurer has violated any provision of this section, the commissioner may take any enforcement action pursuant to the provisions of article 34 of this chapter.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8r.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicate otherwise:

(1) "Biological product" means the same as the term is defined in 42 U.S.C. § 262.

(2) "Commissioner" means the Insurance Commissioner of West Virginia.

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

(4) "Coverage exemption determination" means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(5) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(6) "Formulary" means a complete list of drugs eligible for coverage under a health

insurance plan.

(7) “Health care provider” means 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.

(8) “Health insurance plan” means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(9) “Insurer” means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(10) “Renewal period” means 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.

(b) For each insurer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Insurers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the insurer for the covered person;

(B)The covered person’s prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person’s medication, as described in subsection (b) of this section, shall continue through the last day of the covered person’s eligibility under the health insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section

include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the insurer that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit an insurer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the insurer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the insurer discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the same insurer, and the following conditions are met:

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

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the insurer shall authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The insurer shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within 24 hours of receipt. Should a response by the insurer not be received within this time allotted, the appeal shall be deemed granted.

(k) If the commissioner suspects that an insurer has violated any provision of this section, the commissioner may take any enforcement action pursuant to the provisions of article 34 of this chapter.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8u.

(a) As used in this section, the following words and phrases have the same meanings given to them in this section, unless the context clearly indicate otherwise:

(1) "Biological product" means the same as the term is defined in 42 U.S.C. § 262.

(2) "Commissioner" means the Insurance Commissioner of West Virginia.

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

(4) “Coverage exemption determination” means a determination made by the third-party payer to cover a medication that would otherwise be excluded from coverage.

(5) “Covered person” means a policyholder, subscriber, enrollee, or other individual participating in a health insurance plan.

(6) “Formulary” means a complete list of drugs eligible for coverage under a health insurance plan.

(7) “Health care provider” means 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.

(8) “Health insurance plan” means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse prescription drugs, health care services, and other covered health care benefits.

(9) “Insurer” means an entity licensed by the commissioner to transact accident and sickness insurance in this state and subject to this chapter, but does not include a group health plan or short term limited duration insurance.

(10) “Renewal period” means 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.

(b) For each insurer that has entered into a health insurance plan contract with a covered person that covers prescription drug benefits:

(1) Insurers shall not limit or exclude coverage of a biological product, for any covered person who is medically stable on such drug as determined by the prescribing provider, if:

(A) The biological product previously had been approved for coverage by the insurer for the covered person;

(B)The covered person’s prescribing provider continues to prescribe the biological product for the medical condition; and

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

(c) Coverage of covered person's medication, as described in subsection (b) of this section, shall continue through the last day of the covered person's eligibility under the health insurance plan, inclusive of any renewal period.

(d) Prohibited limitations and exclusions referred to in subsection (b) of this section include, but are not limited to:

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

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

(3) Moving a prescription drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(4) Removing a prescription drug from a formulary.

(e) This section does not preclude the prescribing provider from prescribing another biological product covered by the insurer that the prescribing provider deems medically necessary for the covered person.

(f) This section does not prohibit an insurer from:

(1) Adding a biological product to its formulary; or

(2) Removing a biological product from its formulary if its manufacturer has removed the biological product for sale in the United States.

(g) To ensure continuity of care, the insurer shall provide the covered person and prescribing practitioner with access to a clear, readily accessible, and convenient process to request a coverage exemption determination.

(h) A coverage exemption determination shall expeditiously grant the exemption determination request if the insurer discontinues the covered person's previous health care plan during open enrollment, the covered person enrolls in a comparable plan offered by the same insurer, and the following conditions are met:

(1) The covered person is medically stable on a biological product as determined by the

prescribing provider; and

(2) The prescribing provider continues to prescribe the biological product to the covered person for the medical condition; and

(3) In comparison to the discontinued health insurance plan, the new health insurance plan:

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

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

(C) Moves the drug to a more restrictive tier, if the insurer uses a formulary with tiers; or

(D) Excludes the drug from a formulary.

(i) Upon the granting of a coverage exemption determination request, the insurer shall authorize coverage no more restrictive than that offered in the discontinued health insurance plan for the biological product prescribed by the covered person's prescribing provider.

(j) The insurer shall respond to a coverage exemption determination request or an appeal within 72 hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within 24 hours of receipt. Should a response by the insurer not be received within this time allotted, the appeal shall be deemed granted.

(k) If the commissioner suspects that an insurer has violated any provision of this section, the commissioner may take any enforcement action pursuant to the provisions of article 34 of this chapter.

(l) This section is effective for policies, contracts, plans, or agreements, beginning on or after January 1, 2021. This section applies to all policies, contracts, plans, or agreements, subject to this article that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

NOTE: The purpose of this bill is to ensure that covered persons who are stable on their biological product 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."

Strike-through indicates language that would be stricken from a heading or present law and underscoring indicates new language that would be added.