

SENATE, No. 814

STATE OF NEW JERSEY 217th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

Sponsored by:

Senator LORETTA WEINBERG

District 37 (Bergen)

Senator THOMAS H. KEAN, JR.

District 21 (Morris, Somerset and Union)

SYNOPSIS

Requires health insurers to limit patient cost-sharing and provide appeal process concerning certain prescription drug coverage.

CURRENT VERSION OF TEXT

As reported by the Senate Commerce Committee with technical review.



(Sponsorship Updated As Of: 3/15/2016)

1 AN ACT concerning health benefits coverage for prescription drugs
2 and supplementing various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. a. Notwithstanding any other provision of law to the
8 contrary, every hospital service corporation contract that provides
9 benefits for expenses incurred in the purchase of prescription drugs
10 and is delivered, issued, executed, or renewed in this State pursuant
11 to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or
12 renewal in this State by the Commissioner of Banking and
13 Insurance, on or after the effective date of this act, shall conform
14 with the following:

15 (1) (a) except as provided for in subparagraphs (b) and (c) of
16 this paragraph, limit a covered person's out-of-pocket financial
17 responsibility, including any copayment or coinsurance, for
18 prescription drugs, including specialty drugs, to no more than \$100
19 per month for each prescription drug for up to a 30-day supply of
20 any single drug;

21 (b) a hospital service corporation contract that is required to
22 provide a bronze level of coverage, as defined in 45 C.F.R.
23 s.156.140, shall ensure that any required enrollee cost-sharing,
24 including any copayment or coinsurance, does not exceed \$200 per
25 month for each prescription drug for up to a 30-day supply of any
26 single drug; and

27 (c) a hospital service corporation contract that meets the
28 requirements of a catastrophic plan, as defined in 45 C.F.R.
29 s.156.155, shall be exempt from the requirements of subparagraphs
30 (a) and (b) of this paragraph;

31 (2) except as provided in paragraph (3) of this subsection, the
32 limits described in paragraph (1) of this subsection shall apply at
33 any point in the benefit design, including before and after any
34 applicable deductible is reached;

35 (3) for prescription drug benefits offered in conjunction with a
36 high-deductible health plan, not provide prescription drug benefits
37 until the expenditures applicable to the deductible under the plan
38 have met the amount of the minimum annual deductibles in effect
39 for self-only and family coverage under section 223(c)(2)(A)(i) of
40 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
41 self-only and family coverage, respectively. Once the foregoing
42 expenditure amount has been met under the plan, coverage for
43 prescription drug benefits shall begin, and the limit on out-of-
44 pocket expenditures for prescription drug benefits shall be as
45 specified in paragraph (1) of this subsection; and

46 (4) implement an exceptions process that allows enrollees to
47 request an exception to any formulary, which exception shall permit
48 a nonformulary drug to be deemed covered under the formulary if

1 the prescribing physician determines that the formulary drug for
2 treatment of the same condition either would not be as effective for
3 the enrollee or would have adverse effects for the enrollee, or both.
4 If an enrollee is denied such an exception, that denial shall be
5 deemed an adverse determination that will be subject to appeal
6 under the carrier's internal appeal process and section 11 of
7 P.L.1997, c.192 (C.26:2S-11).

8 b. The provisions of this section shall apply to all contracts in
9 which the hospital service corporation has reserved the right to
10 change the premium.

11

12 2. a. Notwithstanding any other provision of law to the
13 contrary, every medical service corporation contract that provides
14 benefits for expenses incurred in the purchase of prescription drugs
15 and is delivered, issued, executed, or renewed in this State pursuant
16 to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
17 renewal in this State by the Commissioner of Banking and
18 Insurance, on or after the effective date of this act, shall conform
19 with the following:

20 (1) (a) except as provided for in subparagraphs (b) and (c) of
21 this paragraph, limit a covered person's out-of-pocket financial
22 responsibility, including any copayment or coinsurance, for
23 prescription drugs, including specialty drugs, to no more than \$100
24 per month for each prescription drug for up to a 30-day supply of
25 any single drug;

26 (b) a medical service corporation contract that is required to
27 provide a bronze level of coverage, as defined in 45 C.F.R.
28 s.156.140, shall ensure that any required enrollee cost-sharing,
29 including any copayment or coinsurance, does not exceed \$200 per
30 month for each prescription drug for up to a 30-day supply of any
31 single drug; and

32 (c) a medical service corporation contract that meets the
33 requirements of a catastrophic plan, as defined in 45 C.F.R.
34 s.156.155, shall be exempt from the requirements of subparagraphs
35 (a) and (b) of this paragraph;

36 (2) except as provided in paragraph (3) of this subsection, the
37 limits described in paragraph (1) of this subsection shall apply at
38 any point in the benefit design, including before and after any
39 applicable deductible is reached;

40 (3) for prescription drug benefits offered in conjunction with a
41 high-deductible health plan, not provide prescription drug benefits
42 until the expenditures applicable to the deductible under the plan
43 have met the amount of the minimum annual deductibles in effect
44 for self-only and family coverage under section 223(c)(2)(A)(i) of
45 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
46 self-only and family coverage, respectively. Once the foregoing
47 expenditure amount has been met under the plan, coverage for
48 prescription drug benefits shall begin, and the limit on out-of-

1 pocket expenditures for prescription drug benefits shall be as
2 specified in paragraph (1) of this subsection; and

3 (4) implement an exceptions process that allows enrollees to
4 request an exception to any formulary, which exception shall permit
5 a nonformulary drug to be deemed covered under the formulary if
6 the prescribing physician determines that the formulary drug for
7 treatment of the same condition either would not be as effective for
8 the enrollee or would have adverse effects for the enrollee, or both.
9 If an enrollee is denied such an exception, that denial shall be
10 deemed an adverse determination that will be subject to appeal
11 under the carrier's internal appeal process and section 11 of
12 P.L.1997, c.192 (C.26:2S-11).

13 b. The provisions of this section shall apply to all contracts in
14 which the medical service corporation has reserved the right to
15 change the premium.

16

17 3. a. Notwithstanding any other provision of law to the
18 contrary, every health service corporation contract that provides
19 benefits for expenses incurred in the purchase of prescription drugs
20 and is delivered, issued, executed, or renewed in this State pursuant
21 to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or
22 renewal in this State by the Commissioner of Banking and
23 Insurance, on or after the effective date of this act, shall conform
24 with the following:

25 (1) (a) except as provided for in subparagraphs (b) and (c) of
26 this paragraph, limit a covered person's out-of-pocket financial
27 responsibility, including any copayment or coinsurance, for
28 prescription drugs, including specialty drugs, to no more than \$100
29 per month for each prescription drug for up to a 30-day supply of
30 any single drug;

31 (b) a health service corporation contract that is required to
32 provide a bronze level of coverage, as defined in 45 C.F.R.
33 s.156.140, shall ensure that any required enrollee cost-sharing,
34 including any copayment or coinsurance, does not exceed \$200 per
35 month for each prescription drug for up to a 30-day supply of any
36 single drug; and

37 (c) a health service corporation contract that meets the
38 requirements of a catastrophic plan, as defined in 45 C.F.R.
39 s.156.155, shall be exempt from the requirements of subparagraphs
40 (a) and (b) of this paragraph;

41 (2) except as provided in paragraph (3) of this subsection, the
42 limits described in paragraph (1) of this subsection shall apply at
43 any point in the benefit design, including before and after any
44 applicable deductible is reached;

45 (3) for prescription drug benefits offered in conjunction with a
46 high-deductible health plan, not provide prescription drug benefits
47 until the expenditures applicable to the deductible under the plan
48 have met the amount of the minimum annual deductibles in effect

1 for self-only and family coverage under section 223(c)(2)(A)(i) of
2 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
3 self-only and family coverage, respectively. Once the foregoing
4 expenditure amount has been met under the plan, coverage for
5 prescription drug benefits shall begin, and the limit on out-of-
6 pocket expenditures for prescription drug benefits shall be as
7 specified in paragraph (1) of this subsection; and

8 (4) implement an exceptions process that allows enrollees to
9 request an exception to any formulary, which exception shall permit
10 a nonformulary drug to be deemed covered under the formulary if
11 the prescribing physician determines that the formulary drug for
12 treatment of the same condition either would not be as effective for
13 the enrollee or would have adverse effects for the enrollee, or both.
14 If an enrollee is denied such an exception, that denial shall be
15 deemed an adverse determination that will be subject to appeal
16 under the carrier's internal appeal process and section 11 of
17 P.L.1997, c.192 (C.26:2S-11).

18 b. The provisions of this section shall apply to all contracts in
19 which the health service corporation has reserved the right to
20 change the premium.

21

22 4. a. Notwithstanding any other provision of law to the
23 contrary, every individual health insurance policy that provides
24 benefits for expenses incurred in the purchase of prescription drugs
25 and is delivered, issued, executed, or renewed in this State pursuant
26 to chapter 26 of Title 17B of the New Jersey Statutes, or approved
27 for issuance or renewal in this State by the Commissioner of
28 Banking and Insurance, on or after the effective date of this act,
29 shall conform with the following:

30 (1) (a) except as provided for in subparagraphs (b) and (c) of
31 this paragraph, limit a covered person's out-of-pocket financial
32 responsibility, including any copayment or coinsurance, for
33 prescription drugs, including specialty drugs, to no more than \$100
34 per month for each prescription drug for up to a 30-day supply of
35 any single drug;

36 (b) an individual health insurance policy that is required to
37 provide a bronze level of coverage, as defined in 45 C.F.R.
38 s.156.140, shall ensure that any required enrollee cost-sharing,
39 including any copayment or coinsurance, does not exceed \$200 per
40 month for each prescription drug for up to a 30-day supply of any
41 single drug; and

42 (c) an individual health insurance policy that meets the
43 requirements of a catastrophic plan, as defined in 45 C.F.R.
44 s.156.155, shall be exempt from the requirements of subparagraphs
45 (a) and (b) of this paragraph;

46 (2) except as provided in paragraph (3) of this subsection, the
47 limits described in paragraph (1) of this subsection shall apply at
48 any point in the benefit design, including before and after any

- 1 applicable deductible is reached;
- 2 (3) for prescription drug benefits offered in conjunction with a
3 high-deductible health plan, not provide prescription drug benefits
4 until the expenditures applicable to the deductible under the plan
5 have met the amount of the minimum annual deductibles in effect
6 for self-only and family coverage under section 223(c)(2)(A)(i) of
7 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
8 self-only and family coverage, respectively. Once the foregoing
9 expenditure amount has been met under the plan, coverage for
10 prescription drug benefits shall begin, and the limit on out-of-
11 pocket expenditures for prescription drug benefits shall be as
12 specified in paragraph (1) of this subsection; and
- 13 (4) implement an exceptions process that allows enrollees to
14 request an exception to any formulary, which exception shall permit
15 a nonformulary drug to be deemed covered under the formulary if
16 the prescribing physician determines that the formulary drug for
17 treatment of the same condition either would not be as effective for
18 the enrollee or would have adverse effects for the enrollee, or both.
19 If an enrollee is denied such an exception, that denial shall be
20 deemed an adverse determination that will be subject to appeal
21 under the carrier's internal appeal process and section 11 of
22 P.L.1997, c.192 (C.26:2S-11).
- 23 b. The provisions of this section shall apply to all policies in
24 which the insurer has reserved the right to change the premium.
25
- 26 5. a. Notwithstanding any other provision of law to the
27 contrary, every group health insurance policy that provides benefits
28 for expenses incurred in the purchase of prescription drugs and is
29 delivered, issued, executed, or renewed in this State pursuant to
30 chapter 27 of Title 17B of the New Jersey Statutes, or approved for
31 issuance or renewal in this State by the Commissioner of Banking
32 and Insurance, on or after the effective date of this act, shall
33 conform with the following:
- 34 (1) (a) except as provided for in subparagraphs (b) and (c) of
35 this paragraph, limit a covered person's out-of-pocket financial
36 responsibility, including any copayment or coinsurance, for
37 prescription drugs, including specialty drugs, to no more than \$100
38 per month for each prescription drug for up to a 30-day supply of
39 any single drug;
- 40 (b) a group health insurance policy that is required to provide a
41 bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall
42 ensure that any required enrollee cost-sharing, including any
43 copayment or coinsurance, does not exceed \$200 per month for
44 each prescription drug for up to a 30-day supply of any single drug;
45 and
- 46 (c) a group health insurance policy that meets the requirements
47 of a catastrophic plan, as defined in 45 C.F.R. s.156.155, shall be
48 exempt from the requirements of subparagraphs (a) and (b) of this

1 paragraph;

2 (2) except as provided in paragraph (3) of this subsection, the
3 limits described in paragraph (1) of this subsection shall apply at
4 any point in the benefit design, including before and after any
5 applicable deductible is reached;

6 (3) for prescription drug benefits offered in conjunction with a
7 high-deductible health plan, not provide prescription drug benefits
8 until the expenditures applicable to the deductible under the plan
9 have met the amount of the minimum annual deductibles in effect
10 for self-only and family coverage under section 223(c)(2)(A)(i) of
11 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
12 self-only and family coverage, respectively. Once the foregoing
13 expenditure amount has been met under the plan, coverage for
14 prescription drug benefits shall begin, and the limit on out-of-
15 pocket expenditures for prescription drug benefits shall be as
16 specified in paragraph (1) of this subsection; and

17 (4) implement an exceptions process that allows enrollees to
18 request an exception to any formulary, which exception shall permit
19 a nonformulary drug to be deemed covered under the formulary if
20 the prescribing physician determines that the formulary drug for
21 treatment of the same condition either would not be as effective for
22 the enrollee or would have adverse effects for the enrollee, or both.
23 If an enrollee is denied such an exception, that denial shall be
24 deemed an adverse determination that will be subject to appeal
25 under the carrier's internal appeal process and section 11 of
26 P.L.1997, c.192 (C.26:2S-11).

27 b. The provisions of this section shall apply to all policies in
28 which the insurer has reserved the right to change the premium.

29

30 6. a. Notwithstanding any other provision of law to the
31 contrary, an individual health benefits plan that provides benefits
32 for expenses incurred in the purchase of prescription drugs and is
33 delivered, issued, executed, renewed, or approved for issuance or
34 renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et
35 seq.), or approved for issuance or renewal in this State by the
36 Commissioner of Banking and Insurance, on or after the effective
37 date of this act, shall conform with the following:

38 (1) (a) except as provided for in subparagraphs (b) and (c) of
39 this paragraph, limit a covered person's out-of-pocket financial
40 responsibility, including any copayment or coinsurance, for
41 prescription drugs, including specialty drugs, to no more than \$100
42 per month for each prescription drug for up to a 30-day supply of
43 any single drug;

44 (b) an individual health benefits plan that is required to provide
45 a bronze level of coverage, as defined in 45 C.F.R. s.156.140, shall
46 ensure that any required enrollee cost-sharing, including any
47 copayment or coinsurance, does not exceed \$200 per month for
48 each prescription drug for up to a 30-day supply of any single drug;

1 and

2 (c) an individual health benefits plan that meets the
3 requirements of a catastrophic plan, as defined in 45 C.F.R.
4 s.156.155, shall be exempt from the requirements of subparagraphs
5 (a) and (b) of this paragraph;

6 (2) except as provided in paragraph (3) of this subsection, the
7 limits described in paragraph (1) of this subsection shall apply at
8 any point in the benefit design, including before and after any
9 applicable deductible is reached;

10 (3) for prescription drug benefits offered in conjunction with a
11 high-deductible health plan, not provide prescription drug benefits
12 until the expenditures applicable to the deductible under the plan
13 have met the amount of the minimum annual deductibles in effect
14 for self-only and family coverage under section 223(c)(2)(A)(i)
15 of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
16 self-only and family coverage, respectively. Once the foregoing
17 expenditure amount has been met under the plan, coverage for
18 prescription drug benefits shall begin, and the limit on out-of-
19 pocket expenditures for prescription drug benefits shall be as
20 specified in paragraph (1) of this subsection; and

21 (4) implement an exceptions process that allows enrollees to
22 request an exception to any formulary, which exception shall permit
23 a nonformulary drug to be deemed covered under the formulary if
24 the prescribing physician determines that the formulary drug for
25 treatment of the same condition either would not be as effective for
26 the enrollee or would have adverse effects for the enrollee, or both.
27 If an enrollee is denied such an exception, that denial shall be
28 deemed an adverse determination that will be subject to appeal
29 under the carrier's internal appeal process and section 11 of
30 P.L.1997, c.192 (C.26:2S-11).

31 b. The provisions of this section shall apply to those health
32 benefits plans in which the carrier has reserved the right to change
33 the premium.

34

35 7. a. Notwithstanding any other provision of law to the
36 contrary, a small employer health benefits plan that provides
37 benefits for expenses incurred in the purchase of prescription drugs
38 and is delivered, issued, executed, renewed, or approved for
39 issuance or renewal in this State pursuant to P.L.1992, c.162
40 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this
41 State by the Commissioner of Banking and Insurance, on or after
42 the effective date of this act, shall conform with the following:

43 (1) (a) except as provided for in subparagraphs (b) and (c) of
44 this paragraph, limit a covered person's out-of-pocket financial
45 responsibility, including any copayment or coinsurance, for
46 prescription drugs, including specialty drugs, to no more than \$100
47 per month for each prescription drug for up to a 30-day supply of
48 any single drug;

1 (b) a small employer health benefits plan that is required to
2 provide a bronze level of coverage, as defined in 45 C.F.R.
3 s.156.140, shall ensure that any required enrollee cost-sharing,
4 including any copayment or coinsurance, does not exceed \$200 per
5 month for each prescription drug for up to a 30-day supply of any
6 single drug; and

7 (c) a small employer health benefits plan that meets the
8 requirements of a catastrophic plan, as defined in 45 C.F.R.
9 s.156.155, shall be exempt from the requirements of subparagraphs
10 (a) and (b) of this paragraph;

11 (2) except as provided in paragraph (3) of this subsection, the
12 limits described in paragraph (1) of this subsection shall apply at
13 any point in the benefit design, including before and after any
14 applicable deductible is reached;

15 (3) for prescription drug benefits offered in conjunction with a
16 high-deductible health plan, not provide prescription drug benefits
17 until the expenditures applicable to the deductible under the plan
18 have met the amount of the minimum annual deductibles in effect
19 for self-only and family coverage under section 223(c)(2)(A)(i)
20 of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
21 self-only and family coverage, respectively. Once the foregoing
22 expenditure amount has been met under the plan, coverage for
23 prescription drug benefits shall begin, and the limit on out-of-
24 pocket expenditures for prescription drug benefits shall be as
25 specified in paragraph (1) of this subsection; and

26 (4) implement an exceptions process that allows enrollees to
27 request an exception to any formulary, which exception shall permit
28 a nonformulary drug to be deemed covered under the formulary if
29 the prescribing physician determines that the formulary drug for
30 treatment of the same condition either would not be as effective for
31 the enrollee or would have adverse effects for the enrollee, or both.
32 If an enrollee is denied such an exception, that denial shall be
33 deemed an adverse determination that will be subject to appeal
34 under the carrier's internal appeal process and section 11 of
35 P.L.1997, c.192 (C.26:2S-11).

36 b. The provisions of this section shall apply to those health
37 benefits plan in which the carrier has reserved the right to change
38 the premium.

39

40 8. a. Notwithstanding any other provision of law to the
41 contrary, a health maintenance organization enrollee agreement that
42 provides coverage for the purchase of prescription drugs and is
43 delivered, issued, executed, or renewed in this State pursuant to
44 P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or
45 renewal in this State by the Commissioner of Banking and
46 Insurance, on or after the effective date of this act, shall conform
47 with the following:

48 (1) (a) except as provided for in subparagraphs (b) and (c) of

1 this paragraph, limit a covered person's out-of-pocket financial
2 responsibility, including any copayment or coinsurance, for
3 prescription drugs, including specialty drugs, to no more than \$100
4 per month for each prescription drug for up to a 30-day supply of
5 any single drug;

6 (b) a health maintenance organization enrollee agreement that is
7 required to provide a bronze level of coverage, as defined in 45
8 C.F.R. s.156.140, shall ensure that any required enrollee cost-
9 sharing, including any copayment or coinsurance, does not exceed
10 \$200 per month for each prescription drug for up to a 30-day supply
11 of any single drug; and

12 (c) a health maintenance organization enrollee agreement that
13 meets the requirements of a catastrophic plan, as defined in 45
14 C.F.R. s.156.155, shall be exempt from the requirements of
15 subparagraphs (a) and (b) of this paragraph;

16 (2) except as provided in paragraph (3) of this subsection, the
17 limits described in paragraph (1) of this subsection shall apply at
18 any point in the benefit design, including before and after any
19 applicable deductible is reached;

20 (3) for prescription drug benefits offered in conjunction with a
21 high-deductible health plan, not provide prescription drug benefits
22 until the expenditures applicable to the deductible under the plan
23 have met the amount of the minimum annual deductibles in effect
24 for self-only and family coverage under section 223(c)(2)(A)(i) of
25 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
26 self-only and family coverage, respectively. Once the foregoing
27 expenditure amount has been met under the plan, coverage for
28 prescription drug benefits shall begin, and the limit on out-of-
29 pocket expenditures for prescription drug benefits shall be as
30 specified in paragraph (1) of this subsection; and

31 (4) implement an exceptions process that allows enrollees to
32 request an exception to any formulary, which exception shall permit
33 a nonformulary drug to be deemed covered under the formulary if
34 the prescribing physician determines that the formulary drug for
35 treatment of the same condition either would not be as effective for
36 the enrollee or would have adverse effects for the enrollee, or both.
37 If an enrollee is denied such an exception, that denial shall be
38 deemed an adverse determination that will be subject to appeal
39 under the carrier's internal appeal process and section 11 of
40 P.L.1997, c.192 (C.26:2S-11).

41 b. The provisions of this section shall apply to all agreements
42 in which the health maintenance organization has reserved the right
43 to change the premium.

44

45 9. Notwithstanding any other provision of law to the contrary,
46 the State Health Benefits Commission shall ensure that every
47 contract that provides benefits for expenses incurred in the purchase
48 of prescription drugs, which is purchased by the commission on or

- 1 after the effective date of this act, shall conform with the following:
- 2 a. limit a covered person's out-of-pocket financial
3 responsibility, including any copayment or coinsurance, for
4 prescription drugs, including specialty drugs, to no more than \$100
5 per month for each prescription drug for up to a 30-day supply of
6 any single drug;
- 7 b. except as provided in subsection c. of this section, the limits
8 described in subsection a. of this section shall apply at any point in
9 the benefit design, including before and after any applicable
10 deductible is reached;
- 11 c. for prescription drug benefits offered in conjunction with a
12 high-deductible health plan, not provide prescription drug benefits
13 until the expenditures applicable to the deductible under the plan
14 have met the amount of the minimum annual deductibles in effect
15 for self-only and family coverage under section 223(c)(2)(A)(i) of
16 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
17 self-only and family coverage, respectively. Once the foregoing
18 expenditure amount has been met under the plan, coverage for
19 prescription drug benefits shall begin, and the limit on out-of-
20 pocket expenditures for prescription drug benefits shall be as
21 specified in subsection a. of this section; and
- 22 d. implement an exceptions process that allows enrollees to
23 request an exception to any formulary, which exception shall permit
24 a nonformulary drug to be deemed covered under the formulary if
25 the prescribing physician determines that the formulary drug for
26 treatment of the same condition either would not be as effective for
27 the enrollee or would have adverse effects for the enrollee, or both.
28 If an enrollee is denied such an exception, that denial shall be
29 deemed an adverse determination that will be subject to appeal
30 under the applicable appeal process established by the commission.
31
- 32 10. Notwithstanding any other provision of law to the contrary,
33 the School Employees' Health Benefits Commission shall ensure
34 that every contract that provides benefits for expenses incurred in
35 the purchase of prescription drugs, which is purchased by the
36 commission on or after the effective date of this act, shall conform
37 with the following:
- 38 a. limit a covered person's out-of-pocket financial
39 responsibility, including any copayment or coinsurance, for
40 prescription drugs, including specialty drugs, to no more than \$100
41 per month for each prescription drug for up to a 30-day supply of
42 any single drug;
- 43 b. except as provided in subsection c. of this section, the limits
44 described in subsection a. of this section shall apply at any point in
45 the benefit design, including before and after any applicable
46 deductible is reached;
- 47 c. for prescription drug benefits offered in conjunction with a
48 high-deductible health plan, not provide prescription drug benefits

1 until the expenditures applicable to the deductible under the plan
2 have met the amount of the minimum annual deductibles in effect
3 for self-only and family coverage under section 223(c)(2)(A)(i) of
4 the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for
5 self-only and family coverage, respectively. Once the foregoing
6 expenditure amount has been met under the plan, coverage for
7 prescription drug benefits shall begin, and the limit on out-of-
8 pocket expenditures for prescription drug benefits shall be as
9 specified in subsection a. of this section; and

10 d. implement an exceptions process that allows enrollees to
11 request an exception to any formulary, which exception shall permit
12 a nonformulary drug to be deemed covered under the formulary if
13 the prescribing physician determines that the formulary drug for
14 treatment of the same condition either would not be as effective for
15 the enrollee or would have adverse effects for the enrollee, or both.
16 If an enrollee is denied such an exception, that denial shall be
17 deemed an adverse determination that will be subject to appeal
18 under the applicable appeal process established by the commission.

19

20 11. This act shall take effect on the 90th day after enactment and
21 shall apply to policies or contracts issued or renewed on or after the
22 effective date.