ASSEMBLY, No. 2431

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 1, 2018

Sponsored by:
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)
Assemblywoman ANGELICA M. JIMENEZ
District 32 (Bergen and Hudson)
Assemblywoman BETTYLOU DECROCE
District 26 (Essex, Morris and Passaic)
Assemblyman TIM EUSTACE
District 38 (Bergen and Passaic)

Co-Sponsored by:
Assemblywoman Vainieri Huttle, Assemblymen Mukherji, Bramnick, Assemblywoman Murphy, Assemblyman McKeon, Assemblywomen Jasey, Schepisi, Assemblymen Giblin, Dancer, Conaway and Johnson

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/25/2019)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

applicable deductible is reached;

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

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

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

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

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

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

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

paragraph;

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

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

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

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

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

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

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

and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

after the effective date of this act, shall conform with the following:

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

b. except as provided in subsection c. of this section, the limits described in subsection a. of this section shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

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

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

10. Notwithstanding any other provision of law to the contrary, the School Employees' Health Benefits Commission shall ensure that every contract that provides benefits for expenses incurred in the purchase of prescription drugs, which is purchased by the commission on or after the effective date of this act, shall conform with the following:

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

b. except as provided in subsection c. of this section, the limits described in subsection a. of this section shall apply at any point in the benefit design, including before and after any applicable deductible is reached;

c. for prescription drug benefits offered in conjunction with a high-deductible health plan, not provide prescription drug benefits until the expenditures applicable to the deductible under the plan

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

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

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

STATEMENT

This bill requires certain health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons' cost sharing for prescription drugs. The bill's provisions apply to the following insurers and programs that provide coverage for prescription drugs under a policy or contract: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP).

Unless the plan or contract is required to provide bronze level of coverage or is a catastrophic plan under the federal Affordable Care Act, the bill requires insurers to ensure that plans limit a covered person's out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $100 per month for each prescription drug for up to a 30-day supply of any single drug. If the plan or contract is required to provide a bronze level of coverage, as defined in 45 C.F.R. s.156.140, the plan shall ensure that any required enrollee cost-sharing, including any copayment or coinsurance, does not exceed $200 per month for each prescription

drug for up to a 30-day supply of any single drug. In the case of a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, it is exempt from these requirements.

In the case of high-deductible plans, these cost sharing limits apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the plan shall not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under section 223(c)(2)(A)(i) of the federal Internal Revenue Code (26 U.S.C. 223(c)(2)(A)(i)) for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the plan, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits would be as specified in the bill.

The bill also requires the plans to implement an exceptions process that allows enrollees to request an exception to any formulary, which exception shall permit a nonformulary drug to be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the enrollee or would have adverse effects for the enrollee, or both. If an enrollee is denied such an exception, that denial is deemed an adverse determination that will be subject to appeal.