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HOUSE BILL NO. 304

Offered January 8, 2014
Prefiled December 31, 2013

A BILL to amend and reenact §§ 38.2-4319 and 38.2-4509 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.14:1, relating to accident and sickness insurance; prescription drugs; specialty tier coverage.

Patrons—O'Bannon, BaCote, Lopez, Peace and Ward

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4319 and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.14:1 as follows:

§ 38.2-3407.14:1. Specialty tier prescription coverage.

A. As used in this section, unless the context requires a different meaning:

"Class of drugs" means a group of medications having similar actions designed to treat a particular disease process.

"Coinsurance" means a cost-sharing amount set as a percentage of the total cost of the drug.

"Complex or chronic medical condition" means a physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or undertreated, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis.

"Copayment" means a cost-sharing amount set as a dollar value.

"Health benefit plan" has the same meaning ascribed to the term in § 38.2-3556.

"Health carrier" has the same meaning ascribed to the term in § 38.2-3556.

"Nonpreferred drug" means a specialty drug formulary classification for certain specialty drugs deemed nonpreferred and therefore subject to limits on eligibility for coverage or to higher cost-sharing amounts than preferred specialty drugs.

"Preferred drug" means a specialty drug formulary classification for certain specialty drugs deemed preferred and therefore not subject to limits on eligibility for coverage or not subject to higher cost-sharing amounts than nonpreferred specialty drugs.

"Rare medical condition" means any disease or condition that affects not more than one of every 1,500 individuals in the United States, such as cystic fibrosis, hemophilia, and multiple myeloma.

"Specialty drug" means a prescription drug that:

1. Is prescribed for an individual person with (i) a complex or chronic medical condition or (ii) a rare medical condition;

2. Has a total monthly cost of not less than $600;

3. Is not stocked at a majority of retail pharmacies; and

4. Has one or more of the following characteristics:

a. Is an oral, injectable, or infusible drug product;

b. Has unique storage or shipment requirements, such as refrigeration; or

c. Patients receiving the drug require education and support beyond traditional dispensing activities.

"Specialty drug formulary" means a specialty drug benefit design that distinguishes, for purposes of eligibility for coverage or for cost-sharing, between preferred drugs and nonpreferred drugs.

"Specialty drug tier" means a tier of cost-sharing designed for specialty drugs that imposes a cost-sharing obligation for specialty drugs that (i) is based on a coinsurance and (ii) exceeds the amount for nonspecialty drugs.

B. Any health carrier whose health benefit plan includes coverage for prescription drugs and whose prescription drug benefit utilizes:

1. A specialty drug tier shall ensure that any required copayment or coinsurance applicable to specialty drugs on a specialty tier does not exceed $150 per month for each specialty drug up to a 30-day supply of any single drug; and

2. A specialty drug formulary shall implement an exceptions process that allows enrollees to request an exception to the formulary, which exception shall permit a nonformulary specialty 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, the denial shall be considered an adverse determination that will be subject to the health carrier's internal appeals process established pursuant to § 38.2-3558 and to external review pursuant to § 38.2-3561.

C. A health benefit plan that provides coverage for prescription drugs shall not place all drugs in a given class of drugs on a specialty tier.

D. Nothing in this section shall be construed to require a health benefit plan to:

1. Provide coverage for any additional drugs not otherwise required by law;

2. Implement specific utilization management techniques, such as prior authorization or step therapy; or

3. Cease utilization of tiered cost-sharing structures, including strategies used to incent use of preventive services, disease management, and low-cost treatment options.

E. Nothing in this section shall be construed to require a pharmacist to substitute a drug without the consent of the prescribing physician.

F. A health carrier shall not be precluded from requiring specialty drugs to be obtained through a designated pharmacy or other source of such drugs.

G. This section shall not apply to any health benefit plan sold or offered for sale by a health carrier upon a determination by the Commission that the requirements of this section would result in the assumption by the state of additional costs pursuant to § 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended, relative to benefits required by state law to be offered by qualified plans in a health benefit exchange serving residents of the Commonwealth that exceed the benefits required by federal law.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.1, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, *38.2-3407.14:1,* 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, *38.2-3407.14:1*, 38.2-3407.15, 38.2-3407.17, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.