VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 38.2-3407.9:01 of the Code of Virginia, relating to health insurance; prescription drug formularies; notices.

[H 308]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.9:01 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3407.9:01. Prescription drug formularies.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or health maintenance organization if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed pharmacists, physicians and other licensed health care providers.

B. If an insurer, corporation, or health maintenance organization maintains one or more closed drug formularies, each insurer, corporation or health maintenance organization shall:

1. Make available to participating providers and pharmacists and to any nonpreferred or nonparticipating pharmacists as described in §§ 38.2-3407.7 and 38.2-4312.1, the complete, current drug formulary or formularies, or any updates thereto, maintained by the insurer, corporation, or health maintenance organization, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs;

2. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer, corporation, or health maintenance organization, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the enrollee. The insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request; and

3. Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug when the enrollee has been receiving the specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient. After reasonable investigation and consultation with the prescribing physician, the insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request. For purposes of this subsection, substituting the generic equivalent drug, which has been approved by the U.S. Food and Drug Administration, for a branded version of such drug shall not constitute a change in drug therapy.

C. Each insurer, corporation, or health maintenance organization that applies a formulary to the prescription drug benefits provided as set forth in subsection A shall provide to each affected group health benefit plan policyholder or contract holder or each affected individual health benefit plan policyholder or contract holder not less than 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements. This section does not apply to modifications that occur at the time of coverage renewal.