January 31, 2020

SENATE BILL No. 97

DIGEST OF SB 97 (Updated January 29, 2020 1:15 pm - DI 104)

Citations Affected: IC 5-10; IC 27-8; IC 27-13; noncode.

Synopsis: Insurance drug coverage. Prohibits a state employee health plan, a policy of accident and sickness insurance, or a health maintenance organization from modifying an enrollee's coverage of a drug during the current plan year. Specifies prohibited modifications. Provides for certain exceptions. (The introduced version of this bill was prepared by the interim study committee on public health, behavioral health, and human services.)

Effective: July 1, 2020.

Becker, Charbonneau, Stoops,
Ford J.D.

January 6, 2020, read first time and referred to Committee on Health and Provider Services.
January 30, 2020, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

January 31, 2020

Second Regular Session of the 121st General Assembly (2020)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2019 Regular Session of the General Assembly.

SENATE BILL No. 97

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-23 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 23. (a) As used in this section, "covered individual" means an individual entitled to coverage under a state employee health plan.**

(b) As used in this section, "state employee health plan" means the following:

(1) A self-insurance program established under section 7(b) of this chapter.

(2) A contract for prepaid health care services entered into under section 7(c) of this chapter.

(c) Nothing in this section prevents a covered individual's:

(1) prescribing provider from prescribing a drug that the prescribing provider considers to be medically necessary for the covered individual; or

(2) pharmacist from substituting:

(A) a generic drug under IC 16-42-22; or

(B) a biosimilar biological product under IC 16-42-25.

(d) Nothing in this section prevents a state employee health plan from doing any of the following:

(1) Adding a drug to the state employee health plan formulary.

(2) Removing a drug from the state employee health plan formulary if the drug's manufacturer has removed the drug from sale in the United States.

(e) A state employee health plan may not modify a covered individual's coverage of a drug during the current plan year for the covered individual if:

(1) the covered individual received coverage for the drug during the current plan year;

(2) the covered individual's prescribing provider continues to prescribe the drug for the medical condition; and

(3) the covered individual continues to be entitled to coverage in the state employee health plan.

(f) A prohibited modification under subsection (e) includes, with respect to the covered individual, the following:

(1) The exclusion of coverage for a drug.

(2) Changing:

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the covered individual's out-of-pocket costs for a drug.

(3) The movement of a drug to a more restrictive coverage category or tier.

(4) The discontinuation of coverage of a drug before the date on which a covered individual is no longer entitled to coverage.

(5) The removal of a drug from a formulary, unless any of the following occur:

(A) The federal Food and Drug Administration has issued a statement calling into question the clinical safety of the drug.

(B) The manufacturer of the drug has notified the federal Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as

required by 21 U.S.C. 356c.

(6) A limitation or reduction in the coverage of a drug in any other way, including subjecting it to a new prior authorization or step therapy requirement.

SECTION 2. IC 27-8-36 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 36. Modification of Drug Coverage

Sec. 1. As used in this chapter, "insured" means an individual entitled to coverage under a policy of accident and sickness insurance.

Sec. 2. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 3. Nothing in this chapter prevents an insured's:

(1) prescribing provider from prescribing a drug that the prescribing provider considers to be medically necessary for the insured; or

(2) pharmacist from substituting:

(A) a generic drug under IC 16-42-22; or

(B) a biosimilar biological product under IC 16-42-25.

Sec. 4. Nothing in this chapter prevents a policy of accident and sickness insurance from doing any of the following:

(1) Adding a drug to the policy of accident and sickness insurance formulary.

(2) Removing a drug from the accident and sickness insurance formulary if the drug's manufacturer has removed the drug from sale in the United States.

Sec. 5. (a) An insurer may not modify an insured's coverage of a drug during the current plan year for the insured if:

(1) the insured received coverage for the drug during the current plan year;

(2) the insured's prescribing provider continues to prescribe the drug for the medical condition; and

(3) the insured continues to be entitled to coverage by the policy of accident and sickness insurance.

(b) A prohibited modification under subsection (a) includes, with respect to the insured, the following:

(1) The exclusion of coverage for a drug.

(2) Changing:

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum

amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the insured's out-of-pocket costs for a drug.

(3) The movement of a drug to a more restrictive coverage category or tier.

(4) The discontinuation of coverage of a drug before the date on which an insured is no longer entitled to coverage.

(5) The removal of a drug from a formulary, unless any of the following occur:

(A) The federal Food and Drug Administration has issued a statement calling into question the clinical safety of the drug.

(B) The manufacturer of the drug has notified the federal Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by 21 U.S.C. 356c.

(6) A limitation or reduction in the coverage of a drug in any other way, including subjecting it to a new prior authorization or step therapy requirement.

SECTION 3. IC 27-13-7-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 25. (a) Nothing in this section prevents an enrollee's:**

(1) prescribing provider from prescribing a drug that the prescribing provider considers to be medically necessary for the enrollee; or

(2) pharmacist from substituting:

(A) a generic drug under IC 16-42-22; or

(B) a biosimilar biological product under IC 16-42-25.

(b) Nothing in this section prevents a health maintenance organization from doing any of the following:

(1) Adding a drug to the health maintenance organization formulary.

(2) Removing a drug from the health maintenance organization formulary if the drug's manufacturer has removed the drug from sale in the United States.

(c) A health maintenance organization may not modify an enrollee's coverage of a drug during the current plan year for the covered enrollee if:

(1) the enrollee received coverage for the drug during the current plan year;

(2) the enrollee's prescribing provider continues to prescribe the drug for the medical condition; and

(3) the enrollee continues to be entitled to coverage by the health maintenance organization.

(d) A prohibited modification under subsection (c) includes, with respect to the enrollee, the following:

(1) The exclusion of coverage for a drug.

(2) Changing:

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the enrollee's out-of-pocket costs for a drug.

(3) The movement of a drug to a more restrictive coverage category or tier.

(4) The discontinuation of coverage of a drug before the date on which a covered enrollee is no longer entitled to coverage.

(5) The removal of a drug from a formulary, unless any of the following occur:

(A) The federal Food and Drug Administration has issued a statement calling into question the clinical safety of the drug.

(B) The manufacturer of the drug has notified the federal Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by 21 U.S.C. 356c.

(6) A limitation or reduction in the coverage of a drug in any other way, including subjecting it to a new prior authorization or step therapy requirement.

SECTION 4. [EFFECTIVE JULY 1, 2020] **(a) IC 5-10-8-23, as added by this act, applies to a state employee health plan (as defined by IC 5-10-8-23(b), as added by this act) that is established, entered into, amended, or renewed after June 30, 2020.**

(b) IC 27-8-36, as added by this act, applies to a policy of accident and sickness insurance (as defined by IC 27-8-5-1) that is issued, delivered, amended, or renewed after June 30, 2020.

(c) IC 27-13-7-25, as added by this act, applies to an individual contract (as defined by IC 27-13-1-21) and a group contract (as defined by IC 27-13-1-16) that is entered into, delivered, amended,

or renewed after June 30, 2020.

(d) This SECTION expires July 1, 2023.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 97, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, line 10, after "during the" insert "**current**".

Page 2, delete lines 12 through 14, begin a new line block indented and insert:

"**(1) the covered individual received coverage for the drug during the current plan year;**".

Page 2, delete lines 22 through 23, begin a new line block indented and insert:

"**(2) Changing:**

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the covered individual's out-of-pocket costs for a drug.".

Page 2, line 24, delete "(4)" and insert "**(3)**".

Page 2, line 26, delete "(5)" and insert "**(4)**".

Page 2, line 29, delete "(6)" and insert "**(5)**".

Page 2, line 38, delete "(7)" and insert "**(6)**".

Page 3, line 23, after "during the" insert "**current**".

Page 3, delete lines 24 through 26, begin a new line block indented and insert:

"**(1) the insured received coverage for the drug during the current plan year;**".

Page 3, delete lines 34 through 35, begin a new line block indented and insert:

"**(2) Changing:**

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the insured's out-of-pocket costs for

a drug.".

Page 3, line 36, delete "(4)" and insert "**(3)**".

Page 3, line 38, delete "(5)" and insert "**(4)**".

Page 3, line 40, delete "(6)" and insert "**(5)**".

Page 4, line 7, delete "(7)" and insert "**(6)**".

Page 4, line 27, after "during the" insert "**current**".

Page 4, delete lines 29 through 31, begin a new line block indented and insert:

"**(1) the enrollee received coverage for the drug during the current plan year;**".

Page 4, delete lines 39 through 40, begin a new line block indented and insert:

"**(2) Changing:**

(A) a copayment amount;

(B) a coinsurance rate;

(C) prescription drug cost sharing minimum or maximum amounts;

(D) a deductible; or

(E) a prescription drug maximum out-of-pocket amount in a manner as to raise the enrollee's out-of-pocket costs for a drug.".

Page 4, line 41, delete "(4)" and insert "**(3)**".

Page 5, line 1, delete "(5)" and insert "**(4)**".

Page 5, line 3, delete "(6)" and insert "**(5)**".

Page 5, line 12, delete "(7)" and insert "**(6)**".

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 97 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0.