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PRESCRIPTION DRUG COVERAGE AND FORMULARIES

2001 GENERAL SESSION

STATE OF UTAH

Sponsor: Peter C. Knudson

This act modifies the Insurance Code. This act establishes a minimum benefit for prescription drugs that are excluded from an insurance company's formulary and provides an effective date.

This act affects sections of Utah Code Annotated 1953 as follows:

ENACTS:

31A-22-631, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-631** is enacted to read:

31A-22-631. Minimum benefit coverage for nonformulary prescription drugs.

(1) As used in this section:

(a) "Comparable prescription drug" means a prescription drug that has the equivalent dosage and for which there is general consensus within the medical community that it treats the same medical condition as another prescription drug.

(b) "Necessary information" may include a medical opinion of the insured's physician.

(c) "Pay" means a direct payment to a vendor of a nonformulary prescription drug or a direct reimbursement to an insured who purchased a nonformulary prescription drug.

(2) This section applies generally to all health insurance policies and health maintenance organization contracts.

(3) Consistent with Subsection (4), an insurer who offers a prescription drug benefit may establish a formulary and may determine which prescription drugs to include on or exclude from the formulary.

(4) An insurer who establishes a formulary shall provide a minimum benefit for medically

necessary, federal Food and Drug Administration approved prescription drugs that are excluded from the formulary. The minimum benefit shall be:

(a) no less than 75% of the amount the insurer would have to pay under the policy or contract for the most common comparable prescription drug, not to exceed the benefit amount the insurer would have to pay if the prescription drug were included on the formulary; or

(b) the same amount the insurer would have to pay for the prescription drug under the terms of the policy or contract if the prescription drug were included on the formulary, provided that comparable prescription drugs on the insurer's formulary have:

(i) been ineffective in treating the insured's medical condition; or

(ii) have caused or are reasonably expected to cause an adverse or harmful reaction.

(5) An insured may make a claim for payment of a nonformulary prescription drug under Subsection (4)(a) or (b).

(6) An insurer shall pay a claim submitted under Subsection (4)(a) within 30 days of receiving the necessary information to process the claim.

(7) (a) An insurer shall pay or deny a claim submitted under Subsection (4)(b) within 30 days of receiving the necessary information to process the claim.

(b) If an insurer denies a claim under Subsection (4)(b), the insurer shall:

(i) pay an amount equal to the 75% benefit required by Subsection (4)(a) within the same 30 days in Subsection (7)(a); and

(ii) resolve the amount claimed in excess of the 75% benefit required by Subsection (4)(a) in accordance with the insurer's grievance process.

(8) An insurer shall include an explanation of this section in the written materials it is required to give an enrollee, prior to enrollment, on prescription drug coverage and limitations under Subsection 31A-22-613.5(9).

(9) The commissioner shall encourage and work with insurers to make formulary information available on the Internet.

Section 2. **Effective date.**

This act takes effect on July 1, 2001.

Legislative Review Note
as of 2-13-01 9:18 AM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel