HOUSE BILL 680

Short Title:	Improved Access to SMI Prescription Drugs.	(Public)
Sponsors:	Representatives K. Baker, Sasser, Reeder, and White (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Insurance, if favorable, Rules, Calendar, and Operations of the House	

April 19, 2023

A BILL TO BE ENTITLED

AN ACT TO IMPROVE ACCESS TO PRESCRIPTION MEDICATIONS USED IN THE TREATMENT AND PREVENTION OF SEVERE MENTAL ILLNESS IN ORDER TO ACHIEVE BETTER OUTCOMES FOR PATIENTS WITH SEVERE MENTAL ILLNESS IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-3-221 reads as rewritten:

"**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) The following definitions apply in this section:

(1) Closed formulary. – A list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(2) Enrollee. – An individual who is eligible to receive benefits from the health benefit plan.

(3) Reserved for future codification purposes.

(4) Restricted access drug or device. – A covered prescription drug or device for which reimbursement by the insurer is conditioned upon the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(5) Serious mental illness. – Any of the following mental disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

a. Bipolar disorders, hypomanic, manic, depressive, and mixed.

b. Major depressive disorders, single episode or recurrent.

c. Obsessive-compulsive disorder.

d. Paranoid personality disorder and other psychotic disorders.

e. Schizo-affective disorders, bipolar or depressive.

f. Schizophrenia.

(a1) If an insurer (i) maintains one or more closed formularies ~~for~~ for, or restricts access ~~to~~ to, covered prescription drugs or devices or (ii) requires an enrollee in a plan with an open or closed formulary to use a prescription ~~drug~~ drug, or sequence of prescription drugs, other than the drug the enrollee's health care provider recommends, before the insurer provides coverage for the recommended prescription drug, then the insurer shall do all of the following:

…

(4) ~~An insurer, or a pharmacy benefits manager under contract with an insurer, shall require~~ Require that its pharmacy and therapeutics committee either meet the requirements for conflict of interest set by the Center for Medicare and Medicaid Services or meet the accreditation standards of the National Committee for Quality Assurance or another independent accrediting organization.

…

(b1) Exception Process. – Each insurer shall establish and maintain an expeditious process or procedure, published on either the insurer's ~~Web site~~ website or in policies provided to health care providers, that allows an ~~enrollee~~ enrollee, or the enrollee's prescribing provider acting on behalf of the ~~enrollee~~ enrollee, to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, either coverage for a specific nonformulary drug or device or the drug requested by the prescribing provider, if it is determined to be medically necessary and appropriate by the enrollee's prescribing provider and the prescription drug is covered under the current health benefit plan. The following provisions shall apply:

…

(b3) Exception Process Requirements. – All of the following shall apply to an insurer's exception process:

…

(3) For nonurgent exception requests for a prospective or concurrent ~~review:~~review, the following shall apply:

a. The insurer shall communicate to the enrollee's health care provider if additional information is required within 72 hours after the insurer receives the exception request.

b. The insurer shall communicate an exception request determination to the enrollee's providers within 72 hours after receiving all relevant information.

(4) In the case of an urgent ~~review:~~review, the following shall apply:

a. The insurer shall communicate to the enrollee's health care provider if additional information is required within 24 hours after the insurer receives the exception request.

b. The insurer shall communicate an exception request determination to the enrollee's providers within 24 hours after receiving all relevant information.

(b4) If an enrollee is age 18 or older and is prescribed a drug that is recommended by their health care provider for the prevention or treatment of a serious mental illness, then the insurer shall not require any of the following:

(1) Prior authorization of the prescribed drug.

(2) The use of a prescription drug, or a sequence of prescription drugs, other than the drug the enrollee's health care provider has recommended.

~~(c) As used in this section:~~

~~(1) "Closed formulary" means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.~~

~~(1a) "Health benefit plan" has definition provided in G.S. 58-3-167.~~

~~(2) "Insurer" has the meaning provided in G.S. 58-3-167.~~

~~(3) "Restricted access drug or device" means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.~~

…

(e) ~~This~~ With the exception of the restrictions imposed under subsection (b4) of this section, this section shall not be construed to prevent the health benefit plan from requiring an enrollee to try an A-rated generic equivalent drug, or a biosimilar, as defined under 42 U.S.C. § 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(f) This section shall also apply to a pharmacy benefits manager under contract with an insurer."

SECTION 1.(b) This section becomes effective October 1, 2023, and applies to insurance contracts issued, renewed, or amended on or after that date.

SECTION 2. G.S. 108A-68.1 reads as rewritten:

"**§ 108A-68.1. Certain prescription drugs exempt from prior authorization requirements.**

(a) Prior authorization shall not be required or utilized under the Medicaid program for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.

(b) No Medicaid beneficiary may be required to try a different prescription medication used to treat schizophrenia prior to the approval of coverage for any antipsychotic injectable drug prescribed for the treatment of schizophrenia.

(c) A Medicaid beneficiary may not be required to try a different prescription medication used to treat severe mental illness prior to the approval of coverage for a medication prescribed to the beneficiary for that severe mental illness, a practice known as step therapy, if all of the following conditions are met:

(1) The medication is prescribed by a licensed healthcare provider for the treatment of any of the following mental disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

a. Bipolar disorders, hypomanic, manic, depressive, and mixed.
b. Major depressive disorders, single episode or recurrent.
c. Obsessive-compulsive disorder.
d. Paranoid personality disorder and other psychotic disorders.
e. Schizo-affective disorders, bipolar or depressive.
f. Schizophrenia.

(2) During the preceding calendar year, even if not while the beneficiary is receiving benefits under the Medicaid program, either of the following applied:

a. The beneficiary was prescribed and unsuccessfully treated with a prescription medication that is designated as a preferred drug under any Medicaid prescription drug formulary, whether that preferred drug is a brand or generic drug.
b. The beneficiary was previously prescribed and had obtained prior authorization for the specific medication prescribed.

(d) Nothing in this section shall prohibit the Secretary from implementing a disease management program."

SECTION 3. Except as otherwise provided, this act is effective when it becomes law.