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HOUSE BILL 960

By Terry

AN ACT to amend Tennessee Code Annotated, Title 56, relative to limiting changes to commercial health insurers' prescription drug formularies during the health plan year.

WHEREAS, consumers rely on information presented by commercial health insurers at the time of open enrollment to choose a plan with formulary coverage and cost-sharing information that corresponds to their needs for the health plan year; and

WHEREAS, current law in Tennessee does not protect consumers from commercial health insurers making significant changes to the prescription drug benefit during the health plan year at a time when consumers are not able to switch to an alternate health plan; and

WHEREAS, commercial health insurer practices of making changes to formulary coverage and cost-sharing for medications during the health plan year is becoming increasingly common; and

WHEREAS, these types of health coverage changes can make existing, effective medications financially inaccessible for consumers, forcing them to switch to different medications that may be significantly less effective or even harmful; and

WHEREAS, studies show switching medications without regard to clinical implications, particularly in patients with chronic conditions, can have serious health consequences, including new or increased side effects, new or increased symptoms, allergic reactions or relapse; thus increasing overall health care costs due to additional medical visits, emergency room visits, and even hospitalization; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) As used in this section, "health plan year" means the "plan year" as defined in 45 C.F.R. § 144.103.

(b) Outside of open enrollment periods, a health insurance entity providing health insurance coverage, as those terms are defined in § 56-7-109, and providing coverage for prescription drugs shall not:

(1) Remove any covered prescription drug from its list of covered drugs during the health plan year unless the United States food and drug administration has issued a statement about the drug that calls into question the clinical safety of the drug, or the manufacturer of the drug has notified the United States food and drug administration of any manufacturing discontinuance or potential discontinuance as required by § 506C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 356c);

(2) Reclassify a drug to a more restrictive drug tier or move a drug to a higher cost-sharing tier; or

(3) Reduce the maximum coverage of prescription drug benefits.

(c) This section does not prohibit the addition of prescription drugs to a policy's list of covered drugs during the health plan year.

(d) This section does not apply to a grandfathered health plan as defined in § 1251 of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended, and § 2301 of the federal Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), as amended, both compiled in 42 U.S.C. § 18011.

(e) Notwithstanding § 56-7-1005, nothing in this section applies to the TennCare program or any successor medical assistance program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance and administration division of the department of finance and

administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27.

(f) This section does not apply to § 53-10-204.

SECTION 2. This act shall take effect January 1, 2018, the public welfare requiring it, and shall apply to all contracts providing health insurance coverage that are entered into or renewed on or after that date.