SENATE BILL 11

53RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2018

INTRODUCED BY

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AN ACT

RELATING TO HEALTH COVERAGE; ENACTING NEW SECTIONS OF THE

HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT, THE NEW

MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW

AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH GUIDELINES

RELATING TO STEP THERAPY FOR PRESCRIPTION DRUG COVERAGE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--STEP THERAPY

PROTOCOLS--CLINICAL REVIEW CRITERIA--EXCEPTIONS.--

A. Group health coverage, including any form of

self-insurance, offered, issued or renewed under the Health

Care Purchasing Act that provides coverage for prescription

drugs for which any step therapy protocols are required shall

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establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with group health plan administrators, insurers, health maintenance organizations, health care plans, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest;

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:
(a) minimizes bias and conflicts of interest;
(b) explains the relationship between treatment options and outcomes;
(c) rates the quality of the evidence supporting recommendations; and
(d) considers relevant patient subgroups and preferences; and
(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a group health plan restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, an enrollee and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A group health plan may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible for enrollees and practitioners on the group health plan's publicly accessible website.

D. A group health plan shall expeditiously grant an exception to the group health plan's step therapy protocol if: 
(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the enrollee's current health coverage or previous health coverage, the enrollee has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;

(4) the prescription drug that is the subject of the exception request is not in the best interest of the patient, based on medical necessity; or

(5) while enrolled in the enrollee's current health coverage, the enrollee is stable, or while enrolled in the enrollee's previous health coverage, the enrollee was stable, on a prescription drug selected by the enrollee's practitioner for the medical condition under consideration.

E. Upon the granting of an exception to a group
health plan's step therapy protocol, the group health plan administrator shall authorize coverage for the prescription drug that is the subject of the exception request.

F. A group health plan shall respond to an enrollee's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a group health plan shall respond within twenty-four hours of receipt of the exception request. In the event the group health plan does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A group health plan administrator's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act.

H. The provisions of this section shall not be construed to prevent a:

(1) group health plan from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

I. The provisions of this section shall apply only
to a group health plan delivered, issued for delivery or
renewed on or after January 1, 2019.

J. As used in this section, "medically necessary"
means that a prescription drug is appropriate:

(1) to improve or preserve health, life or
function;

(2) to slow the deterioration of health, life
or function; or

(3) for the early screening, prevention,
evaluation, diagnosis or treatment of a disease, condition,
illness or injury."

SECTION 2. A new section of the Public Assistance Act is
enacted to read:

"[NEW MATERIAL] MEDICAL ASSISTANCE--PRESCRIPTION DRUG
COVERAGE--STEP THERAPY PROTOCOLS--CLINICAL REVIEW CRITERIA--
EXCEPTIONS.--

A. By January 1, 2019, the secretary shall require
any medical assistance plan for which any step therapy
protocols are required to establish clinical review criteria
for those step therapy protocols. The clinical review criteria
shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs
subject to step therapy protocols be taken in the specific
sequence required by the step therapy protocol;

(2) are developed and endorsed by an
interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with health care plans, medical assistance plans, health maintenance organizations, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest;

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups
and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a medical assistance plan restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, a recipient and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A medical assistance plan may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible for recipients and practitioners on the medical assistance plan's publicly accessible website.

D. A medical assistance plan shall expeditiously grant an exception to the medical assistance plan's step therapy protocol if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject
of the exception request is expected to be ineffective based on
the known clinical characteristics of the patient and the known
characteristics of the prescription drug regimen;

(3) while under the recipient's current
medical assistance plan, or under the recipient's previous
health coverage, the recipient has tried the prescription drug
that is the subject of the exception request or another
prescription drug in the same pharmacologic class or with the
same mechanism of action as the prescription drug that is the
subject of the exception request and that prescription drug was
discontinued due to lack of efficacy or effectiveness,
diminished effect or an adverse event;

(4) the prescription drug that is the subject
of the exception request is not in the best interest of the
patient, based on medical necessity; or

(5) while enrolled in the recipient's current
medical assistance plan, the recipient is stable, or while
enrolled in the recipient's previous health coverage, the
recipient was stable, on a prescription drug selected by the
recipient's practitioner for the medical condition under
consideration.

E. Upon the granting of an exception to a medical
assistance plan's step therapy protocol, a medical assistance
plan shall authorize coverage for the prescription drug that is
the subject of the exception request.
F. A medical assistance plan shall respond to a recipient's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a medical assistance plan shall respond within twenty-four hours of receipt of the exception request. In the event the medical assistance plan does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A medical assistance plan's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to department rules.

H. The provisions of this section shall not be construed to prevent:

(1) a medical assistance plan from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

I. As used in this section, "medically necessary" means that a prescription drug is appropriate:

(1) to improve or preserve health, life or function;

(2) to slow the deterioration of health, life
or function; or

(3) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."

SECTION 3. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--STEP THERAPY
PROTOCOLS--CLINICAL REVIEW CRITERIA--EXCEPTIONS.---

A. Each individual health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with insurers, health maintenance organizations, health care plans, pharmacy benefits managers and any other entities; and 2) recuse themselves if
there is a conflict of interest;

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health insurance policy, health care plan

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or certificate of insurance restricts coverage of a
prescription drug for the treatment of any medical condition
through the use of a step therapy protocol, an insured and the
practitioner prescribing the prescription drug shall have
access to a clear, readily accessible and convenient process to
request a step therapy exception determination. An insurer may
use its existing medical exceptions process to satisfy this
requirement. The process shall be made easily accessible for
insureds and practitioners on the insurer's publicly accessible
website.

D. An insurer shall expeditiously grant an
exception to the health insurance policy's, health care plan's
or certificate of insurance's step therapy protocol if:

(1) the prescription drug that is the subject
of the exception request is contraindicated or will likely
cause an adverse reaction by or physical or mental harm to the
patient;

(2) the prescription drug that is the subject
of the exception request is expected to be ineffective based on
the known clinical characteristics of the patient and the known
characteristics of the prescription drug regimen;

(3) while under the insured's current health
insurance policy, health care plan or certificate of insurance,
or under the insured's previous health coverage, the insured
has tried the prescription drug that is the subject of the
exception request or another prescription drug in the same
pharmacologic class or with the same mechanism of action as the
prescription drug that is the subject of the exception request
and that prescription drug was discontinued due to lack of
efficacy or effectiveness, diminished effect or an adverse
event;

(4) the prescription drug that is the subject
of the exception request is not in the best interest of the
patient, based on medical necessity; or

(5) while enrolled in the insured's current
health insurance policy, health care plan or certificate of
insurance, the insured is stable, or while enrolled in the
insured's previous health coverage, the insured was stable, on
a prescription drug selected by the insured's practitioner for
the medical condition under consideration.

E. Upon the granting of an exception to a health
insurance policy's, health care plan's or certificate of
insurance's step therapy protocol, an insurer shall authorize
coverage for the prescription drug that is the subject of the
exception request.

F. An insurer shall respond to an insured's
exception request within seventy-two hours of receipt. In
cases where exigent circumstances exist, an insurer shall
respond within twenty-four hours of receipt of the exception
request. In the event the insurer does not respond to an
exception request within the time frames required pursuant to
this subsection, the exception request shall be granted.

G. An insurer's denial of a request for an
exception for step therapy protocols shall be subject to review
and appeal pursuant to the Patient Protection Act.

H. The provisions of this section shall not be
construed to prevent:

(1) a health insurance policy, health care
plan or certificate of insurance from requiring a patient to
ty a generic equivalent of a prescription drug before
providing coverage for the equivalent brand-name prescription
drug; or

(2) a practitioner from prescribing a
prescription drug that the practitioner has determined to be
medically necessary.

I. The provisions of this section shall apply only
to a health insurance policy, health care plan or certificate
of insurance delivered, issued for delivery or renewed on or
after January 1, 2019.

J. As used in this section, "medically necessary"
means that a prescription drug is appropriate:

(1) to improve or preserve health, life or
function;

(2) to slow the deterioration of health, life
or function; or

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(3) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."

SECTION 4. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--STEP THERAPY PROTOCOLS--CLINICAL REVIEW CRITERIA--EXCEPTIONS.--

A. Each group or blanket health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with insurers, health maintenance organizations, health care plans, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest;
(b) using analytical and methodological experts to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health insurance policy, health care plan or certificate of insurance restricts coverage of a
prescription drug for the treatment of any medical condition
through the use of a step therapy protocol, an insured and the
practitioner prescribing the prescription drug shall have
access to a clear, readily accessible and convenient process to
request a step therapy exception determination. An insurer may
use its existing medical exceptions process to satisfy this
requirement. The process shall be made easily accessible for
insureds and practitioners on the insurer's publicly accessible
website.

D. An insurer shall expeditiously grant an
exception to the health insurance policy's, health care plan's
or certificate of insurance's step therapy protocol if:

   (1) the prescription drug that is the subject
   of the exception request is contraindicated or will likely
   cause an adverse reaction by or physical or mental harm to the
   patient;

   (2) the prescription drug that is the subject
   of the exception request is expected to be ineffective based on
   the known clinical characteristics of the patient and the known
   characteristics of the prescription drug regimen;

   (3) while under the insured's current health
   insurance policy, health care plan or certificate of insurance,
or under the insured's previous health coverage, the insured
   has tried the prescription drug that is the subject of the
   exception request or another prescription drug in the same
pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;

(4) the prescription drug that is the subject of the exception request is not in the best interest of the patient, based on medical necessity; or

(5) while enrolled in the insured's current health insurance policy, health care plan or certificate of insurance, the insured is stable, or while enrolled in the insured's previous health coverage, the insured was stable, on a prescription drug selected by the insured's practitioner for the medical condition under consideration.

E. Upon the granting of an exception to a health insurance policy, health care plan or certificate of insurance's step therapy protocol, an insurer shall authorize coverage for the prescription drug that is the subject of the exception request.

F. An insurer shall respond to an insured's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, an insurer shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to .209069.3
this subsection, the exception request shall be granted.

G. An insurer's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act.

H. The provisions of this section shall not be construed to prevent:

(1) a health insurance policy, health care plan or certificate of insurance from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

I. The provisions of this section shall apply only to a health insurance policy, health care plan or certificate of insurance delivered, issued for delivery or renewed on or after January 1, 2019.

J. As used in this section, "medically necessary" means that a prescription drug is appropriate:

(1) to improve or preserve health, life or function;

(2) to slow the deterioration of health, life or function; or

(3) for the early screening, prevention,
evaluation, diagnosis or treatment of a disease, condition, illness or injury."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--STEP THERAPY PROTOCOLS--CLINICAL REVIEW CRITERIA--EXCEPTIONS.--

A. Each individual or group health maintenance organization contract delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with carriers, insurers, health care plans, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest;

(b) using analytical and methodological
experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health maintenance organization contract restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy
protocol, an enrollee and the practitioner prescribing the
description shall have access to a clear, ready
accessible and convenient process to request a step therapy
exception determination. A carrier may use its existing
medical exceptions process to satisfy this requirement. The
process shall be made easily accessible for enrollees and
practitioners on the carrier's publicly accessible website.

D. A carrier shall expeditiously grant an exception
to the health maintenance organization contract's step therapy
protocol if:

(1) the prescription drug that is the subject
of the exception request is contraindicated or will likely
cause an adverse reaction by or physical or mental harm to the
patient;

(2) the prescription drug that is the subject
of the exception request is expected to be ineffective based on
the known clinical characteristics of the patient and the known
characteristics of the prescription drug regimen;

(3) while under the enrollee's current health
maintenance organization contract, or under the enrollee's
previous health coverage, the enrollee has tried the
prescription drug that is the subject of the exception request
or another prescription drug in the same pharmacologic class or
with the same mechanism of action as the prescription drug that
is the subject of the exception request and that prescription

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drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;

(4) the prescription drug that is the subject of the exception request is not in the best interest of the patient, based on medical necessity; or

(5) while enrolled in the enrollee's current health maintenance organization contract, the enrollee is stable, or while enrolled in the enrollee's previous health coverage, the enrollee was stable, on a prescription drug selected by the enrollee's practitioner for the medical condition under consideration.

E. Upon the granting of an exception to a health maintenance organization contract's step therapy protocol, a carrier shall authorize coverage for the prescription drug that is the subject of the exception request.

F. A carrier shall respond to an enrollee's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a carrier shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A carrier's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act.
H. The provisions of this section shall not be construed to prevent:

(1) a health maintenance organization contract from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

I. The provisions of this section shall apply only to a health maintenance organization contract delivered, issued for delivery or renewed on or after January 1, 2019.

J. As used in this section, "medically necessary" means that a prescription drug is appropriate:

(1) to improve or preserve health, life or function;

(2) to slow the deterioration of health, life or function; or

(3) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--STEP THERAPY PROTOCOLS--CLINICAL REVIEW CRITERIA--EXCEPTIONS.--
A. Each individual or group nonprofit health care plan contract delivered or issued for delivery in this state that provides a prescription drug benefit for which any step therapy protocols are required shall establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with health care plans, insurers, health maintenance organizations, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest;

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(c) offering opportunities for public review and comment;

(3) are based on high-quality studies,
research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a health care plan restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, a subscriber and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A health care plan may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible for subscribers and practitioners on the health care plan's

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publicly accessible website.

D. A health care plan shall expeditiously grant an exception to the health care plan's step therapy protocol if:

   (1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

   (2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

   (3) while under the subscriber's current health care plan, or under the subscriber's previous health coverage, the subscriber has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;

   (4) the prescription drug that is the subject of the exception request is not in the best interest of the patient, based on medical necessity; or

   (5) while enrolled in the subscriber's current health care plan, the subscriber is stable, or while enrolled
in the subscriber's previous health coverage, the subscriber was stable, on a prescription drug selected by the subscriber's practitioner for the medical condition under consideration.

E. Upon the granting of an exception to a health care plan's step therapy protocol, a health care plan shall authorize coverage for the prescription drug that is the subject of the exception request.

F. A health care plan shall respond to a subscriber's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a health care plan shall respond within twenty-four hours of receipt of the exception request. In the event the insurer does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A health care plan's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act.

H. The provisions of this section shall not be construed to prevent:

(1) a health care plan from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a
prescription drug that the practitioner has determined to be medically necessary.

I. The provisions of this section shall apply only to a health care plan delivered, issued for delivery or renewed on or after January 1, 2019.

J. As used in this section, "medically necessary" means that a prescription drug is appropriate:
   
   (1) to improve or preserve health, life or function;
   
   (2) to slow the deterioration of health, life or function; or
   
   (3) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."