The People of the State of New York, represented in Senate and Assembly, do enact the Consumer Prescription Drug Bill of Rights as follows:

Section 1. **Access to Appropriate Drugs at Reasonable Price, Formulary Exceptions, Standing Prior Authorizations** The insurance law is amended by adding a new section 4806 to read as follows:

(a) An insurer offering a prescription drug benefit with a formulary of approved or preferred drugs shall have a procedure by which it determines whether a formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an insured. If the insurer determines that no formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an insured, the insurer shall cover the cost of an off-formulary drug for that insured, at no additional cost to the insured beyond what the insured would otherwise pay for a preferred brand name drug on the formulary. The determinations whether a drug provides appropriate therapeutic benefits and whether a non-formulary drug is necessary to meet the particular health care needs of the insured are utilization review decisions and are reviewable in accordance with Article 49 of this Chapter, including External Appeal.

(b) Standing Prior Authorizations

(i) For purposes of this Section, "Prior authorization requirement" means any practice implemented by an insurer in which coverage of a prescription drug or device is dependent upon a covered person or a health care practitioner obtaining approval from the insurer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a drug or device.

(ii) An insurer which requires prior authorizations for particular prescription drugs shall have a procedure by which an insured who is being prescribed such drug for a chronic condition may obtain a standing prior authorization for drug for the lesser of the following from the date of the approval: (a) Twelve months; (b)

The last day of the covered person's eligibility under the policy or plan.

(iii) As a condition of such standing prior authorization, if according to the available medical and scientific evidence the patient's chronic condition is likely to change during the standing referral period, the insurer or health plan may require the prescribing health care practitioner to certify to the insurer, not more frequently than on a quarterly basis, that the patient's chronic condition has not changed materially with respect to the need for the prescription.

(iv) A twelve-month standing prior authorization provided under division (b)(ii) of this section does not apply to and is not required for any of the following:

Medications that have a typical course of administration of less than one year or for which available medical or scientific evidence does not support a twelve-month period of use, in which case the standing prior authorization period shall be the typical course of administration or the period of use supported by the available medical or scientific evidence;

Medications that require an initial trial period to determine effectiveness and tolerability, except that after such trial period a one-year, or greater, prior authorization period will be given;

Medications that are schedule II controlled substance or a schedule III controlled substance containing hydrocodone.

(v) For drugs used to treat acute conditions, insurers shall grant standing prior authorizations for the period that the medical and scientific evidence shows to be the anticipated period for the course of treatment to have its intended effect.

(vi) The standing prior authorizations provided for in this section are no longer valid and automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information finding that the drug in question is no longer approved or safe for the prescribed purpose.

(vii) If an AB-rated generic drug that is therapeutically equivalent to the drug subject to a standing prior authorization becomes available, the insurer may substitute such newly released drug for the drug subject to the standing prior authorization, provided advance notice is given to the insured .

(viii)

(ix) The determination whether the drug is being prescribed to treat a chronic condition and the period over which the course of treatment for an acute condition is anticipated to have its intended effect are utilization review decisions and are reviewable in accordance with Article 49 of this Chapter, including External Appeal.

(c) Transitional Coverage for Formulary Changes:

(i) If a formulary drug being prescribed for an insured is removed by the insurer from its formulary for reasons other than a determination that the approval for the use of that drug has been withdrawn by the U.S. Food and Drug Administration, the insurer shall continue to cover that drug for that insured for a transitional period to the end of the plan year at the same copayment as charged when the drug was on formulary. Thereafter, the insured may seek continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

(ii) If a formulary drug being prescribed for an insured is moved by the insurer to a higher cost sharing tier in its formulary for reasons other than release of an AB-rated generic drug, the insurer shall continue to cover that drug for that insured for a transitional period to the end of the plan year at the same copayment as charged when the drug was on formulary. Thereafter, the insured may seek continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

(iii) If an insurer that provides prescription drug coverage enrolls a new insured who is currently being prescribed a drug for a chronic health

condition, or as part of an ongoing course of treatment for an acute condition, and that drug is not on the insurer's formulary, the insurer shall cover that drug for that insured at no additional cost to the insured beyond what the insured would otherwise pay for a preferred brand name drug on the formulary, for a transitional period of ninety (90) days from the effective date of enrollment. The insured must adhere to the insurer's quality assurance requirements and provide to the insurer necessary medical information related to the prescription and otherwise adhere to the insurer's policies and procedures including, but not limited to procedures regarding obtaining pre-authorization and a treatment plan approved by the insurer. In no event shall this subsection be construed to require an insurer to provide coverage for benefits not otherwise covered. The transitional period does not preclude the insured from seeking continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

Section 2. **Access to Appropriate Drugs at Reasonable Price, Formulary Exceptions, Standing Prior Authorizations** The Public Health Law is amended to add new section 4406-H

(d) A health maintenance organization offering a prescription drug benefit with a formulary of approved or preferred drugs shall have a procedure by which it determines whether a formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an enrollee. If the health maintenance organization determines that no formulary drug provides appropriate therapeutic benefits to meet the particular health care needs of an enrollee, the health maintenance organization shall cover the cost of an off-formulary drug for that enrollee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for a preferred brand name drug on the formulary. The determinations whether a drug provides appropriate therapeutic benefits and whether a non-formulary drug is necessary to meet the particular health care needs of the insured are utilization review decisions and are reviewable in accordance with Article 49 of this Chapter, including External Appeal.

(e) Standing Prior Authorizations

(x) For purposes of this Section, “Prior authorization requirement” means any practice implemented by a health maintenance organization in which coverage of a prescription drug or device is dependent upon a covered person or a health care practitioner obtaining approval from the health maintenance prior to the service, device, or drug being performed, received, or prescribed, as applicable. “Prior authorization” includes prospective or utilization review procedures conducted prior to providing a drug or device.

(xi) A health maintenance organization which requires prior authorizations for particular prescription drugs shall have a procedure by which an enrollee who is being prescribed such drug for a chronic condition may obtain a standing prior authorization for drug for the lesser of the following from the date of the approval: (a) Twelve months; (b) The last day of the enrollee’s eligibility under the policy or plan.

(xii) As a condition of such standing prior authorization, if according to the available medical and scientific evidence the enrollee’s chronic condition is likely to change during the standing referral period, the insurer or health plan may require the prescribing health care practitioner to certify to the health maintenance organization, not more frequently than on a quarterly basis, that the enrollee’s chronic condition has not changed materially with respect to the need for the prescription.

(xiii) A twelve-month standing prior authorization provided under division (b)(ii) of this section does not apply to and is not required for any of the following:

Medications that have a typical course of administration of less than one year or for which available medical or scientific evidence does not support a twelve-month period of use, in which case the standing prior authorization period shall be the typical course of administration or the period of use supported by the available medical or scientific evidence;

Medications that require an initial trial period to determine effectiveness and tolerability, except that after such trial period a one-year, or greater, prior authorization period will be given;

Medications that are schedule II controlled substance or a schedule III controlled substance containing hydrocodone.

(xiv) For drugs used to treat acute conditions, insurers shall grant standing prior authorizations for the period that the medical and scientific evidence shows to be the anticipated period for the course of treatment to have its intended effect.

(xv) The standing prior authorizations provided for in this section are no longer valid and automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information finding that the drug in question is no longer approved or safe for the prescribed purpose.

(xvi) If an AB-rated generic drug that is therapeutically equivalent to the drug subject to a standing prior authorization becomes available, the health maintenance organization may substitute such newly released drug for the drug subject to the standing prior authorization, provided advance notice is given to the enrollee.

(xvii)

(xviii) The determination whether the drug is being prescribed to treat a chronic condition and the period over which the course of treatment for an acute condition is anticipated to have its intended effect are utilization review decisions and are reviewable in accordance with Article 49 of this Chapter, including External Appeal.

(f) Transitional Coverage for Formulary Changes:

(j) If a formulary drug being prescribed for an enrollee is removed by the health maintenance organization from its formulary for reasons other than a determination that the approval for the use of that drug has been withdrawn by the U.S. Food and Drug Administration, the health maintenance organization shall continue to cover that drug

for that enrollee for a transitional period to the end of the plan year at the same copayment as charged when the drug was on formulary. Thereafter, the enrollee may seek continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

(ii) If a formulary drug being prescribed for an insured is moved by the health maintenance organization to a higher cost sharing tier in its formulary for reasons other than release of an AB-rated generic drug, the health maintenance organization shall continue to cover that drug for that enrollee for a transitional period to the end of the plan year at the same copayment as charged when the drug was on formulary. Thereafter, the enrollee may seek continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

(iii) If a health maintenance organization that provides prescription drug coverage enrolls a new enrollee who is currently being prescribed a drug for a chronic health condition, or as part of an ongoing course of treatment for an acute condition, and that drug is not on the health maintenance organization's formulary, the health maintenance organization shall cover that drug for that enrollee at no additional cost to the enrollee beyond what the enrollee would otherwise pay for a preferred brand name drug on the formulary, for a transitional period of ninety (90) days from the effective date of enrollment. The enrollee must adhere to the health maintenance organization's quality assurance requirements and provide to the health maintenance organization necessary medical information related to the prescription and otherwise adhere to the health maintenance organization's policies and procedures including, but not limited to procedures regarding obtaining pre-authorization and a treatment plan approved by the health maintenance organization. In no event shall this subsection be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered. The transitional period does not preclude the enrollee from seeking continued coverage of the drug, if appropriate, pursuant to the provisions of subsection (a) of this section.

Section 3. **Publication of Prior Authorization requirements**

Section 4903 of the Insurance Law is amended to add a new subsection (i) as follows:

(i) Health plans shall make available to all participating health care providers on their web sites or provider portals a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

(ii) Health plans shall make available on their web sites information about the policies, contracts, or agreements offered by them that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(iii) Health plans shall give thirty (30) days advance written notice to participating providers of any changes in prior authorization requirements. Health plans shall also give thirty (30) days advance written notice to plan participants of any changes in prior authorization requirements with respect to any services, drugs or devices which such participant is currently being prescribed or has been prescribed in the preceding year.

Section 4. **Publication of Prior Authorization Requirements**

Section 4903 of the Public Health Law is amended to add a new subsection (9) as follows:

a. Health plans shall make available to all participating health care providers on their web sites or provider portals a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

b. Health plans shall make available on their web sites information about the policies, contracts, or agreements offered by them that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

c. Health plans shall give thirty (30) days advance written notice to participating providers of any changes in prior authorization requirements. Health plans shall also give thirty (30) days advance written notice to plan participants of any changes in prior authorization requirements with respect to any services, drugs or devices which such participant is currently being prescribed or has been prescribed in the preceding year.

Section 5. **Off-Formulary Drug Appeals** Section 4910(b) of the Insurance Law is amended to add a new subsection (5) as follows:

(5)

(A) The insured has had a drug prescription denied on the ground that it is not on the health care plan's formulary, and that the health care plan has a covered drug on the formulary which is effective to meet the particular health care needs of an insured, and,

(B) The insured's attending physician, who shall be a licensed physician or other health care provider qualified to prescribe drugs to treat the insured for the health service sought, certifies that available formulary drugs are not sufficiently effective to meet the insured's health needs, or are otherwise contraindicated for the insured, and recommends an off-formulary drug that will be effective to treat the insured

Section 6. Off-Formulary Drug Appeals Section 4910 (2) of the Public Health Law is amended to add a new subsection (e) to read as follows:

(e) A) The enrollee has had a drug prescription denied on the ground that it is not on the health maintenance organization's formulary, and that the health maintenance organization has a covered drug on the formulary which is effective to meet the particular health care needs of an enrollee, and,

(B) The enrollee's attending physician, who shall be a licensed physician or other health care provider qualified to prescribe drugs to treat the insured for the health

service sought, certifies that available formulary drugs are not sufficiently effective to meet the enrollee's health needs, or are otherwise contraindicated for the enrollee, and recommends an off-formulary drug that will be effective to treat the enrollee.

Section 7. **Off-Formulary Drug Appeals**. Section 4914(b)(4) of the Insurance Law is amended by adding a new subsection (D) as follows:

(D) For external appeals requested pursuant to paragraph five of subsection (b) of section four thousand nine hundred ten of this title relating to an off-formulary drug denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the non-formulary drug shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(I) that the off formulary drug prescription shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the available medical and scientific evidence, the formulary drug deemed sufficient by the health plan will not be as effective in addressing the insured's health problem for which a drug has been prescribed as the off-formulary drug prescribed by the treating physician or otherwise be appropriate to meet the particular health care needs of the insured, which is more likely to provide a beneficial clinical outcome; or

(II) upholding the health plan's denial of coverage.

Section 8. Off-Formulary Drug Appeals. Section 4914 (2) of the Public Health Law is amended by adding new subdivision (e) to read as follows:

(e) For external appeals requested pursuant to subdivision (e) of subsection (2) of section four thousand nine hundred ten of this title relating to an off-formulary drug denial, the external appeal agent shall review the utilization review agent's

final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the non-formulary drug shall be covered by the health maintenance organization; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(I) that the off formulary drug prescription shall be covered by the health maintenance organization either when the reviewer or a majority of the panel of reviewers determines, upon review of the available medical and scientific evidence, the formulary drug deemed sufficient by the health maintenance organization will not be as effective in addressing the enrollee's health problem for which a drug has been prescribed as the off-formulary drug prescribed by the treating physician or otherwise be appropriate to meet the particular health care needs of the enrollee, which is more likely to provide a beneficial clinical outcome; or

(II) upholding the health maintenance organization's denial of coverage;

Section 9 **Access to Retail Pharmacies** The opening paragraph of paragraph 28 of subsection (i) of section 3216 of the insurance law, as added by chapter 589 of the laws of 2011, is designated subparagraph (A) and a new subparagraph (B) is added to read as follows:

(B) Notwithstanding any other provision of this paragraph, if a prescriber, after consulting with the insurer regarding the appropriateness of mail order delivery given: (i) the residence or delivery location of the insured; (ii) the medical condition of the insured; (iii) the storage requirements of the drug; (iv) the availability of the insured to receive the prescription; or (v) the insured's ability to comprehend pharmaceutical guidance and support over the telephone, determines that a drug as prescribed on an individual basis is most appropriately filled at a retail location, provided that an in-network retail pharmacy of the patient's choosing agrees to the same reimbursement amount and is able to fill the prescription, the prescriber's determination shall be final.

Section 10. **Access to Retail Pharmacies** The opening paragraph of paragraph 18 of subsection (1) of section 3221 of the insurance law is designated subparagraph (A) and a new subparagraph (B) is added to read as follows:

(B) Notwithstanding any other provision of this paragraph, if a prescriber, after consulting with the insurer regarding the appropriateness of mail order delivery given: (i) the residence or delivery location of the insured; (ii) the medical condition of the insured; (iii) the storage requirements of the drug; (iv) the availability of the insured to receive the prescription; or (v) the insured's ability to comprehend pharmaceutical guidance and support over the telephone, determines that a drug as prescribed on an individual basis is most appropriately filled at a retail location, provided that an in-network retail pharmacy of the patient's choosing agrees to the same reimbursement amount and is able to fill the prescription, the prescriber's determination shall be final.

Section 11. **Access to Retail Pharmacies.** The opening paragraph of subsection (kk) of section 4303 of the insurance law is designated paragraph 1 and a new paragraph 2 is added to read as follows:

(2) Notwithstanding any other provision of this subsection, if a prescriber, after consulting with the insurer regarding the appropriateness of mail order delivery given: (A) the residence or delivery location of the covered person; (B) the medical condition of the covered person; (C) the storage requirements of the drug; (D) the availability of the covered person to receive the prescription; or (E) the covered person's ability to comprehend pharmaceutical guidance and support over the telephone, determines that a drug as prescribed on an individual basis is most appropriately filled at a retail location, provided that an in-network retail pharmacy of the patient's choosing agrees to the same reimbursement amount and is able to fill the prescription, the prescriber's determination shall be final.

Section 12. **Prescription synchronization**. The insurance law is amended by adding a new section 3224-d to read as follows:

§ 3224-d. (a) Every individual or group health insurance policy providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily pro-rated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among

the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

(i) The medications are covered by the policy or plan.

(ii) The medications are used for treatment and management of chronic conditions that are subject to refills.

(iii) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(iv) The medications meet all prior authorization criteria specific to medications at the time of the synchronization request.

(v) The medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(vi) The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) No individual or group health insurance policy providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every individual or group health insurance policy must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this paragraph shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(i) The prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(ii) The prescriber prescribes a different drug.

§ 13. **Prescription synchronization**. The insurance law is amended by adding a new section 4303-a to read as follows:

§ 4303-a.

(a) Every hospital service corporation and health service corporation providing prescription drug coverage when applicable to permit synchronization shall permit and apply a daily pro-rated cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a thirty day supply, when it is agreed among the covered individual, a health care practitioner, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered individual for the management or treatment of that chronic illness provided that all of the following apply:

(i) The medications are covered by the policy or plan.

(ii) The medications are used for treatment and management of chronic conditions that are subject to refills.

(iii) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(iv) The medications meet all prior authorization criteria specific to medications at the time of the synchronization request.

(v) The medications are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(vi) The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) No hospital service corporation or health service corporation providing prescription drug coverage shall deny coverage for the dispensing of a medication for partial fill when it is for purposes of synchronizing the patient's medications. When applicable to permit synchronization, every hospital service corporation or health service corporation providing prescription drug coverage must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(c) Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any pro-rated copay for the beneficiary or fee paid for alignment services.

(d) Nothing in this section shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

(e) The requirements of this paragraph shall apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(i) The prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(ii) The prescriber prescribes a different drug.

Section 14. **Prescription Drug Synchronization.** Subdivision 9 of section 367-a of the social services law is amended by adding a new paragraph (i) to read as follows:

(i)(i) The department of health shall establish a program for synchronization of medications when it is agreed among the recipient, a provider and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the patient for the management or treatment of a chronic illness provided that the medications:

(A) are covered by the department of health pursuant to this title;

(B) are used for treatment and management of chronic conditions that are subject to refills;

(C) are not a schedule II controlled substance or a schedule III controlled substance containing hydrocodone;

(D) meet all prior authorization criteria specific to the medications at the time of the synchronization request;

(E) are of a formulation that can be effectively split over required short fill periods to achieve synchronization; and

(F) do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(ii) The department of health shall not deny coverage for the dispensing of a medication by a network pharmacy for a partial supply when it is for the purpose of synchronizing the patient's medications. When applicable to permit synchronization, the department of health shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(iii) To permit synchronization, the department of health shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to this section.

(iv) The dispensing fee paid to a network pharmacy contracted to provide services pursuant to this section for a partial supply associated with a medication synchronization shall be paid in full and shall not be prorated.

(v) The requirement of this paragraph applies only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(I) the prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(II) the prescriber prescribes a different drug.

(vi) Nothing in this paragraph shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a recipient.

§ 15. **Prescription Drug Synchronization.** Subdivision 4 of section 364-j of the social services law is amended by adding a new paragraph (w) to read as follows:

(w)(i) The department of health or a managed care organization contracted to provide services pursuant to this section shall establish a program for synchronization of medications when it is agreed among the recipient, a provider and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the patient for the management or treatment of a chronic illness provided that the medications:

(A) are covered by Medicaid services or a managed care organization contracted to provide services pursuant to this chapter;

(B) are used for treatment and management of chronic conditions that are subject to refills;

(C) are not a schedule II controlled substance or a schedule III controlled substance containing hydrocodone;

(D) meet all prior authorization criteria specific to the medications at the time of the synchronization request;

(E) are of a formulation that can be effectively split over required short fill periods to achieve synchronization; and

(F) do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(ii) The department of health or a managed care organization contracted to provide services under this section shall not deny coverage for the dispensing of a medication by a network pharmacy for a partial supply when it is for the purpose of synchronizing the patient's medications. When applicable to permit synchronization, the department of health or a managed care organization contracted to provide services under this title shall allow a pharmacy to override any denial code indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

(iii) To permit synchronization, the department of health or a managed care organization contracted to provide services pursuant to this title shall apply a

prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to this section.

(iv) The dispensing fee paid to a network pharmacy contracted to provide services pursuant to this section for a partial supply associated with a medication synchronization shall be paid in full and shall not be prorated.

(v) The requirement of this paragraph applies only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(A) the prescriber changes the dosage or frequency of administration of the prescription drug subject to a medication synchronization; or

(B) the prescriber prescribes a different drug.

(vi) Nothing in this paragraph shall be deemed to require health care practitioners and pharmacists to synchronize the refilling of multiple prescriptions for a covered individual.

Section 16: **Pharmacy Benefit Management**

Section 280-a of the public health law is amended by adding two new subdivisions 3 and 4 to read as follows:

3. No pharmacy benefit manager shall, with respect to contracts between such pharmacy benefit manager and a pharmacy or, alternatively, such pharmacy benefit manager and a pharmacy's contracting agent, such as a pharmacy services administrative organization:

(a) prohibit or penalize a pharmacist or pharmacy from disclosing to an individual purchasing a prescription medication information regarding:

(1) the cost of the prescription medication to the individual, or

(2) the availability of any therapeutically equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price; or

(b) charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy paid. If an individual pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not redact or recoup the adjudicated cost.

4. Any provision of a contract that violates the provisions of this section shall be deemed to be void and unenforceable.

Section 17: **Limits on Patient Drug Costs, Explanations of Benefits** Subsection (h) of section 4325 of the insurance law, as added by chapter 487 of the laws of 2010, is amended to read as follows:

(h) (i)No corporation or insurer organized or licensed under this chapter which provides coverage for prescription drugs shall require, or enter into a contract which permits, a copayment which exceeds the usual and customary cost of such prescribed drug or which exceeds the total price paid to the pharmacy for such prescribed drug after the insured has met the annual deductible requirement.

(ii) In determining any coinsurance amount required to be paid for a prescription drug, no insurer or corporation organized under this chapter shall base its computation on a price higher than the actual price paid by the pharmacy for the drug, taking into account any rebates specific to the drug. The Department of Financial Services shall issue regulations setting forth the method each insurer or corporation organized under this chapter must use to determine the actual price paid.by the pharmacy.

iii) Each insurer or corporation licensed under this article which offers prescription drug coverage must itself or through its pharmacy benefit manager issue a written explanation of benefit form to its enrollees with respect to each prescription filled, containing all categories of information required of explanation of benefits forms for medical benefits.

Section 18. **Limits on Copayments** Section 6826-a of the education law is amended by adding a new subdivision 3 to read as follows:

3. The copayment amount shall not exceed the total price paid to the pharmacy for the prescribed drug, except in cases where the insured has not met the annual deductible requirement.

The copayment charged to a consumer for a prescription drug shall not exceed the amount which would be charged if the drug were purchased without insurance coverage.

Section 19: **Drug Substitutions.** Subdivision 6 of section 6810 of the education law is amended by adding a new paragraph (b-1) to read as follows:

(b-1) The prescriber or pharmacist shall inform the patient whether he or she has prescribed or substituted a different generic drug product from the generic drug product the patient has previously received.

Notification required pursuant to this paragraph shall be provided both written and orally, contemporaneously with the filling of the prescription.

Section 20: Paragraph (1) of subdivision (e) of section 3231 of the insurance law is amended by adding a new subparagraph (C) to read as follows:

(C) an insurer shall annually certify to the Department that, during the prior benefit year, the insurer made available to enrollees at the point of sale at least a majority (i.e., greater than 50 percent) of the Rebates.

(i) For purposes of this paragraph, “Rebate” means:

(1) Negotiated price concessions including but not limited to base rebates and reasonable estimates of any price protection rebates and performance-based rebates that may accrue directly or indirectly to the Issuer during the coverage year from a manufacturer, dispensing pharmacy, or other party to the transaction, and (2) Reasonable estimates of any fees and other administrative costs that are passed through to the Issuer and serve to reduce the Issuer’s prescription drug liabilities for the coverage year.

(ii) In providing the certification required under this Section, an Issuer shall not publish or otherwise reveal information regarding the actual amount of Rebates the Issuer received on a product-, manufacturer-, or pharmacy-specific basis. Such information is protected as a trade secret, is not a public record as defined in the Public Officers Law and shall not be disclosed directly or indirectly. An insurer shall impose the confidentiality protections of this Section on any third parties or vendors with which it contracts that may receive or have access to Rebate information.

Section 21: Subdivision (b) of section 3221 of the Insurance Law is amended by adding a new paragraph (1) to read as follows:

(b) No such policy shall be delivered or issued for delivery in this state unless a schedule of the premium rates pertaining to such form shall have been filed with the superintendent. …

(1) an insurer shall annually certify to the Department that, during the prior benefit year, the insurer made available to enrollees at the point of sale at least a majority (i.e., greater than 50 percent) of the Rebates.

(A) For purposes of this paragraph, "Rebate" means:

(i) Negotiated price concessions including but not limited to base rebates and reasonable estimates of any price protection rebates and performance-based rebates that may accrue directly or indirectly to the Issuer during the coverage year from a manufacturer, dispensing pharmacy, or other party to the transaction, and (ii.) Reasonable estimates of any fees and other administrative costs that are passed through to the Issuer and serve to reduce the Issuer's prescription drug liabilities for the coverage year.

(B) In providing the certification required under this Section, an Issuer shall not publish or otherwise reveal information regarding the actual amount of Rebates the Issuer received on a product-, manufacturer-, or pharmacy-specific basis. Such information is protected as a trade secret, is not a public record as defined in the Public Officers Law and shall not be disclosed directly or indirectly. An insurer shall impose the confidentiality protections of this Section on any third parties or vendors with which it contracts that may receive or have access to Rebate information.