

## **Bulletin 293**

### **DRUG BENEFITS IN STANDARD AND BASIC HEALTH PLANS**

Bureau of Insurance Rule 750 requires coverage of prescription drugs in Standard and Basic plans. Questions have arisen as to the extent to which coverage of certain drugs may be limited when less expensive alternatives are available. There are two ways in which such limitations may be applied.

1) For plans other than the Standard Indemnity plan, the 1998 amendments to the rule allow the use of a formulary for which a special copayment may be used, midway between the copay for other brand name drugs and the copay for generic drugs. This mid-level copayment is \$25 for the Basic plans and \$10 for the Standard HMO plan. This provision does not apply to the Standard Indemnity plan because that plan uses coinsurance percentages instead of fixed copayments.

2) Alternatively, if the plan includes utilization review procedures, as permitted by the rule, the plan may require prior approval before certain specified drugs may be prescribed, or before brand-name and/or non-formulary drugs may be prescribed for certain specified conditions. The prior approval may be based on evidence that it is medically inappropriate to substitute a lower-cost alternative. However, the utilization review procedure must comply with the requirements of Rule 850 and must be clearly disclosed to those applying for or covered by the plan.

July 7, 1999

---

Alessandro A. Iuppa  
Superintendent of Insurance

NOTE: This bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties or privileges nor is it intended to provide legal advice. Readers are encouraged to consult applicable statutes and regulations and to contact the Bureau of Insurance if additional information is needed.