HOUSE BILL 192

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

INTRODUCED BY

Gail Chasey

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PRESCRIPTION DRUGS; REQUIRING THAT INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS PERMIT LICENSED PHARMACISTS TO INITIATE THE PRIOR AUTHORIZATION PROCESS; MANDATING INSURERS TO COMPLY WITH TRANSPARENCY MEASURES; ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] REQUIREMENT FOR REIMBURSEMENT WHERE PHARMACISTS INITIATE PRIOR AUTHORIZATION.--

A. An individual or a group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in New Mexico that requires covered individuals to obtain prior authorization

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[~~bracketed material~~] = delete

before making reimbursement for a prescription shall permit any pharmacist licensed pursuant to the Pharmacy Act to initiate the prior authorization process.

B. An insurer shall notify a person requesting prior authorization on behalf of a covered individual of its determination regarding the prior authorization as expeditiously as the insured individual's health condition requires, but no later than twenty-four hours after receipt of the request. When an insurer fails to inform the person requesting prior authorization within twenty-four hours, the prior authorization shall be deemed to have been granted.

C. Prior authorization request forms and information regarding the procedure for submission and determination of prior authorization requests shall be prominently available on the insurer's web site in font no smaller than twelve-point Times New Roman and available to prescribers and pharmacists upon request in written form pursuant to rules promulgated by the superintendent. In the event an insurer fails to supply this information online and make it accessible from its main web site, a thirty-day supply of the prescription for which prior authorization is sought shall automatically be covered by the insurer."

Section 2. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] AVAILABILITY OF FORMULARY INFORMATION.--An

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insurer that limits covered drugs to those listed on a formulary shall make information about each plan's formulary available prominently on its web site in font no smaller than twelve-point Times New Roman and, by request, in writing pursuant to rules promulgated by the superintendent. Information about the plan's formulary made available pursuant to this section shall include:

A. a list of drugs included on the formulary;

B. the manner in which the formulary functions, including any tiered cost-sharing structure and utilization management procedures;

C. the process for obtaining an exception to a plan's formulary or tiered cost-sharing structure;

D. a description of how a covered individual may obtain additional information regarding the formulary;

E. information regarding the pharmacies, by geographic location, from which a covered individual may obtain drugs covered by the insurer; and

F. information regarding how covered individuals may obtain drugs at out-of-network pharmacies."

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

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE GRIEVANCES, COVERAGE DETERMINATIONS AND APPEALS PROCEDURES.--

A. All grievances, coverage determinations,

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[bracketed material] = delete

reconsiderations, exceptions and appeal rights and procedures available to covered individuals shall be prominently displayed, in font no smaller than twelve-point Times New Roman, on the plan's web site and provided in writing to insured individuals upon policy issuance and renewal. This information shall be provided to all pharmacies accepting reimbursement from an insurer, and pharmacies shall provide this information to a covered person in oral and written form whenever an adverse coverage determination is made.

B. For the purposes of this section:

(1) "adverse coverage determination" means an insurer's coverage determination for a prescription drug in which it determines that coverage for the drug is denied or reduced, subject to a condition precedent, or terminated; and

(2) "coverage determination" means an insurer's decision as to whether or not it will pay for a prescription drug for a covered individual, or whether coverage for the drug will be subject to a condition precedent."

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

"[NEW MATERIAL] REQUIREMENT FOR REIMBURSEMENT WHERE PHARMACISTS INITIATE PRIOR AUTHORIZATION.--

A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in New Mexico that requires covered individuals to obtain prior

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authorization before making reimbursement for a prescription shall permit any pharmacist licensed pursuant to the Pharmacy Act to initiate the prior authorization process.

B. An insurer shall notify a person requesting prior authorization on behalf of an insured individual of its determination regarding the prior authorization as expeditiously as the insured individual's health condition requires, but no later than twenty-four hours after receipt of the request. When an insurer fails to inform the person requesting prior authorization within twenty-four hours, the prior authorization shall be deemed to have been granted.

C. Prior authorization request forms and information regarding the procedure for submission and determination of prior authorization requests shall be prominently available on the insurer's web site in font no smaller than twelve-point Times New Roman and available to prescribers and pharmacists upon request in written form pursuant to rules promulgated by the superintendent. In the event an insurer fails to supply this information online and make it accessible from its main web site, a thirty-day supply of the prescription for which prior authorization is sought shall automatically be covered by the insurer."

Section 5. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] AVAILABILITY OF FORMULARY INFORMATION.--An

underscored material = new
[~~bracketed material~~] = delete

insurer that limits covered drugs to those listed on a formulary shall make information about each plan's formulary available prominently on its web site in font no smaller than twelve-point Times New Roman and, by request, in writing pursuant to rules promulgated by the superintendent. Information about the plan's formulary made available pursuant to this section shall include:

A. a list of drugs included on the formulary;

B. the manner in which the formulary functions, including any tiered cost-sharing structure and utilization management procedures;

C. the process for obtaining an exception to a plan's formulary or tiered cost-sharing structure;

D. a description of how a covered individual may obtain additional information regarding the formulary;

E. information regarding the pharmacies, by geographic location, from which a covered individual may obtain drugs covered by the insurer; and

F. information regarding how insured persons may obtain drugs at out-of-network pharmacies."

Section 6. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE GRIEVANCES, COVERAGE DETERMINATIONS AND APPEALS PROCEDURES.--

A. All grievances, reconsiderations, exceptions,

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[bracketed material] = delete

coverage determinations and appeal rights and procedures available to insured persons shall be prominently displayed, in font no smaller than twelve-point Times New Roman, on the plan's web site and provided in writing to insured individuals upon policy issuance and renewal. This information shall be provided to all pharmacies accepting reimbursement from an insurer, and pharmacies shall provide this information to a covered individual in oral and written form whenever an adverse coverage determination is made.

B. For the purposes of this section:

(1) "adverse coverage determination" means an insurer's coverage determination for a prescription drug in which it determines that coverage for the drug is denied or reduced, subject to a condition precedent, or terminated; and

(2) "coverage determination" means an insurer's decision as to whether or not it will pay for a prescription drug for a covered individual, or whether coverage for the drug will be subject to a condition precedent."

Section 7. A new section of Chapter 59A, Article 46 NMSA 1978 is enacted to read:

"[NEW MATERIAL] REQUIREMENT FOR REIMBURSEMENT WHERE PHARMACISTS INITIATE PRIOR AUTHORIZATION.--

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in New Mexico that requires covered individuals to obtain prior

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authorization before making reimbursement for a prescription shall permit any pharmacist licensed pursuant to the Pharmacy Act to initiate the prior authorization process.

B. A health maintenance organization shall notify a person requesting prior authorization on behalf of a covered individual of its determination regarding the prior authorization as expeditiously as the covered individual's health condition requires, but no later than twenty-four hours after receipt of the request. When a health maintenance organization fails to inform the person requesting prior authorization within twenty-four hours, the prior authorization shall be deemed to have been granted.

C. Prior authorization request forms and information regarding the procedure for submission and determination of prior authorization requests shall be prominently available on the health maintenance organization's web site in font no smaller than twelve-point Times New Roman and available to prescribers and pharmacists upon request in written form pursuant to rules promulgated by the superintendent. In the event a health maintenance organization fails to supply this information online and make it accessible from its main web site, a thirty-day supply of the prescription for which prior authorization is sought shall automatically be covered by the health maintenance organization."

Section 8. A new section of Chapter 59A, Article 46 NMSA

1978 is enacted to read:

"[NEW MATERIAL] AVAILABILITY OF FORMULARY INFORMATION.--A health maintenance organization that limits covered drugs to those listed on a formulary shall make information about each plan's formulary available prominently on its web site in font no smaller than twelve-point Times New Roman and, by request, in writing pursuant to rules promulgated by the superintendent. Information about the plan's formulary made available pursuant to this section shall include:

A. a list of drugs included on the formulary;

B. the manner in which the formulary functions, including any tiered cost-sharing structure and utilization management procedures;

C. the process for obtaining an exception to a plan's formulary or tiered cost-sharing structure;

D. a description of how a covered individual may obtain additional information regarding the formulary;

E. information regarding the pharmacies, by geographic location, from which a covered individual may obtain drugs covered by the health maintenance organization; and

F. information regarding how covered individuals may obtain drugs at out-of-network pharmacies."

Section 9. A new section of Chapter 59A, Article 46 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE GRIEVANCES,

underscored material = new
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COVERAGE DETERMINATIONS AND APPEALS PROCEDURES.--

A. All grievances, coverage determinations, reconsideration, exceptions and appeal rights and procedures available to covered individuals shall be prominently displayed, in font no smaller than twelve-point Times New Roman, on the plan's web site and provided in writing to insured individuals upon policy issuance and renewal. This information shall be provided to all pharmacies accepting reimbursement from a health maintenance organization, and pharmacies shall provide this information to a covered individual in oral and written form whenever an adverse coverage determination is made.

B. For the purposes of this section:

(1) "adverse coverage determination" means a health maintenance organization's coverage determination for a prescription drug where it determines that coverage for the drug is denied or reduced, subject to a condition precedent, or terminated; and

(2) "coverage determination" means a health maintenance organization's decision as to whether or not it will pay for a prescription drug for a covered individual, or whether coverage for the drug will be subject to a condition precedent."