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AN ACT

RELATING TO HEALTH INSURANCE; ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROHIBIT CERTAIN FORMULARY CHANGES AND TO REQUIRE WRITTEN NOTICE TO AFFECTED ENROLLEES BEFORE MAKING CERTAIN MODIFICATIONS TO THE FORMULARY; PROVIDING FOR CONTINGENT APPLICABILITY.

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:

"PRESCRIPTION DRUGS--PROHIBITED FORMULARY CHANGES-- NOTICE REQUIREMENTS.--

A. As of January 1, 2014, 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 categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within one hundred twenty days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:

- (1) reclassify a drug to a higher tier of

1 the formulary;

2 (2) reclassify a drug from a preferred
3 classification to a non-preferred classification, unless that
4 reclassification results in the drug moving to a lower tier
5 of the formulary;

6 (3) increase the cost-sharing, copayment,
7 deductible or co-insurance charges for a drug;

8 (4) remove a drug from the formulary;

9 (5) establish a prior authorization
10 requirement;

11 (6) impose or modify a drug's quantity
12 limit; or

13 (7) impose a step-therapy restriction.

14 B. The administrator for the group health coverage
15 shall give the affected enrollee at least sixty days' advance
16 written notice of the impending change when it is determined
17 that one of the following modifications will made to a
18 formulary:

19 (1) reclassification of a drug to a higher
20 tier of the formulary;

21 (2) reclassification of a drug from a
22 preferred classification to a non-preferred classification,
23 unless that reclassification results in the drug moving to a
24 lower tier of the formulary;

25 (3) an increase in the cost-sharing,

1 copayment, deductible or coinsurance charges for a drug;

2 (4) removal of a drug from the formulary;

3 (5) addition of a prior authorization

4 requirement;

5 (6) imposition or modification of a drug's
6 quantity limit; or

7 (7) imposition of a step-therapy restriction
8 for a drug.

9 C. Notwithstanding the provisions of Subsections A
10 and B of this section, the administrator for group health
11 coverage may immediately and without prior notice remove a
12 drug from the formulary if the drug:

13 (1) is deemed unsafe by the federal food and
14 drug administration; or

15 (2) has been removed from the market for any
16 reason.

17 D. The administrator for group health coverage
18 prescription drug benefits shall provide to each affected
19 enrollee the following information in plain language
20 regarding prescription drug benefits:

21 (1) notice that the group health plan uses
22 one or more drug formularies;

23 (2) an explanation of what the drug
24 formulary is;

25 (3) a statement regarding the method the

1 group health plan uses to determine the prescription drugs to
2 be included in or excluded from a drug formulary; and

3 (4) a statement of how often the group
4 health plan administrator reviews the contents of each drug
5 formulary.

6 E. As used in this section:

7 (1) "formulary" means the list of
8 prescription drugs covered by group health coverage; and

9 (2) "step therapy" means a protocol that
10 establishes the specific sequence in which prescription drugs
11 for a specified medical condition and medically appropriate
12 for a particular patient are to be prescribed."

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

15 "PRESCRIPTION DRUGS--PROHIBITED FORMULARY CHANGES--
16 NOTICE REQUIREMENTS.--

17 A. As of January 1, 2014, an individual or group
18 health insurance policy, health care plan or certificate of
19 health insurance that is delivered, issued for delivery or
20 renewed in this state and that provides prescription drug
21 benefits categorized or tiered for purposes of cost-sharing
22 through deductibles or coinsurance obligations shall not make
23 any of the following changes to coverage for a prescription
24 drug within one hundred twenty days of any previous change to
25 coverage for that prescription drug, unless a generic version

1 of the prescription drug is available:

2 (1) reclassify a drug to a higher tier of
3 the formulary;

4 (2) reclassify a drug from a preferred
5 classification to a non-preferred classification, unless that
6 reclassification results in the drug moving to a lower tier
7 of the formulary;

8 (3) increase the cost-sharing, copayment,
9 deductible or co-insurance charges for a drug;

10 (4) remove a drug from the formulary;

11 (5) establish a prior authorization
12 requirement;

13 (6) impose or modify a drug's quantity
14 limit; or

15 (7) impose a step-therapy restriction.

16 B. The insurer shall give the affected insured at
17 least sixty days' advance written notice of the impending
18 change when it is determined that one of the following
19 modifications will be made to a formulary:

20 (1) reclassification of a drug to a higher
21 tier of the formulary;

22 (2) reclassification of a drug from a
23 preferred classification to a non-preferred classification,
24 unless that reclassification results in the drug moving to a
25 lower tier of the formulary;

- 1 (3) an increase in the cost-sharing,
- 2 copayment, deductible or coinsurance charges for a drug;
- 3 (4) removal of a drug from the formulary;
- 4 (5) addition of a prior authorization
- 5 requirement;
- 6 (6) imposition or modification of a drug's
- 7 quantity limit; or
- 8 (7) imposition of a step-therapy restriction
- 9 for a drug.

10 C. Notwithstanding the provisions of Subsections A
11 and B of this section, the insurer may immediately and
12 without prior notice remove a drug from the formulary if the
13 drug:

- 14 (1) is deemed unsafe by the federal food and
- 15 drug administration; or
- 16 (2) has been removed from the market for any
- 17 reason.

18 D. The insurer shall provide to each affected
19 insured the following information in plain language regarding
20 prescription drug benefits:

- 21 (1) notice that the insurer uses one or more
- 22 drug formularies;
- 23 (2) an explanation of what the drug
- 24 formulary is;
- 25 (3) a statement regarding the method the

1 insurer uses to determine the prescription drugs to be
2 included in or excluded from a drug formulary; and

3 (4) a statement of how often the insurer
4 reviews the contents of each drug formulary.

5 E. As used in this section:

6 (1) "formulary" means the list of
7 prescription drugs covered by a policy, plan or certificate
8 of health insurance; and

9 (2) "step therapy" means a protocol that
10 establishes the specific sequence in which prescription drugs
11 for a specified medical condition and medically appropriate
12 for a particular patient are to be prescribed."

13 SECTION 3. A new section of Chapter 59A, Article 23
14 NMSA 1978 is enacted to read:

15 "PRESCRIPTION DRUGS--PROHIBITED FORMULARY CHANGES--
16 NOTICE REQUIREMENTS.--

17 A. As of January 1, 2014, an individual or group
18 health insurance policy, health care plan or certificate of
19 health insurance that is delivered, issued for delivery or
20 renewed in this state and that provides prescription drug
21 benefits categorized or tiered for purposes of cost-sharing
22 through deductibles or coinsurance obligations shall not make
23 any of the following changes to coverage for a prescription
24 drug within one hundred twenty days of any previous change to
25 coverage for that prescription drug, unless a generic version

1 of the prescription drug is available:

2 (1) reclassify a drug to a higher tier of
3 the formulary;

4 (2) reclassify a drug from a preferred
5 classification to a non-preferred classification, unless that
6 reclassification results in the drug moving to a lower tier
7 of the formulary;

8 (3) increase the cost-sharing, copayment,
9 deductible or co-insurance charges for a drug;

10 (4) remove a drug from the formulary;

11 (5) establish a prior authorization
12 requirement;

13 (6) impose or modify a drug's quantity
14 limit; or

15 (7) impose a step-therapy restriction.

16 B. The insurer shall give the affected insured at
17 least sixty days' advance written notice of the impending
18 change when it is determined that one of the following
19 modifications will be made to a formulary:

20 (1) reclassification of a drug to a higher
21 tier of the formulary;

22 (2) reclassification of a drug from a
23 preferred classification to a non-preferred classification,
24 unless that reclassification results in the drug moving to a
25 lower tier of the formulary;

- 1 (3) an increase in the cost-sharing,
- 2 copayment, deductible or coinsurance charges for a drug;
- 3 (4) removal of a drug from the formulary;
- 4 (5) addition of a prior authorization
- 5 requirement;
- 6 (6) imposition or modification of a drug's
- 7 quantity limit; or
- 8 (7) imposition of a step-therapy restriction
- 9 for a drug.

10 C. Notwithstanding the provisions of Subsections A
11 and B of this section, the insurer may immediately and
12 without prior notice remove a drug from the formulary if the
13 drug:

- 14 (1) is deemed unsafe by the federal food and
- 15 drug administration; or
- 16 (2) has been removed from the market for any
- 17 reason.

18 D. The insurer shall provide to each affected
19 insured the following information in plain language regarding
20 prescription drug benefits:

- 21 (1) notice that the insurer uses one or more
- 22 drug formularies;
- 23 (2) an explanation of what the drug
- 24 formulary is;
- 25 (3) a statement regarding the method the

1 insurer uses to determine the prescription drugs to be
2 included in or excluded from a drug formulary; and

3 (4) a statement of how often the insurer
4 reviews the contents of each drug formulary.

5 E. As used in this section:

6 (1) "formulary" means the list of
7 prescription drugs covered by a policy, plan or certificate
8 of health insurance; and

9 (2) "step therapy" means a protocol that
10 establishes the specific sequence in which prescription drugs
11 for a specified medical condition and medically appropriate
12 for a particular patient are to be prescribed."

13 SECTION 4. A new section of the Health Maintenance
14 Organization Law is enacted to read:

15 "PRESCRIPTION DRUGS--PROHIBITED FORMULARY CHANGES--
16 NOTICE REQUIREMENTS.--

17 A. As of January 1, 2014, an individual or group
18 health maintenance organization contract that is delivered,
19 issued for delivery or renewed in this state and that
20 provides prescription drug benefits categorized or tiered for
21 purposes of cost-sharing through deductibles or coinsurance
22 obligations shall not make any of the following changes to
23 coverage for a prescription drug within one hundred twenty
24 days of any previous change to coverage for that prescription
25 drug, unless a generic version of the prescription drug is

1 available:

2 (1) reclassify a drug to a higher tier of
3 the formulary;

4 (2) reclassify a drug from a preferred
5 classification to a non-preferred classification, unless that
6 reclassification results in the drug moving to a lower tier
7 of the formulary;

8 (3) increase the cost-sharing, copayment,
9 deductible or co-insurance charges for a drug;

10 (4) remove a drug from the formulary;

11 (5) establish a prior authorization
12 requirement;

13 (6) impose or modify a drug's quantity
14 limit; or

15 (7) impose a step-therapy restriction.

16 B. The health maintenance organization shall give
17 the affected subscriber at least sixty days' advance written
18 notice of the impending change when it is determined that one
19 of the following modifications will be made to a formulary:

20 (1) reclassification of a drug to a higher
21 tier of the formulary;

22 (2) reclassification of a drug from a
23 preferred classification to a non-preferred classification,
24 unless that reclassification results in the drug moving to a
25 lower tier of the formulary;

- 1 (3) an increase in the cost-sharing,
- 2 copayment, deductible or coinsurance charges for a drug;
- 3 (4) removal of a drug from the formulary;
- 4 (5) addition of a prior authorization
- 5 requirement;
- 6 (6) imposition or modification of a drug's
- 7 quantity limit; or
- 8 (7) imposition of a step-therapy restriction
- 9 for a drug.

10 C. Notwithstanding the provisions of Subsections A
11 and B of this section, the health maintenance organization
12 may immediately and without prior notice remove a drug from
13 the formulary if the drug:

- 14 (1) is deemed unsafe by the federal food and
- 15 drug administration; or
- 16 (2) has been removed from the market for any
- 17 reason.

18 D. The health maintenance organization shall
19 provide to each affected subscriber the following information
20 in plain language regarding prescription drug benefits:

- 21 (1) notice that the health maintenance
- 22 organization uses one or more drug formularies;
- 23 (2) an explanation of what the drug
- 24 formulary is;
- 25 (3) a statement regarding the method the

1 health maintenance organization uses to determine the
2 prescription drugs to be included in or excluded from a drug
3 formulary; and

4 (4) a statement of how often the health
5 maintenance organization reviews the contents of each drug
6 formulary.

7 E. As used in this section:

8 (1) "formulary" means the list of
9 prescription drugs covered pursuant to a health maintenance
10 organization contract; and

11 (2) "step therapy" means a protocol that
12 establishes the specific sequence in which prescription drugs
13 for a specified medical condition and medically appropriate
14 for a particular patient are to be prescribed."

15 SECTION 5. A new section of the Nonprofit Health Care
16 Plan Law is enacted to read:

17 "PRESCRIPTION DRUGS--PROHIBITED FORMULARY CHANGES--
18 NOTICE REQUIREMENTS.--

19 A. As of January 1, 2014, an individual or group
20 health care plan that is delivered, issued for delivery or
21 renewed in this state and that provides prescription drug
22 benefits categorized or tiered for purposes of cost-sharing
23 through deductibles or coinsurance obligations shall not make
24 any of the following changes to coverage for a prescription
25 drug within one hundred twenty days of any previous change to

1 coverage for that prescription drug, unless a generic version
2 of the prescription drug is available:

3 (1) reclassify a drug to a higher tier of the
4 formulary;

5 (2) reclassify a drug from a preferred
6 classification to a non-preferred classification, unless that
7 reclassification results in the drug moving to a lower tier
8 of the formulary;

9 (3) increase the cost-sharing, copayment,
10 deductible or co-insurance charges for a drug;

11 (4) remove a drug from the formulary;

12 (5) establish a prior authorization
13 requirement;

14 (6) impose or modify a drug's quantity limit;
15 or

16 (7) impose a step-therapy restriction.

17 B. The health care plan shall give the affected
18 subscriber at least sixty days' advance written notice of the
19 impending change when it is determined that one of the
20 following modifications will be made to a formulary:

21 (1) reclassification of a drug to a higher
22 tier of the formulary;

23 (2) reclassification of a drug from a
24 preferred classification to a non-preferred classification,
25 unless that reclassification results in the drug moving to a

1 lower tier of the formulary;

2 (3) an increase in the cost-sharing,
3 copayment, deductible or coinsurance charges for a drug;

4 (4) removal of a drug from the formulary;

5 (5) addition of a prior authorization
6 requirement;

7 (6) imposition or modification of a drug's
8 quantity limit; or

9 (7) imposition of a step-therapy restriction
10 for a drug.

11 C. Notwithstanding the provisions of Subsections A
12 and B of this section, the health care plan may immediately
13 and without prior notice remove a drug from the formulary if
14 the drug:

15 (1) is deemed unsafe by the federal food and
16 drug administration; or

17 (2) has been removed from the market for any
18 reason.

19 D. The health care plan shall provide to each
20 affected subscriber the following information in plain
21 language regarding prescription drug benefits:

22 (1) notice that the health care plan uses one
23 or more drug formularies;

24 (2) an explanation of what the drug formulary
25 is;

1 (3) a statement regarding the method the
2 health care plan uses to determine the prescription drugs to
3 be included in or excluded from a drug formulary; and

4 (4) a statement of how often the health care
5 plan reviews the contents of each drug formulary.

6 E. As used in this section:

7 (1) "formulary" means the list of prescription
8 drugs covered by a health care plan; and

9 (2) "step therapy" means a protocol that
10 establishes the specific sequence in which prescription drugs
11 for a specified medical condition and medically appropriate
12 for a particular patient are to be prescribed."

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