

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR  
HOUSE BILL 112

**53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017**

AN ACT

RELATING TO HEALTH COVERAGE; AMENDING 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 MAKE CHANGES TO PRESCRIPTION DRUG BENEFITS  
ADMINISTRATION REQUIREMENTS.

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

SECTION 1. Section 13-7-15 NMSA 1978 (being Laws 2013,  
Chapter 138, Section 1) is amended to read:

"13-7-15. 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

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underscoring material = new  
[bracketed material] = delete

1 purposes of cost-sharing through deductibles or coinsurance  
2 obligations shall ~~[not]~~ only make any of the following changes  
3 to coverage for a prescription drug ~~[within one hundred twenty~~  
4 ~~days of any previous change to coverage for that prescription~~  
5 ~~drug, unless a generic version of the prescription drug is~~  
6 ~~available]~~ at the time of group health plan renewal:

7 (1) reclassify a drug to a higher tier of the  
8 formulary;

9 (2) reclassify a drug from a preferred  
10 classification to a non-preferred classification, unless that  
11 reclassification results in the drug moving to a lower tier of  
12 the formulary;

13 (3) increase the cost-sharing, copayment,  
14 deductible or coinsurance charges for a drug;

15 (4) remove a drug from the formulary;

16 (5) establish a prior authorization  
17 requirement;

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

19 or

20 (7) impose a step-therapy restriction.

21 B. Nothing in this section shall be construed to  
22 prohibit a group health plan administrator from adding a new  
23 drug, generic or otherwise, to a group health plan formulary  
24 during a plan year.

25 ~~[B.]~~ C. The administrator for the group health

1 coverage shall ~~[give the affected enrollee at least sixty days'~~  
 2 ~~advance written notice of the impending change when it is~~  
 3 ~~determined that one of the following modifications will made to~~  
 4 ~~a formulary:~~

5 ~~(1) reclassification of a drug to a higher~~  
 6 ~~tier of the formulary;~~

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

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

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

14 ~~(5) addition of a prior authorization~~  
 15 ~~requirement;~~

16 ~~(6) imposition or modification of a drug's~~  
 17 ~~quantity limit; or~~

18 ~~(7) imposition of a step-therapy restriction~~  
 19 ~~for a drug] make available to enrollees the formulary for a~~  
 20 ~~given plan year no later than sixty days prior to the~~  
 21 ~~enrollment deadline for the plan year.~~

22 D. A group health plan administrator shall  
 23 establish the following provisions relating to any new drug at  
 24 the time that the drug is added to a group health plan  
 25 formulary and shall not modify any of the following provisions

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1 until the renewal date for the following plan year:

2 (1) drug tier classification;

3 (2) classification as preferred or non-  
4 preferred;

5 (3) copayment, deductible or coinsurance  
6 requirements for a drug;

7 (4) prior authorization requirements;

8 (5) drug quantity limit; or

9 (6) any step-therapy restriction.

10 E. When a group health plan administrator adds a  
11 generic drug to a group health plan formulary at any time other  
12 than at the time of group health plan renewal, the group health  
13 plan administrator may adjust the cost-sharing, copayment,  
14 deductible or coinsurance requirements, in accordance with the  
15 existing schedule of benefits, applicable to the drug's  
16 therapeutic equivalent that was already in the drug formulary  
17 for that plan year; provided that the drug is equivalent in  
18 dosage form, safety, strength, chemical composition, route of  
19 administration, quality, performance characteristics and side  
20 effects. The group health plan administrator shall not make  
21 any change to the cost-sharing, copayment, deductible or  
22 coinsurance requirements applicable to the generic drug's  
23 equivalent more than once during any plan year. A group health  
24 plan administrator shall give enrollees at least sixty days'  
25 advance written notice before making any changes to

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1 cost-sharing, copayment, deductible or coinsurance requirements  
 2 applicable to the generic drug's therapeutic equivalent.

3 ~~[G.]~~ F. Notwithstanding the provisions of  
 4 Subsections A and B of this section, the administrator for  
 5 group health coverage may immediately and without prior notice  
 6 remove a drug from the formulary if the drug:

7 (1) is deemed unsafe by the federal food and  
 8 drug administration; or

9 (2) has been removed from the market for any  
 10 reason.

11 ~~[D.]~~ G. The administrator for group health coverage  
 12 prescription drug benefits shall provide to each affected  
 13 enrollee the following information in plain language regarding  
 14 prescription drug benefits:

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

17 (2) an explanation of what the drug formulary  
 18 is;

19 (3) a statement regarding the method the group  
 20 health plan uses to determine the prescription drugs to be  
 21 included in or excluded from a drug formulary; and

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

24 ~~[E.]~~ H. As used in this section:

25 (1) "formulary" means the list of prescription

1 drugs covered by group health coverage; and

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

6 SECTION 2. Section 59A-22-49.4 NMSA 1978 (being Laws  
7 2013, Chapter 138, Section 2) is amended to read:

8 "59A-22-49.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
9 CHANGES--NOTICE REQUIREMENTS.--

10 A. [~~As of January 1, 2014~~] An individual or group  
11 health insurance policy, health care plan or certificate of  
12 health insurance that is delivered, issued for delivery or  
13 renewed in this state and that provides prescription drug  
14 benefits categorized or tiered for purposes of cost-sharing  
15 through deductibles or coinsurance obligations shall [~~not~~] only  
16 make any of the following changes to coverage for a  
17 prescription drug [~~within one hundred twenty days of any~~  
18 ~~previous change to coverage for that prescription drug, unless~~  
19 ~~a generic version of the prescription drug is available~~] at the  
20 time that the health insurance policy, health care plan or  
21 certificate of health insurance is renewed:

22 (1) reclassify a drug to a higher tier of the  
23 formulary;

24 (2) reclassify a drug from a preferred  
25 classification to a non-preferred classification, unless that

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1 reclassification results in the drug moving to a lower tier of  
2 the formulary;

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

5 (4) remove a drug from the formulary;

6 (5) establish a prior authorization  
7 requirement;

8 (6) impose or modify a drug's quantity limit;  
9 or

10 (7) impose a step-therapy restriction.

11 B. Nothing in this section shall be construed to  
12 prohibit an insurer from adding a new drug, generic or  
13 otherwise, to a formulary during a plan year.

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

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

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

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

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- 1                                   ~~(4) removal of a drug from the formulary;~~  
2                                   ~~(5) addition of a prior authorization~~  
3 ~~requirement;~~  
4                                   ~~(6) imposition or modification of a drug's~~  
5 ~~quantity limit; or~~  
6                                   ~~(7) imposition of a step-therapy restriction~~  
7 ~~for a drug] make available to insureds the formulary for a~~  
8 ~~given policy, plan or certificate year no later than sixty days~~  
9 ~~prior to the enrollment deadline for the policy, plan or~~  
10 ~~certificate year.~~

11                                   D. An insurer shall establish the following  
12 provisions relating to any new drug at the time that the drug  
13 is added to a formulary and shall not modify any of the  
14 following until the renewal date for the following policy, plan  
15 or certificate year:

- 16                                   (1) drug tier classification;  
17                                   (2) classification as preferred or non-  
18 preferred;  
19                                   (3) copayment, deductible or coinsurance  
20 requirements for a drug;  
21                                   (4) prior authorization requirements;  
22                                   (5) drug quantity limit; or  
23                                   (6) any step-therapy restriction.

24                                   E. When an insurer adds a generic drug to a  
25 formulary at any time other than at the time of policy, plan or



1 certificate renewal, the insurer may adjust the cost-sharing,  
 2 copayment, deductible or coinsurance requirements, in  
 3 accordance with the existing schedule of benefits, applicable  
 4 to the drug's therapeutic equivalent that was already in the  
 5 drug formulary for that policy, plan or certificate year;  
 6 provided that the drug is equivalent in dosage form, safety,  
 7 strength, chemical composition, route of administration,  
 8 quality, performance characteristics and side effects. The  
 9 insurer shall not make any change to the cost-sharing,  
 10 copayment, deductible or coinsurance requirements applicable to  
 11 the generic drug's equivalent more than once during any policy,  
 12 plan or certificate year. An insurer shall give insureds at  
 13 least sixty days' advance written notice before making any  
 14 changes to cost-sharing, copayment, deductible or coinsurance  
 15 requirements applicable to the generic drug's therapeutic  
 16 equivalent.

17 ~~[G.]~~ F. Notwithstanding the provisions of  
 18 Subsections A and B of this section, the insurer may  
 19 immediately and without prior notice remove a drug from the  
 20 formulary if the drug:

21 (1) is deemed unsafe by the federal food and  
 22 drug administration; or

23 (2) has been removed from the market for any  
 24 reason.

25 ~~[D.]~~ G. The insurer shall provide to each affected

1 insured the following information in plain language regarding  
2 prescription drug benefits:

3 (1) notice that the insurer uses one or more  
4 drug formularies;

5 (2) an explanation of what the drug formulary  
6 is;

7 (3) a statement regarding the method the  
8 insurer uses to determine the prescription drugs to be included  
9 in or excluded from a drug formulary; and

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

12 [~~E.~~] H. As used in this section:

13 (1) "formulary" means the list of prescription  
14 drugs covered by a policy, plan or certificate of health  
15 insurance; and

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

20 **SECTION 3.** Section 59A-23-7.13 NMSA 1978 (being Laws  
21 2013, Chapter 138, Section 3) is amended to read:

22 "59A-23-7.13. PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
23 CHANGES--NOTICE REQUIREMENTS.--

24 A. [~~As of January 1, 2014~~] An individual or group  
25 health insurance policy, health care plan or certificate of

1 health insurance that is delivered, issued for delivery or  
 2 renewed in this state and that provides prescription drug  
 3 benefits categorized or tiered for purposes of cost-sharing  
 4 through deductibles or coinsurance obligations shall ~~not~~ only  
 5 make any of the following changes to coverage for a  
 6 prescription drug ~~[within one hundred twenty days of any~~  
 7 ~~previous change to coverage for that prescription drug, unless~~  
 8 ~~a generic version of the prescription drug is available]~~ at the  
 9 time of the health insurance policy's, health care plan's or  
 10 certificate of health insurance's renewal:

11 (1) reclassify a drug to a higher tier of the  
 12 formulary;

13 (2) reclassify a drug from a preferred  
 14 classification to a non-preferred classification, unless that  
 15 reclassification results in the drug moving to a lower tier of  
 16 the formulary;

17 (3) increase the cost-sharing, copayment,  
 18 deductible or coinsurance charges for a drug;

19 (4) remove a drug from the formulary;

20 (5) establish a prior authorization  
 21 requirement;

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

23 or

24 (7) impose a step-therapy restriction.

25 B. Nothing in this section shall be construed to

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1 prohibit an insurer from adding a new drug, generic or  
2 otherwise, to a formulary during a policy, plan or certificate  
3 year.

4 ~~[B.] C. The insurer shall [give the affected~~  
5 ~~insured at least sixty days' advance written notice of the~~  
6 ~~impending change when it is determined that one of the~~  
7 ~~following modifications will be made to a formulary:~~

8 ~~(1) reclassification of a drug to a higher~~  
9 ~~tier of the formulary;~~

10 ~~(2) reclassification of a drug from a~~  
11 ~~preferred classification to a non-preferred classification,~~  
12 ~~unless that reclassification results in the drug moving to a~~  
13 ~~lower tier of the formulary;~~

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

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

17 ~~(5) addition of a prior authorization~~  
18 ~~requirement;~~

19 ~~(6) imposition or modification of a drug's~~  
20 ~~quantity limit; or~~

21 ~~(7) imposition of a step-therapy restriction~~  
22 ~~for a drug] make available to insureds the formulary for a~~

23 given policy, plan or certificate year no later than sixty days  
24 prior to the enrollment deadline for the policy, plan or  
25 certificate year.

underscored material = new  
[bracketed material] = delete

1           D. An insurer shall establish the following  
2 provisions relating to any new drug at the time that the drug  
3 is added to a formulary and shall not modify any of the  
4 following until the renewal date for the following policy, plan  
5 or certificate year:

6                   (1) drug tier classification;

7                   (2) classification as preferred or non-  
8 preferred;

9                   (3) copayment, deductible or coinsurance  
10 requirements for a drug;

11                   (4) prior authorization requirements;

12                   (5) drug quantity limit; or

13                   (6) any step-therapy restriction.

14           E. When an insurer adds a generic drug to a  
15 formulary at any time other than at the time of policy, plan or  
16 certificate renewal, the insurer may adjust the cost-sharing,  
17 copayment, deductible or coinsurance requirements, in  
18 accordance with the existing schedule of benefits, applicable  
19 to the drug's therapeutic equivalent that was already in the  
20 drug formulary for that policy, plan or certificate year;  
21 provided that the drug is equivalent in dosage form, safety,  
22 strength, chemical composition, route of administration,  
23 quality, performance characteristics and side effects. The  
24 insurer shall not make any change to the cost-sharing,  
25 copayment, deductible or coinsurance requirements applicable to

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1 the generic drug's equivalent more than once during any policy,  
2 plan or certificate year. An insurer shall give insureds at  
3 least sixty days' advance written notice before making any  
4 changes to cost-sharing, copayment, deductible or coinsurance  
5 requirements applicable to the generic drug's therapeutic  
6 equivalent.

7 ~~[G.]~~ F. Notwithstanding the provisions of  
8 Subsections A and B of this section, the insurer may  
9 immediately and without prior notice remove a drug from the  
10 formulary if the drug:

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

15 ~~[D.]~~ G. The insurer shall provide to each affected  
16 insured the following information in plain language regarding  
17 prescription drug benefits:

- 18 (1) notice that the insurer uses one or more  
19 drug formularies;
- 20 (2) an explanation of what the drug formulary  
21 is;
- 22 (3) a statement regarding the method the  
23 insurer uses to determine the prescription drugs to be included  
24 in or excluded from a drug formulary; and
- 25 (4) a statement of how often the insurer

1 reviews the contents of each drug formulary.

2 ~~[E.]~~ H. As used in this section:

3 (1) "formulary" means the list of prescription  
4 drugs covered by a policy, plan or certificate of health  
5 insurance; and

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

10 **SECTION 4.** Section 59A-46-50.4 NMSA 1978 (being Laws  
11 2013, Chapter 138, Section 4) is amended to read:

12 "59A-46-50.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
13 CHANGES--NOTICE REQUIREMENTS.--

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

24 (1) reclassify a drug to a higher tier of the  
25 formulary;

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

5 (3) increase the cost-sharing, copayment,  
6 deductible or coinsurance charges for a drug;

7 (4) remove a drug from the formulary;

8 (5) establish a prior authorization  
9 requirement;

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

12 (7) impose a step-therapy restriction.

13 B. Nothing in this section shall be construed to  
14 prohibit a health maintenance organization from adding a new  
15 drug, generic or otherwise, to a health maintenance  
16 organization contract formulary during a contract year.

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

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

24 ~~(2) reclassification of a drug from a~~  
25 ~~preferred classification to a non-preferred classification,~~



1 ~~unless that reclassification results in the drug moving to a~~  
 2 ~~lower tier of the formulary;~~

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

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

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

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

10 ~~(7) imposition of a step-therapy restriction~~  
 11 ~~for a drug] make available to enrollees the formulary for a~~  
 12 ~~given contract year no later than sixty days prior to the~~  
 13 ~~enrollment deadline for the contract year.~~

14 D. A health maintenance organization shall  
 15 establish the following provisions relating to any new drug at  
 16 the time that the drug is added to a formulary and shall not  
 17 modify any of the following until the renewal date for the  
 18 following contract year:

19 (1) drug tier classification;

20 (2) classification as preferred or non-  
 21 preferred;

22 (3) copayment, deductible or coinsurance  
 23 requirements for a drug;

24 (4) prior authorization requirements;

25 (5) drug quantity limit; or

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1                   (6) any step-therapy restriction.

2                   E. When a health maintenance organization adds a  
3 generic drug to a formulary at any time other than at the time  
4 of health maintenance organization contract renewal, the health  
5 maintenance organization may adjust the cost-sharing,  
6 copayment, deductible or coinsurance requirements, in  
7 accordance with the existing schedule of benefits, applicable  
8 to the drug's therapeutic equivalent that was already in the  
9 drug formulary for that contract year; provided that the drug  
10 is equivalent in dosage form, safety, strength, chemical  
11 composition, route of administration, quality, performance  
12 characteristics and side effects. The health maintenance  
13 organization shall not make any change to the cost-sharing,  
14 copayment, deductible or coinsurance requirements applicable to  
15 the generic drug's equivalent more than once during any  
16 contract year. A health maintenance organization shall give  
17 enrollees at least sixty days' advance written notice before  
18 making any changes to cost-sharing, copayment, deductible or  
19 coinsurance requirements applicable to the generic drug's  
20 therapeutic equivalent.

21                   [~~G.~~] F. Notwithstanding the provisions of  
22 Subsections A and B of this section, [~~the~~] a health maintenance  
23 organization may immediately and without prior notice remove a  
24 drug from the formulary if the drug:

25                   (1) is deemed unsafe by the federal food and

1 drug administration; or

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

4 [~~D.—The~~] G. A health maintenance organization  
5 shall provide to each affected subscriber the following  
6 information in plain language regarding prescription drug  
7 benefits:

8 (1) notice that the health maintenance  
9 organization uses one or more drug formularies;

10 (2) an explanation of what the drug formulary  
11 is;

12 (3) a statement regarding the method the  
13 health maintenance organization uses to determine the  
14 prescription drugs to be included in or excluded from a drug  
15 formulary; and

16 (4) a statement of how often the health  
17 maintenance organization reviews the contents of each drug  
18 formulary.

19 [~~E.~~] H. As used in this section:

20 (1) "formulary" means the list of prescription  
21 drugs covered pursuant to a health maintenance organization  
22 contract; and

23 (2) "step therapy" means a protocol that  
24 establishes the specific sequence in which prescription drugs  
25 for a specified medical condition and medically appropriate for

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1 a particular patient are to be prescribed."

2 SECTION 5. Section 59A-47-45.4 NMSA 1978 (being Laws  
3 2013, Chapter 138, Section 5) is amended to read:

4 "59A-47-45.4. PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
5 CHANGES--NOTICE REQUIREMENTS.--

6 A. [~~As of January 1, 2014~~] An individual or group  
7 health care plan that is delivered, issued for delivery or  
8 renewed in this state and that provides prescription drug  
9 benefits categorized or tiered for purposes of cost-sharing  
10 through deductibles or coinsurance obligations shall [~~not~~] only  
11 make any of the following changes to coverage for a  
12 prescription drug [~~within one hundred twenty days of any~~  
13 ~~previous change to coverage for that prescription drug, unless~~  
14 ~~a generic version of the prescription drug is available~~] at the  
15 time of health care plan renewal:

16 (1) reclassify a drug to a higher tier of the  
17 formulary;

18 (2) reclassify a drug from a preferred  
19 classification to a non-preferred classification, unless that  
20 reclassification results in the drug moving to a lower tier of  
21 the formulary;

22 (3) increase the cost-sharing, copayment,  
23 deductible or coinsurance charges for a drug;

24 (4) remove a drug from the formulary;

25 (5) establish a prior authorization requirement;

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

2 (7) impose a step-therapy restriction.

3 B. Nothing in this section shall be construed to  
 4 prohibit a health care plan from adding a new drug, generic or  
 5 otherwise, to a health care plan formulary during a plan year.

6 ~~[B.] C. The health care plan shall [give the~~  
 7 ~~affected subscriber at least sixty days' advance written notice~~  
 8 ~~of the impending change when it is determined that one of the~~  
 9 ~~following modifications will be made to a formulary:~~

10 ~~(1) reclassification of a drug to a higher tier~~  
 11 ~~of the formulary;~~

12 ~~(2) reclassification of a drug from a preferred~~  
 13 ~~classification to a non-preferred classification, unless that~~  
 14 ~~reclassification results in the drug moving to a lower tier of~~  
 15 ~~the formulary;~~

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

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

19 ~~(5) addition of a prior authorization~~  
 20 ~~requirement;~~

21 ~~(6) imposition or modification of a drug's~~  
 22 ~~quantity limit; or~~

23 ~~(7) imposition of a step-therapy restriction for~~  
 24 ~~a drug] make available to subscribers the formulary for a given~~  
 25 ~~policy, plan or certificate year no later than sixty days prior~~

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1 to the enrollment deadline for the plan year.

2 D. A health care plan shall establish the following  
3 provisions relating to any new drug at the time that the drug  
4 is added to a formulary and shall not modify any of the  
5 following until the renewal date for the following plan year:

6 (1) drug tier classification;

7 (2) classification as preferred or non-  
8 preferred;

9 (3) copayment, deductible or coinsurance  
10 requirements for a drug;

11 (4) prior authorization requirements;

12 (5) drug quantity limit; or

13 (6) any step-therapy restriction.

14 E. When a health care plan adds a generic drug to a  
15 formulary at any time other than at the time of health care  
16 plan renewal, the health care plan may adjust the cost-sharing,  
17 copayment, deductible or coinsurance requirements, in  
18 accordance with the existing schedule of benefits, applicable  
19 to the drug's therapeutic equivalent that was already in the  
20 drug formulary for that plan year; provided that the drug is  
21 equivalent in dosage form, safety, strength, chemical  
22 composition, route of administration, quality, performance  
23 characteristics and side effects. The health care plan shall  
24 not make any change to the cost-sharing, copayment, deductible  
25 or coinsurance requirements applicable to the generic drug's

1 equivalent more than once during any health care plan year. A  
 2 health care plan shall give subscribers at least sixty days'  
 3 advance written notice before making any changes to  
 4 cost-sharing, copayment, deductible or coinsurance requirements  
 5 applicable to the generic drug's therapeutic equivalent.

6           ~~[G.]~~ F. Notwithstanding the provisions of  
 7 Subsections A and B of this section, the health care plan may  
 8 immediately and without prior notice remove a drug from the  
 9 formulary if the drug:

10                   (1) is deemed unsafe by the federal food and  
 11 drug administration; or

12                   (2) has been removed from the market for any  
 13 reason.

14           ~~[D.]~~ G. The health care plan shall provide to each  
 15 affected subscriber the following information in plain language  
 16 regarding prescription drug benefits:

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

19                   (2) an explanation of what the drug formulary  
 20 is;

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

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

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[E-] H. As used in this section:

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

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

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