SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 112

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

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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purposes of cost-sharing through deductibles or coinsurance obligations shall [~~not~~] only 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~~] at the time of group health plan renewal:

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

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

(3) increase the cost-sharing, copayment, deductible or [~~co-insurance~~] coinsurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

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

(7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

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

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until the renewal date for the following plan year:

(1) drug tier classification;

(2) classification as preferred or non-preferred;

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

(4) prior authorization requirements;

(5) drug quantity limit; or

(6) any step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

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

(1) "formulary" means the list of prescription

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drugs covered by group health coverage; 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."

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

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

A. [~~As of January 1, 2014~~] An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall [~~not~~] only 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~~] at the time that the health insurance policy, health care plan or certificate of health insurance is renewed:

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

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

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

(3) increase the cost-sharing, copayment, deductible or [~~co-insurance~~] coinsurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

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

(7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

(1) drug tier classification;

(2) classification as preferred or non-preferred;

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

(4) prior authorization requirements;

(5) drug quantity limit; or

(6) any step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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health insurance that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall [~~not~~] only 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~~] at the time of the health insurance policy's, health care plan's or certificate of health insurance's renewal:

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

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

(3) increase the cost-sharing, copayment, deductible or [~~co-insurance~~] coinsurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

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

(7) impose a step-therapy restriction.

B. Nothing in this section shall be construed to

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

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

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

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

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

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

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

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

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

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

(1) drug tier classification;

(2) classification as preferred or non-preferred;

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

(4) prior authorization requirements;

(5) drug quantity limit; or

(6) any step-therapy restriction.

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

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

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

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

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

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

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

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

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

(4) a statement of how often the insurer

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reviews the contents of each drug formulary.

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

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

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

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

A. [~~As of January 1, 2014~~] An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall [~~not~~] only 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~~] at the time of health maintenance organization contract renewal:

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

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

(3) increase the cost-sharing, copayment, deductible or [~~co-insurance~~] coinsurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

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

(7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

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

(1) drug tier classification;

(2) classification as preferred or non-preferred;

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

(4) prior authorization requirements;

(5) drug quantity limit; or

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(6) any step-therapy restriction.

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

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

(1) is deemed unsafe by the federal food and

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drug administration; or

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

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

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

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

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

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

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

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

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a particular patient are to be prescribed."

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

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

A. [~~As of January 1, 2014~~] An individual or group health care plan that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall [~~not~~] only 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~~] at the time of health care plan renewal:

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

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

(3) increase the cost-sharing, copayment, deductible or [~~co-insurance~~] coinsurance charges for a drug;

(4) remove a drug from the formulary;

(5) establish a prior authorization requirement;

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

(7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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to the enrollment deadline for the plan year.

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

(1) drug tier classification;

(2) classification as preferred or non-preferred;

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

(4) prior authorization requirements;

(5) drug quantity limit; or

(6) any step-therapy restriction.

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

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

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

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

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

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

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

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

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

(4) a statement of how often the health care 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."

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