

1 SENATE CORPORATIONS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR
2 SENATE BILL 156

3 **51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013**

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10 AN ACT

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

17
18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

19 SECTION 1. A new section of the Health Care Purchasing
20 Act is enacted to read:

21 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY
22 CHANGES--NOTICE REQUIREMENTS.--

23 A. As of January 1, 2014, group health coverage,
24 including any form of self-insurance, offered, issued or
25 renewed under the Health Care Purchasing Act that provides

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1 coverage for prescription drugs categorized or tiered for
2 purposes of cost-sharing through deductibles or coinsurance
3 obligations shall not make any of the following changes to
4 coverage for a prescription drug within one hundred twenty days
5 of any previous change to coverage for that prescription drug,
6 unless a generic version of the prescription drug is available:

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 co-insurance 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. The administrator for the group health coverage
22 shall give the enrollee at least sixty days' advance written
23 notice of the impending change when it is determined that one
24 of the following modifications will made to a formulary:

25 (1) reclassification of a drug to a higher

1 tier of the formulary;

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

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

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

9 (5) addition of a prior authorization
 10 requirement;

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

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

15 C. Notwithstanding the provisions of Subsections A
 16 and B of this section, the administrator for group health
 17 coverage may immediately and without prior notice remove a drug
 18 from the formulary if the drug:

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

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

23 D. The administrator for group health coverage
 24 prescription drug benefits shall provide to each enrollee the
 25 following information in plain language regarding prescription

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1 drug benefits:

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

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

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

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

11 E. As used in this section:

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

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

18 SECTION 2. A new section of Chapter 59A, Article 22 NMSA
19 1978 is enacted to read:

20 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY
21 CHANGES--NOTICE REQUIREMENTS.--

22 A. As of January 1, 2014, an individual or group
23 health insurance policy, health care plan or certificate of
24 health insurance that is delivered, issued for delivery or
25 renewed in this state and that provides prescription drug

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1 benefits categorized or tiered for purposes of cost-sharing
 2 through deductibles or coinsurance obligations shall not make
 3 any of the following changes to coverage for a prescription
 4 drug within one hundred twenty days of any previous change to
 5 coverage for that prescription drug, unless a generic version
 6 of the prescription drug is available:

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 co-insurance 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. The insurer shall give the insured at least
 22 sixty days' advance written notice of the impending change when
 23 it is determined that one of the following modifications will
 24 be made to a formulary:

25 (1) reclassification of a drug to a higher

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1 tier of the formulary;

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

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

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

9 (5) addition of a prior authorization
10 requirement;

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

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

15 C. Notwithstanding the provisions of Subsections A
16 and B of this section, the insurer may immediately and without
17 prior notice remove a drug from the formulary if the drug:

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

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

22 D. The insurer shall provide to each insured the
23 following information in plain language regarding prescription
24 drug benefits:

25 (1) notice that the insurer uses one or more

1 drug formularies;

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

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

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

9 E. As used in this section:

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

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

17 SECTION 3. A new section of Chapter 59A, Article 23 NMSA
18 1978 is enacted to read:

19 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY
20 CHANGES--NOTICE REQUIREMENTS.--

21 A. As of January 1, 2014, an individual or group
22 health insurance policy, health care plan or certificate of
23 health insurance that is delivered, issued for delivery or
24 renewed in this state and that provides prescription drug
25 benefits categorized or tiered for purposes of cost-sharing

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1 through deductibles or coinsurance obligations shall not make
2 any of the following changes to coverage for a prescription
3 drug within one hundred twenty days of any previous change to
4 coverage for that prescription drug, unless a generic version
5 of the prescription drug is available:

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

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

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

14 (4) remove a drug from the formulary;

15 (5) establish a prior authorization
16 requirement;

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

19 (7) impose a step-therapy restriction.

20 B. The insurer shall give the insured at least
21 sixty days' advance written notice of the impending change when
22 it is determined that one of the following modifications will
23 be made to a formulary:

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

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

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

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

8 (5) addition of a prior authorization
9 requirement;

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

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

14 C. Notwithstanding the provisions of Subsections A
15 and B of this section, the insurer may immediately and without
16 prior notice remove a drug from the formulary if the drug:

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

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

21 D. The insurer shall provide to each insured the
22 following information in plain language regarding prescription
23 drug benefits:

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

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

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

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

8 E. As used in this section:

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

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

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

18 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY
19 CHANGES--NOTICE REQUIREMENTS.--

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

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1 prescription drug within one hundred twenty days of any
2 previous change to coverage for that prescription drug, unless
3 a generic version of the prescription drug is available:

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

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

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

12 (4) remove a drug from the formulary;

13 (5) establish a prior authorization
14 requirement;

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

16 or

17 (7) impose a step-therapy restriction.

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

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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.

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

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

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

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

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

25 (2) an explanation of what the drug formulary

1 is;

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

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

9 E. As used in this section:

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

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

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

19 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY
20 CHANGES--NOTICE REQUIREMENTS.--

21 A. As of January 1, 2014, an individual or group
22 health care plan that is delivered, issued for delivery or
23 renewed in this state and that provides prescription drug
24 benefits categorized or tiered for purposes of cost-sharing
25 through deductibles or coinsurance obligations shall not make

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1 any of the following changes to coverage for a prescription
2 drug within one hundred twenty days of any previous change to
3 coverage for that prescription drug, unless a generic version
4 of the prescription drug is available:

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

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

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

13 (4) remove a drug from the formulary;

14 (5) establish a prior authorization requirement;

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

16 (7) impose a step-therapy restriction.

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

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

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

1 the formulary;

2 (3) an increase in the cost-sharing, copayment,
3 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 for
10 a drug.

11 C. Notwithstanding the provisions of Subsections A
12 and B of this section, the health care plan may immediately and
13 without prior notice remove a drug from the formulary if the
14 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 subscriber the following information in plain language
21 regarding prescription drug benefits:

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

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

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1 (3) a statement regarding the method the health
2 care plan uses to determine the prescription drugs to be
3 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 for
12 a particular patient are to be prescribed."

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