

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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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

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[bracketed material] = delete

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.

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."

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~~bracketed material~~ = delete