SENATE BILL 291

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

INTRODUCED BY

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AN ACT

RELATING TO HEALTH COVERAGE; AMENDING AND ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH LIMITATIONS ON HEALTH COVERAGE AND PROVIDER CONTRACT CHANGES.

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 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~~] less than ninety days prior to the beginning date of the plan year in which these changes are to take effect or at any time during a current plan year:

(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 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. The administrator for the group health coverage shall give the affected enrollee at least sixty days' advance written notice of the impending change when it is determined~~

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~~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.~~

~~C.~~] B. Notwithstanding the provisions of [~~Subsections~~] Subsection A [~~and B~~] 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

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reason.

[~~D.~~] C. 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.~~] D. As used in this section:

(1) "formulary" means the list of prescription 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.--

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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 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~~] less than ninety days prior to the beginning date of the policy, plan or certificate year in which these changes are to take effect or at any time during a current policy, plan or certificate year:

(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 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;

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or

(7) impose a step-therapy restriction.

[~~B. 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.~~

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

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

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

[~~D.~~] C. 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 reviews the contents of each drug formulary.

[~~E.~~] D. 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

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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~~] A group or blanket 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 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~~] less than ninety days prior to the beginning date of the policy, plan or certificate year in which these changes are to take effect or at any time during a current policy, plan or certificate year:

(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 coinsurance charges for a drug;

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(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. 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.~~

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~~C.~~] B. Notwithstanding the provisions of [~~Subsections~~] Subsection A [~~and B~~] 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.~~] C. 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 reviews the contents of each drug formulary.

[~~E.~~] D. 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

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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 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~~] less than ninety days prior to the beginning date of the plan year in which these changes are to take effect or at any time during a current plan year:

(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;

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(3) increase the cost-sharing, copayment, deductible or 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. 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, 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~~

underscored material = new
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~~(7) imposition of a step-therapy restriction for a drug.~~

~~C.~~] B. Notwithstanding the provisions of [~~Subsections~~] Subsection A [~~and B~~] of this section, the 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 drug administration; or

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

[~~D.~~] C. The 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.~~] D. As used in this section:

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(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 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 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~~] less than ninety days prior to the beginning date of the plan year in which these changes are to take effect or at any time during a current plan year:

(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 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. 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;~~

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

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

~~C.~~] B. Notwithstanding the provisions of [~~Subsections~~] Subsection A [~~and B~~] 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.~~] C. 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.

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

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(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."

SECTION 6. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER CONTRACTS.--

A. A group health plan administrator, including the administrator of any form of self-insurance offered, issued or renewed under the Health Care Purchasing Act, that contracts with a provider for a full plan year's health care services or supplies to be delivered to enrollees of a group health plan shall execute that provider contract no sooner than ninety days from the beginning date of the plan year in which the health care services or supplies are to be delivered pursuant to that provider contract.

B. A provider contract shall not be modified or rescinded during the plan year to which it applies.

C. Nothing in this section shall be construed to prohibit a group health plan administrator from executing a new provider contract at any time for health care services or supplies to be delivered during the plan year in which the new

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provider contract is executed; provided that the provider contract terminate by the end of the plan year in which it was executed.

D. As used in this section:

(1) "new provider contract" means a contract entered into with a provider with which a group health plan administrator did not enter into a contract for health care services or supplies to be delivered during the current or preceding plan year; and

(2) "provider" means:

(a) a health facility licensed by the department of health; or

(b) an individual or group of individuals licensed or otherwise authorized to provide health care services or supplies in the ordinary course of business."

SECTION 7. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER PROVIDER CONTRACTS.--

A. An insurer that contracts with a provider for a full plan year's services to be delivered to insureds under an individual health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall execute that provider contract no sooner than ninety days from the beginning date of

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the plan year in which the health care services or supplies are to be delivered pursuant to that provider contract.

B. A provider contract shall not be modified or rescinded during the policy, plan or certificate year to which it applies.

C. Nothing in this section shall be construed to prohibit an insurer from executing a new provider contract at any time for health care services or supplies to be delivered during that policy, plan or certificate year; provided that the provider contract terminate by the end of the policy, plan or certificate year in which it was executed.

D. As used in this section:

(1) "new provider contract" means a contract entered into with a provider with which an insurer did not enter into a contract for health care services or supplies to be delivered during the current or preceding policy, plan or certificate year; and

(2) "provider" means:

(a) a health facility licensed by the department of health; or

(b) an individual or group of individuals licensed or otherwise authorized to provide health care services or supplies in the ordinary course of business."

SECTION 8. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

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"[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER PROVIDER CONTRACTS.--

A. An insurer that contracts with a provider for a full plan year's services to be delivered to insureds under a group or blanket health insurance policy, health plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall execute the provider contract no sooner than ninety days from the beginning date of the plan year in which the health care services or supplies are to be delivered pursuant to that provider contract.

B. A provider contract shall not be modified or rescinded during the policy, plan or certificate year to which it applies.

C. Nothing in this section shall be construed to prohibit an insurer from executing a new provider contract at any time for health care services or supplies to be delivered during the policy, plan or certificate year in which the new provider contract is executed; provided that the provider contract terminate by the end of the policy, plan or certificate year in which it was executed.

D. As used in this section:

(1) "new provider contract" means a contract entered into with a provider with which an insurer did not enter into a contract for health care services or supplies to be delivered during the current or preceding policy, plan or

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certificate year; and

(2) "provider" means:

(a) a health facility licensed by the department of health; or

(b) an individual or group of individuals licensed or otherwise authorized to provide health care services or supplies in the ordinary course of business."

SECTION 9. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER PROVIDER CONTRACTS.--

A. A health maintenance organization that contracts with a provider for a full plan year's services to be delivered to enrollees under an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state shall execute the provider contract no sooner than ninety days from the beginning date of the plan year in which the health care services or supplies are to be delivered pursuant to that provider contract.

B. A provider contract shall not be modified or rescinded during the plan year to which it applies.

C. Nothing in this section shall be construed to prohibit a carrier from executing a new provider contract at any time for health care services or supplies to be delivered during the plan year in which the new provider contract is

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executed; provided that the provider contract terminate by the end of the plan year in which it was executed.

D. As used in this section:

(1) "new provider contract" means a contract entered into with a provider with which the group health plan administrator did not enter into a contract for health care services or supplies to be delivered during the current or preceding plan year;

(2) "provider" means:

(a) a health facility licensed by the department of health; or

(b) an individual or group of individuals licensed or otherwise authorized to provide health care services or supplies in the ordinary course of business; and

(3) "provider contract" means a contract for health care services or supplies that a carrier enters into with a health care provider for health care services or supplies that the carrier will provide to enrollees pursuant to an individual or group health maintenance organization contract."

SECTION 10. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER PROVIDER CONTRACTS.--

A. A health care plan that contracts with a

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provider for a full calendar year's services to be delivered to subscribers under an individual or group health care plan contract that is delivered, issued for delivery or renewed in this state shall execute that provider contract no sooner than ninety days from the beginning date of the plan year in which the health care services or supplies are to be delivered pursuant to that provider contract.

B. A provider contract shall not be modified or rescinded during the plan year to which it applies.

C. Nothing in this section shall be construed to prohibit a health care plan from executing a new provider contract for health care services or supplies to be delivered during the plan year in which the new provider contract is executed; provided that the new provider contract terminate by the end of the plan year in which it was executed.

D. As used in this section:

(1) "new provider contract" means a contract entered into with a provider with which the health care plan did not enter into a contract for health care services or supplies to be delivered during the current or preceding plan year; and

(2) "provider contract" means a contract for health care services or supplies that a health care plan enters into with a provider for health care services or supplies that the health care plan will provide to subscribers pursuant to an

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individual or group health care plan contract."