

1 SENATE BILL 156

2 **51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013**

3 INTRODUCED BY

4 Jacob Candelaria

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9  
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.

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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. Group health coverage, including any form of  
24 self-insurance, offered, issued or renewed under the Health  
25 Care Purchasing Act that provides coverage for prescription

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1 drugs categorized or tiered for purposes of cost-sharing  
2 through deductibles or coinsurance obligations shall not,  
3 unless a generic version of the prescription drug is available,  
4 prior to the annual anniversary date of the group health  
5 coverage:

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 administrator for the group health coverage  
21 shall give the enrollee at least sixty days' advance written  
22 notice of the impending change when it is determined that one  
23 of the following modifications will 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. The administrator for group health coverage  
15 prescription drug benefits shall provide to each enrollee the  
16 following information in plain language regarding prescription  
17 drug benefits:

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

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

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

25 (4) a statement of how often the group health

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1 plan administrator reviews the contents of each drug formulary.

2 D. As used in this section:

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

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

9 SECTION 2. A new section of Chapter 59A, Article 22 NMSA  
10 1978 is enacted to read:

11 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
12 CHANGES--NOTICE REQUIREMENTS.--

13 A. An individual or group health insurance policy,  
14 health care plan or certificate of health insurance that is  
15 delivered, issued for delivery or renewed in this state and  
16 that provides prescription drug benefits categorized or tiered  
17 for purposes of cost-sharing through deductibles or coinsurance  
18 obligations shall not, unless a generic version of the  
19 prescription drug is available, prior to the annual anniversary  
20 date of the policy, plan or certificate:

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

23 (2) reclassify 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) increase the cost-sharing, copayment,  
3 deductible or co-insurance charges for a drug;

4 (4) remove a drug from the formulary;

5 (5) establish a prior authorization  
6 requirement;

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

8 or

9 (7) impose a step-therapy restriction.

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

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

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

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

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

23 (5) addition of a prior authorization  
24 requirement;

25 (6) imposition or modification of a drug's

1 quantity limit; or

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

4 C. The insurer shall provide to each insured the  
5 following information in plain language regarding prescription  
6 drug benefits:

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

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

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

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

16 D. As used in this section:

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

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

24 SECTION 3. A new section of Chapter 59A, Article 23 NMSA  
25 1978 is enacted to read:

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1           "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
2 CHANGES--NOTICE REQUIREMENTS.--

3           A. An individual or group health insurance policy,  
4 health care plan or certificate of health insurance that is  
5 delivered, issued for delivery or renewed in this state and  
6 that provides prescription drug benefits categorized or tiered  
7 for purposes of cost-sharing through deductibles or coinsurance  
8 obligations shall not, unless a generic version of the  
9 prescription drug is available, prior to the annual anniversary  
10 date of the policy, plan or certificate:

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 co-insurance 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. The insurer shall give the insured at least

1 sixty days' advance written notice of the impending change when  
2 it is determined that one of the following modifications will  
3 be made to a formulary:

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

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

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

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

13 (5) addition of a prior authorization  
14 requirement;

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

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

19 C. The insurer shall provide to each insured the  
20 following information in plain language regarding prescription  
21 drug benefits:

22 (1) notice that the insurer uses one or more  
23 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  
2 insurer uses to determine the prescription drugs to be included  
3 in or excluded from a drug formulary; and

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

6 D. As used in this section:

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

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

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

16 "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
17 CHANGES--NOTICE REQUIREMENTS.--

18 A. An individual or group health maintenance  
19 organization contract that is delivered, issued for delivery or  
20 renewed in this state and that provides prescription drug  
21 benefits categorized or tiered for purposes of cost-sharing  
22 through deductibles or coinsurance obligations shall not,  
23 unless a generic version of the prescription drug is available,  
24 prior to the annual anniversary date of the contract:

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

1 formulary;

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

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

8 (4) remove a drug from the formulary;

9 (5) establish a prior authorization  
10 requirement;

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

13 (7) impose a step-therapy restriction.

14 B. The health maintenance organization shall give  
15 the subscriber at least sixty days' advance written notice of  
16 the 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.

8 C. The health maintenance organization shall  
9 provide to each subscriber the following information in plain  
10 language regarding prescription drug benefits:

- 11 (1) notice that the health maintenance  
12 organization uses one or more drug formularies;  
13 (2) an explanation of what the drug formulary  
14 is;  
15 (3) a statement regarding the method the  
16 health maintenance organization uses to determine the  
17 prescription drugs to be included in or excluded from a drug  
18 formulary; and  
19 (4) a statement of how often the health  
20 maintenance organization reviews the contents of each drug  
21 formulary.

22 D. As used in this section:

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

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

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

7           "[NEW MATERIAL] PRESCRIPTION DRUGS--PROHIBITED FORMULARY  
8 CHANGES--NOTICE REQUIREMENTS.--

9           A. An individual or group health care plan that is  
10 delivered, issued for delivery or renewed in this state and  
11 that provides prescription drug benefits categorized or tiered  
12 for purposes of cost-sharing through deductibles or coinsurance  
13 obligations shall not, unless a generic version of the  
14 prescription drug is available, prior to the annual anniversary  
15 date of the health care plan:

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 co-insurance 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. The health care plan shall give the subscriber  
4 at least sixty days' advance written notice of the impending  
5 change when it is determined that one of the following  
6 modifications will be made to a formulary:

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

9 (2) reclassification of 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) an increase in the cost-sharing, copayment,  
14 deductible or coinsurance charges for a drug;

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

16 (5) addition of a prior authorization  
17 requirement;

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

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

22 C. The health care plan shall provide to each  
23 subscriber the following information in plain language  
24 regarding prescription drug benefits:

25 (1) notice that the health care plan uses one or

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1 more drug formularies;

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

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

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

9 D. As used in this section:

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

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