AN ACT

RELATING TO HEALTH INSURANCE; 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 PROHIBIT CERTAIN FORMULARY CHANGES AND TO REQUIRE WRITTEN NOTICE TO AFFECTED ENROLLEES BEFORE MAKING CERTAIN MODIFICATIONS TO THE FORMULARY; PROVIDING FOR CONTINGENT APPLICABILITY.

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

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

"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 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:

(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 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 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. Notwithstanding the provisions of Subsections 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 reason.

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

"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 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:

(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 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 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. Notwithstanding the provisions of Subsections 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. 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. 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. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"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 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:

(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 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 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. Notwithstanding the provisions of Subsections 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. 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. 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. A new section of the Health Maintenance Organization Law is enacted to read:

"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:

(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 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

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

C. Notwithstanding the provisions of Subsections 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. 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. 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 a particular patient are to be prescribed."

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

"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:

(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 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;

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

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

C. Notwithstanding the provisions of Subsections 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. 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. 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."