F I S C A L I M P A C T R E P O R T

SPONSOR SCORC **ORIGINAL DATE** 02/01/13 **LAST UPDATED** 03/11/13 **HB**

SHORT TITLE Formulary Changes In Health Laws **SB** CS/156/aHBIC

ANALYST Geisler/Trowbridge

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY13	FY14	FY15	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		.01, Minimal, See Narrative			Recurring	General, Federal, and Other State funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received in Previous Analysis From
Public School Insurance Authority (PSIA)
Public Regulation Commission (PRC)
Retiree Health Care Authority (RHCA)
Attorney General's Office (AGO)
General Services Department (GSD)
Human Services Department (HSD)

SUMMARY

Synopsis of HBIC Amendment

The House Business and Industry Committee amendment to the Senate Corporations & Transportation Committee substitute for Senate Bill 156 clarifies that notice of formulary or other prescription drug coverage changes shall be made to enrollees and subscribers "affected" by the changes.

Synopsis of Original Bill

The Senate Corporations & Transportation Committee substitute for Senate Bill 156 (SB 156) limits changes to prescription drug coverage for a particular drug to every 120 days, unless a generic version of the drug is available. SB 156 also allows a group health coverage administrator to remove a drug from its formulary immediately and without prior notice if the drug is deemed unsafe by the federal Food and Drug Administration or has been removed from the market for any other reasons.

SB 156 would amend the Health Care Purchasing Act, the New Mexico Insurance Code, the Health Maintenance Organization Law, and the Nonprofit Health Care Plan Law to prohibit various health care payers that provide coverage for prescription drugs categorized or tiered for purposes of cost-sharing through deductibles or coinsurance from making any of the following changes to coverage for a prescription drug within one hundred twenty days of any change to coverage for that prescription drug, unless a generic version of a prescription drug is available:

- Reclassify the drug to a higher tier of the formulary;
- Reclassify a drug from a preferred classification to a non-preferred classification unless it is to a lower tier of the formulary;
- Increase the cost-sharing, co payment, deductible or co-insurance charges for a drug;
- Remove a drug from the formulary;
- Establish a prior authorization requirement;
- Impose or modify a drug's quantity limit; or
- Impose a step therapy restriction.

SB 156 has a second provision which would require the insurer to give an enrollee at least 60 days' advance written notice of the impending change shown in the above list. SB 156 also specifies that insurance plan administrators shall provide to each enrollee the following information in plain language regarding prescription drug benefits:

- Notice that the group health plan uses one or more drug formularies;
- An explanation of what the drug formulary is;
- 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
- A statement on how often the plan administrator reviews the contents of each drug formulary.

Definitions for terms used in the new section of the act are included. The bill's effective date is January 1, 2014.

FISCAL IMPLICATIONS

The cost impact of SB 156 would be fairly minimal to the Medicaid program as well as the state health insurance programs for state employees, teachers, and retirees.

The Public School Insurance Authority (PSIA) notes the bill will increase prescription drug cost trends for insurance plans in New Mexico as well as the health insurance plans for state employees as insurance companies or pharmacy benefit managers (PBM) will be restricted from reforming coverage rules no more than four times per year. Also, the notification to members of the formulary change will result in a chargeback for mailing to the group. This is currently done via the website of the PBM.

The Human Services Department (HSD) notes that SB 156 would increase costs to the Medicaid program by not allowing a Managed Care Organization to act efficiently in managing a preferred drug list or a formulary. However, the cost increase would occur only if future co-pays are based on the cost of the drug. If the delays in making formulary changes impacted 0.5 percent of the amount spent on drug items in the Medicaid managed care programs each year (approximately

$203 million), the impact to the Medicaid program would be $1.015 million annually in state and federal funds combined. Of this amount $304.5 thousand would come from the General Fund. The Medicaid program spent approximately $3.6 billion in FY12.

SIGNIFICANT ISSUES

SB 156 will reduce the likelihood that consumers will face multiple changes in their insurance coverage and out-of-pocket costs for prescription drugs within a short period of time due to insurance plans changing their prescription drug formularies. Consumers will also receive adequate notice of these changes in insurance plan coverage of their prescriptions.

The Attorney General's Office (AGO) reports that under current state law, health insurance plans have the freedom to reclassify drug tiers and increase cost sharing without notifying enrollees. The changes proposed by SB 156 will somewhat limit the ability of plans to immediately respond to market conditions, but will allow enrollees an opportunity to find alternative formularies before changes in their drug costs occur. The changes proposed by SB 156 appear to be lawful.

The AGO notes that the federal Patient Protection and Affordable Care Act (ACA) requires health plans to provide 60 days notice to enrollees before making "material" changes to their health plan. It may be possible that the changes contemplated by this bill are covered by that federal law.

OTHER SUBSTANTIVE ISSUES

The HSD notes that SB 156 presumably attempts to exclude application to the Medicaid Managed Care Organizations of when a health care payer can change a formulary by specifying that Section 4.A applies when formularies are categorized or tiered "for purposes of cost-sharing." Medicaid managed care formularies are generally tiered for the purpose of ensuring that drug items are a medically appropriate choice as well as an economically prudent choice. Copayments for Medicaid recipients are limited to a few categories of eligibility, and the copayment amounts are not based on the tiers of a formulary but rather are at one set amount. If in the future, however, the Medicaid program did implement variable copayment requirements based on the cost of the drug, it is likely that the provisions in this bill would limit the ability of the Medicaid Managed Care Organizations to be as economically efficient as they could be.

The provisions of the 60 days' advance notice contained in Section 4.B do appear to apply to current Medicaid Managed Care Organizations and would slow their ability to act appropriately and in a timely manner regarding their formularies

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

The Public Regulation Commission (PRC) and PSIA report that PBMs will not have restrictions on the timing of formulary changes.

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