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

SPONSOR Cadena/Ivey-Soto **ORIGINAL DATE** 2/04/2020 **LAST UPDATED** 2/15/2020 **HB** 292/aHSEIC/aHFl#1

SHORT TITLE Prescription Drug Cost Sharing **SB**

ANALYST Chilton

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY20	FY21	FY22	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
State agency personnel time	$14.0	$42.0	$0	$56.0	Nonrecurring	General Fund
Cost to state medical insurance plans		$0.0	$0.0	$0.0		
Total	$14.0	$42.0	$0.0	$56.0	Nonrecurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Relation with Senate Bill 1, Senate Bill 16, and Senate Joint Memorial 1.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Regulation and Licensing Department (RLD)
University of New Mexico Health Sciences Center (UNM HSC)
Office of the Superintendent of Insurance (OSI)
Human Services Department (HSD)
General Services Department (GSD), 1/30/2020 and revised 2/13/2020 and 2/15/2020 to indicate lower per member per month costs for subsidizing insulin costs for its members and then no cost.
Retiree Health Care Authority (RHCA)
Public Schools Insurance Authority (PSIA)
Department of Health (DOH)

SUMMARY

Synopsis of House Floor #1 Amendment

The House Floor #1 Amendment substitutes a monthly maximum out-of-pocket cost of $25 instead of $50. It uses the language “a preferred formulary prescription insulin drug or a

medically necessary alternative" instead of "preferred formulary prescription insulin drugs or medically necessary alternatives" throughout the bill by substituting this new language for that added in the HSEIC amendment.

Synopsis of HSEIC Amendment

The House State Government, Elections and Indian Affairs Committee amendment applies the same two changes to each of the three sections of the bill referring to different types of health insurance products:

1) Modifies the term "prescription insulin drugs" with "preferred formulary" to indicate that those insulin products included in an insurance company's formulary would be included in the $50/month out-of-pocket limitation while others not on the list would not be included.
2) After the above phrase, "preferred formulary prescription insulin drugs," adds "or medically necessary alternatives." This refers to other insulin products that might not be on a given insurer's preferred formulary, but was medically necessary for a given patient. Such medically-necessary insulin products would be made available to patients at a maximum $50 per month out-of-pocket cost.

Synopsis of Original Bill

House Bill 292, Prescription Drug Cost Sharing, has two major aims:

- Capping the out-of-pocket cost for insulin for insured diabetic patients at $50 per month, and
- Requiring the Office of the Superintendent of Insurance to convene an advisory group to study the cost of prescription drugs and methods to make them more available.

Section 1, 2 and 3 of the bill apply the out-of-pocket insulin cost limitation to group health coverage through the Health Purchasing Act, individual and group health insurance plans, and health maintenance organization contracts respectively. Other types of insurance are also covered, by inference.

Section 4 specifies the members of the advisory group to be convened by the superintendent of insurance. They would include

- Secretary of Human Services Department
- Secretary of Health Department
- Secretary of General Services Department
- Dean of the University of New Mexico School of Pharmacy.

The group would be required to submit a report to the Legislative Health and Human Services Committee by October 1, 2020. Its recommendations would cover cutting costs of medications prescribed for a wide, specified array of common chronic conditions; this part of the act takes effect May 20, 2020; other parts of the act take effect January 1, 2021.

FISCAL IMPLICATIONS

There is no appropriation associated with House Bill 292. Agencies sending representatives to

meetings of the advisory group would have to cover their time and travel costs. HSD is the only agency responding that estimates these costs; its analysis is as follows:

> Participation in the advisory group would likely require some staff time and data analysis from the HSD/Medicaid pharmacy team. The total cost of .03 percent of time for both the HSD Secretary and the Medicaid Pharmacist to serve on the advisory committee would be $11,052.84.

Assuming that the personnel cost related to participation in the advisory group would be similar for the five named agencies in the group (OSI, HSD, DOH, GSD, and the School of Pharmacy at UNM, the figure above represents HSD's estimate multiplied by five; the advisory group is to meet starting at the end of May 2020 and make its report by October 1; therefore one-fourth of the personnel cost is attributed to fiscal year 2020 and three-fourths to fiscal year 2021.

HSD notes that Medicaid does not charge co-pays or other out-of-pocket fees for medications, including insulin.

Initially, cost estimates for state medical insurance plans were high; however, the HSEIC and House Floor amendments establishing that preferred formulary insulin prescription products would be used unless the prescribing provider thought an alternative was medically necessary, the cost estimate dropped dramatically, and after negotiation with the pharmacy benefit manager, Express Scripts, was reduced to zero, at least for GSD, and probably for the entire suite of state-provided insurance products. As the number of covered lives is large and the prevalence of diabetes is high, especially in elderly members of state insurance health plans, the impact of the negotiations with Express Scripts, the pharmacy benefit manager for all of the plans, is large.

Insuring Agency	Covered Lives	Projected number of members with diabetes
General Services Department	57,377	14,344
NM Public School Insurance Authority	47,235	11,808
Albuquerque Public Schools	15,809	3.952
Retiree Health Care Authority	55,000	13,750
Total	**175,421**	**43,855**

According to the CDC (https://www.cdc.gov/media/releases/2017/p0718-diabetes-report.html), 25 per cent of Americans over the age of 65 have diabetes, with the highest prevalence among Native Americans, Hispanic and black, non-Hispanic persons.

SIGNIFICANT ISSUES

The American Diabetes Association points to the importance of limiting out-of-pocket costs for diabetics so that they will be able to comply with recommended therapy for their chronic illness and avoid the complications of diabetes, a disease that becomes more common every year in New Mexico and throughout the United States. The CDC has estimated that one in eight diabetic patients restrict the amount of insulin they use because of its high cost, and one in four patients ask their care providers for lower cost prescriptions, as quoted by UNM HSC.

The same problems – high costs and inability to comply with prescribed medication regimens

because of cost – affect other common medical problems as well (e.g., depression, asthma), but are especially acute with diabetes. RHCA indicates that the "diabetes trend is expected to reach 20 percent for the next three years and has been the costliest traditional therapy class for the past six years."

GSD notes that treating diabetes is expensive, and cites American Diabetes Association figures that estimate that there are 241,000 people with diabetes in New Mexico, 182,000 diagnosed and 59,000 still to be diagnosed, and that 13,000 people in New Mexico are newly diagnosed with diabetes per year. The largest proportion of diagnosed diabetes is type II, once known as "adult-onset diabetes," but renamed because it is being increasingly seen in children alongside type I diabetes. Type I diabetes has genetic components and is unrelated to diet a, exercise and obesity, which, along with heredity are the major factors associated with type II diabetes. Type I patients always require insulin; some patients with type II diabetes can be managed with other drugs.

That the prices of drugs other than insulin have also risen quickly in recent years results in similar problems for other chronic problems beyond diabetes, which explains the reasoning behind formation of the study group anticipated in Section 4 of House Bill 292.

DOH sends evidence of the importance of this problem to diabetics:

> According to the American Diabetes Association one in four insulin users said cost impacted their insulin use:
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> - 23 percent miss doses weekly
> - 26 percent take less than prescribed
> - 27 percent choose between insulin and housing
> - 30 percent choose between insulin and utilities
> - 36 percent choose between insulin and other medication
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> http://main.diabetes.org/dorg/PDFs/2018-insulin-affordability-survey.pdf
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> For example, the Health Care Cost Institute used health care claims data to investigate trends in total health care spending on individuals with type 1 diabetes between 2012 and 2016. They found that insulin use rose only modestly, but that increases in insulin spending were primarily driven by increases in insulin prices, and to a lesser extent, a shift towards use of more expensive products. The study determined that a person with type 1 diabetes incurred annual insulin costs in 2016 of $5,705, on average, while in 2012 the average cost was double that at $2,864 per patient in 2012. (*https://healthcostinstitute.org/research/publications/entry/spending-on-individuals-with-type-1-diabetes-and-the-role-of-rapidly-increasing-insulin-prices*). This new average would compute to a monthly average cost for insulin of $475.
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> In response, there has been interest in addressing these increases. In May 2018 the American Diabetes Association testified before Congress on this issue, and in October 2018 the Minnesota Attorney General filed suit against insulin makers for price gouging (*https://healthcostinstitute.org/research/publications/entry/spending-on-individuals-with-type-1-diabetes-and-the-role-of-rapidly-increasing-insulin-prices*). Other states have considered legislation similar to HB292; so far insulin is the only prescription included in these bills. The states of Colorado and Illinois capped insulin co-payment amounts at $100/month. States that have active bills related to consumer insulin payments in their current legislative seasons include Kentucky ($100/month), Minnesota, Pennsylvania ($100/month), Virginia ($30/month), and Washington ($100/month).

RELATIONSHIP

Relates to Senate Bill 1, which would study and purchase medical products, presumably including insulin, through wholesalers from Canada. Senate Bill 16 and Senate Joint Memorial 1 both deal with a downstream cost of uncontrolled diabetes, peripheral artery disease and resultant need for amputation.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Diabetic patients would continue to have to choose between paying high costs for insulin and other diabetic-supplies and skimping on prescribed amounts of these medications. Means of controlling costs for other common chronic conditions would remain unstudied. Downstream costs for those whose chronic conditions were not well controlled due to the impossibility of compliance with prescribed medications would likely increase.

LAC/sb