FISCAL IMPACT REPORT

SPONSOR STBTC **LAST UPDATED** 03/17/2023
ORIGINAL DATE 03/10/2023
BILL NUMBER CS/Senate Bill 51/STBTCS/aSFl /aHHHC

SHORT TITLE Cost-Sharing Contributions for Prescriptions

ANALYST Chilton/Toal

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
GSD Risk Management Division		$3,600.0	$3,600.0	$7,200.0	Recurring	General Fund
NMPSIA added benefit, no cost share		$2,150.0	$2,150.0	$4,300.0	Recurring	Health Care Benefits Administration Fund
RHCA added benefit, no cost share		$1,539.43	$3,078.86	$4,618.29	Recurring	Healthcare Benefits Administration Fund
OSI actuarial analyses		Indeterminate but possibly substantial	Indeterminate but possibly substantial	Indeterminate but possibly substantial	Recurring	Health Care Affordability Fund (HCAF) or General Fund
Health Insurance Exchange added benefit, no cost share		Indeterminate but possibly substantial	Indeterminate but possibly substantial	Indeterminate but possibly substantial	Recurring	HCAF or health insurance premium tax
Total		$7,289.4-$10,000.0	$8,828.6-$10,000.0	$16,118.0-$20,000.0	Recurring	Multiple funds

Note that the estimates in this table were made prior to committee adoption of the substitute bill and do not include some added costs from the new provision in the substitute that cost-sharing amounts be the same regardless of which in-network or nonparticipating pharmacy will fill a patient's prescription.

Relates to House Bill 132 and House Bill 51

Sources of Information
LFC Files

Responses Received Regarding the Original and the Substitute Bills
General Services Department (GSD)
Office of the Superintendent of Insurance (OSI)
Office of the Attorney General (NMAG)
Retiree Health Care Authority (RHCA)

Responses Received Regarding the Original Bill
Department of Health (DOH)
Human Services Department (HSD)
Public School Insurance Authority (PSIA)

No Response Received
Albuquerque Public Schools (APS)

SUMMARY

Synopsis of HHHC Amendment to Senate Bill 51

The HHHC amendment begins by removing all parts of the Senate Floor amendment. It adds to the title of the bill a description of a new section of the bill which would prohibit discrimination against entities participating in the federal 340B drug pricing program. The new subsection 7A defines terms used in subsection 7B, which states that pharmacy benefit managers and third parties cannot discriminate against entities that participate in the 340B program by:

- Reimbursing a covered entity less than it would an entity not covered by the 340B program,
- Assessing covered entities fees or other assessments different from non-covered entities,
- preventing or interfering with a patient's right to use a 340B program drug from a covered entity,
- Imposing different requirements for covered vs. non-covered entities, including:
    - requiring use of a pharmacy network,
    - requiring use of different audit procedures,
    - requiring claim procedures that would not be required of non-covered entities, or
    - charging additional fees or other provisions that would interfere with a patient's right to receive a 340B drug from a covered entity.

Synopsis of SFl#1 to Senate Bill 51

Removed by HHHC amendment above
The Senate floor amendment to Senate Bill 51 adds a new section 7 at the end of the bill that requires drug manufacturers make any rebates, discounts, coupons, or other price reductions available to all customers throughout the longer of a plan year or a calendar year. "Manufacturer" is defined as the maker of a prescription drug product of any kind, the licensor of manufacturing of a drug product, or an entity that changes the wholesale price of a drug it manufactures or markets. The addition is also represented in the title of the bill.

Synopsis of STBTC Substitute for Senate Bill 51

The STBTC substitute for Senate Bill 51 joins provisions of an earlier version of Senate Bill 51 with a provision of House Bill 132, applying the combination to each of the types of insurance products. The main purpose of the earlier version of Senate Bill 51 was to assure that discounts provided to pharmacies, pharmacy benefit managers (PBMs), or wholesalers would be passed on to the patient, reducing the patient's cost-sharing amount. House Bill 132 aimed to be certain that insurers would allow access to any willing local pharmacy or mail-order pharmacy on the same basis, with the same patient cost-sharing for any prescription filled at any of these willing

pharmacies; the bill would require that insurers provide the same cost-sharing at nonaffiliated as at affiliated pharmacies.

Section 1A of the bill would create a new section within the Health Care Purchasing Law (Section 13-7 NMSA 1978), which states the full value of discounts or payments received by the insurer would be credited against any cost-sharing (defined in Section 1F) that would be the patient's obligation.

Section 1B states cost-sharing to the patient must be the same at affiliated and nonaffiliated pharmacies; the same would be true of locations where infusions of medications are given.

Section 1C requires insurers to required insured patients to pay only the least of the following at the point of sale:

- The applicable cost-sharing amount,
- The amount that would be paid without the patient having any coverage for the prescription,
- The total of what the insurer would pay plus the patient's cost-share amount,
- The value of the manufacturer's rebate to the insurer or PBM.

If the prescription drug rebate is greater than the patient's cost-share, the remainder is retained by the insurer. These provisions do not apply to excepted benefit plans, which include those covered by the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored or high deductible plans until a patient's deductible has been met.

Section 2 requires insurers and PBMs to disclose to buyers the option to contract for drug cost-sharing protections.

Section 3 applies the same requirements as in Section 1 to individual and group health insurance policies covered under Section 59A-22 NMSA 1978, with the same exceptions.
Section 4 applies the same requirements as in Section 1 to group health plans (other than small group health plans) or blanket health plans covered under Section 59A-23 NMSA 1978, with the same exceptions.

Section 5 applies the same requirements as in Section 1 to individual or group health maintenance organization contracts covered under Health Maintenance Organization Law, Section 59A-46 NMSA 1978, with the same exceptions.

Section 6 applies the same requirements as Section 1 to nonprofit health plans covered under the Nonprofit Health Plan Law, Section 59A-47 NMSA 1978, with the same exceptions.

This bill does not contain an effective date and, as a result, would go into effect June 16, 2023, (90 days after the Legislature adjourns) if signed into law; however, most of the provisions of the act have their onset on January 1, 2024.

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 51.

The fiscal impact of this bill is difficult to calculate and depends on which group—pharmacy benefit managers, state insurance programs, or consumers—will benefit from or feel the pain of the provisions in this bill. NMPSIA estimated a recurring cost to that agency of $2.150 million per year, RHCA sees a full-year cost of $3.079 million, and GSD estimates an annual cost of $3.6 million. APS has not given an estimate yet. The amounts entered into the table above are, therefore, highly speculative and do not include additional costs related to the substitute bill's new provision that cost-sharing for patients must be the same at any community or mail-order pharmacy. In addition, OSI has not indicated a cost to that office for enforcing the provision of the act. And as stated in the note below the table, the added costs of allowing patients to use any local or mail-order pharmacy have not been added to the estimates given.

There is no appropriation in Senate Bill 51.

SIGNIFICANT ISSUES

New Mexico and the other states in the United States suffer from very high drug costs relative to the rest of the developed world. As noted by DOH, "A U.S. Health and Human Services Department (HHS) funded study in 2018 found that U.S. drug prices are more than 2.5 times more expensive than other high-income countries. Additionally, a small survey of 1,170 New Mexico residents found that 33 percent cut pills in half, skipped doses of medicine, or did not fill a prescription due to cost."
Thus, any strategy that decreases costs of drugs to consumers would be welcome. This bill may decrease costs to consumers if rebates to insurance companies and pharmacy benefit managers (PBMs) are passed on to those consumers and if PBMs absorb the cost of these rebates or the insurance companies and state health insurance entities who may see compensatory higher costs from PBMs do not pass those additional costs on to their consumers.

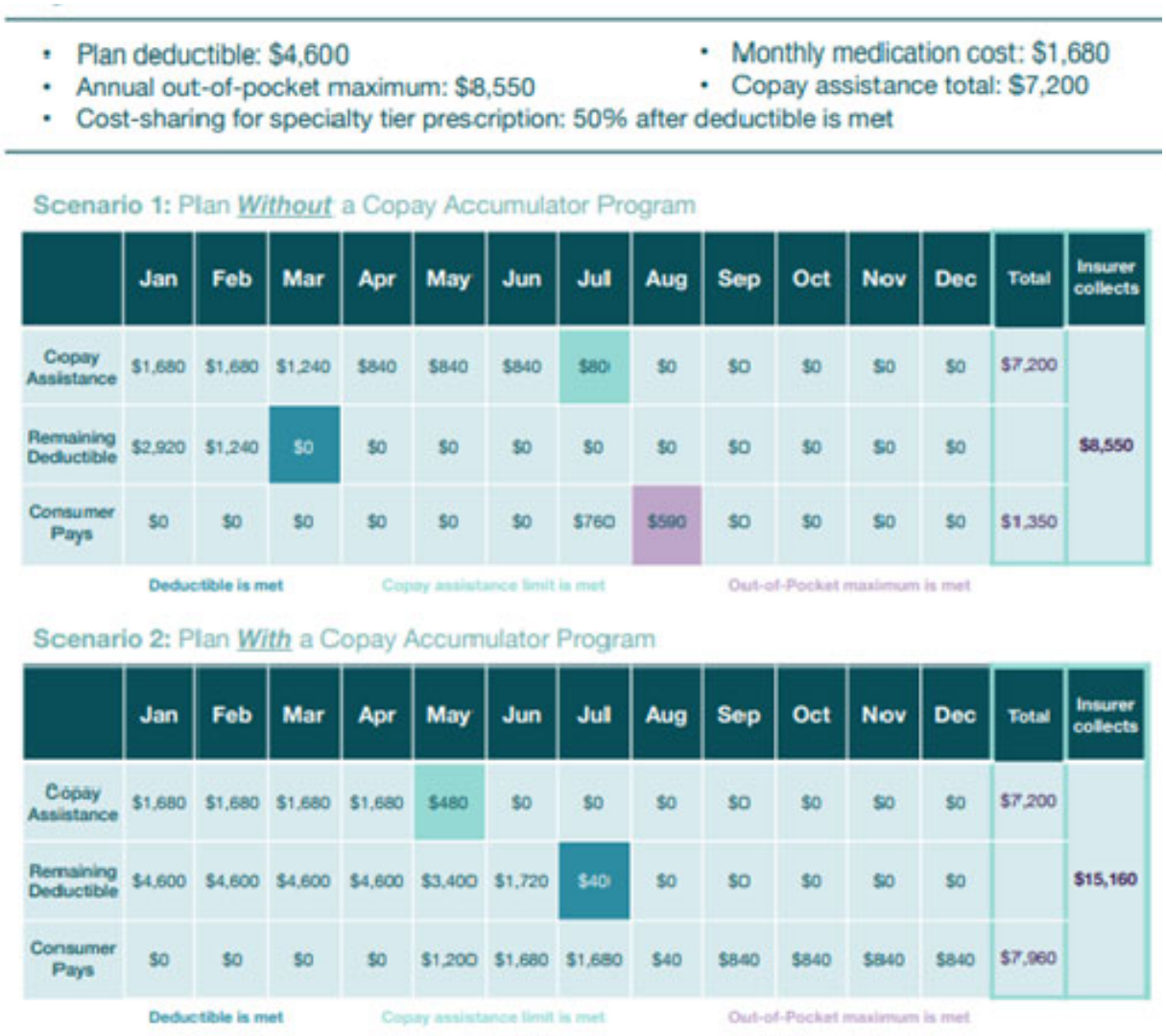
In addition, the survival of community pharmacies is vital to New Mexicans, especially those in rural areas. The provision that cost-sharing must be the same regardless of which pharmacy fills a prescription would help assure that patients would use local pharmacies, although that provision comes at a price, as noted in the "Fiscal Impacts" section.

Each of the three Health Purchasing Act entities that have responded with analysis of this bill (GSD, RHCA, and PSIA) mention concern that incentives and discounts provided through their prescription benefit managers (PBMs) may be significantly reduced if this bill were passed, thereby increasing the net cost to the plans and ultimately to the consumer.

DOH explains some of the complexities of drug pricing as follows, with the accompanying table:

> Pharmacy benefit managers (PBMs) and insurance companies incentivize the use of lower cost drug options through a variety of tools. One method is patient cost sharing. Patients must meet a deductible or out-of-pocket maximum amount prior to additional benefit payments. Some patients utilize funds from patient assistance grants (charitable donations) or manufacturer copay programs to help cover their medication copays. Patient assistance grants often have a maximum payment per patient. Once the patient has received their maximum payment from the grant or manufacturer copay card, the patient is responsible for their full insurance copay going forward.
>
> In New Mexico, over 67 percent of plans have copay accumulator adjustment policies. These policies implemented by PBMs or plans prevent payments by patient assistance

grants or manufacturer copay programs from counting toward the patient's deductible or out-of-pocket maximum. Plans with copay accumulator adjustment policies can impact the ability of patients on fixed incomes to afford their medication copays. The following graphic from the AIDS institute helps to explain the impact on patients and insurers of copay accumulator programs.



- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% after deductible is met
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan *Without* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$8,550
Consumer Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Deductible is met — Copay assistance limit is met — Out-of-Pocket maximum is met

Scenario 2: Plan *With* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		$15,160
Consumer Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met — Copay assistance limit is met — Out-of-Pocket maximum is met

https://aidsinstitute.net/documents/final_TAI_2022-Report-Update_020122.pdf

A concern regarding co-pay assistance programs is that they shift patient spending toward higher cost branded medications. This concern has largely been discredited as copay assistance programs help patients afford their coinsurance or co-payment. The medication must have already been approved by the insurance. Prior to branded medications being approved by insurance, patients must go through a step therapy or prior authorization process to prove the need for the branded product over less expensive generic alternatives. Additionally, a study conducted by IQVIA of claims data from 2013-2017 shows that 99.6 percent of co-pay assistance was used for treatments without generic alternatives. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

RELATIONSHIP

Relates to House Bill 51, which would establish a Prescription Cost Affordability Board, and House Bill 132, which requires parity between cost-sharing amounts experienced by patients using any willing local or mail-order pharmacy.

TECHNICAL ISSUES

The provision in Section 1A (and other subsections A) means that every insurer licensed in the state under the various code sections will have to "credit the enrollee for the full value of discounts provided or payments made by third parties at the time of the prescription drug claim." This means, for example, that coupons provided by a pharmaceutical manufacturer (typically for high priced drugs) will have to be honored by the insurer. The bill does not indicate whether this must be done for all drugs or only those that are an insurer's formulary, or if they must honor the coupon if the insurer covers other therapeutically equivalent drugs at lower cost. "Third parties" are not defined.

Section 1C (and other subsections C) requires that the maximum amount of cost sharing be the least of four possibilities, the last of which is "the value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug." This will be difficult for an insurer or PBM to calculate given the myriad of ways manufacturer rebates are paid.

Section 1E (and other subsections E) states that after January 1, 2024, any rebate amount shall be counted toward the insured's out of pocket prescription drug costs. It is not clear what "any rebate" means.

In Section 7 as added in the HHHC amendment, neither "entity" nor "third party" are defined.

The bill does not direct the OSI to issue regulations, though regulations are likely appropriate.

NMAG makes the following comments:

- Absent clearly defined terms in pharmacy benefits legislation, a company can make a "reasonable interpretation" of the law, even if it is the wrong interpretation, and not be penalized. See United States et al ex rel Schutte v. SuperValu Inc., U.S. Supreme Court Docket No. 21-1326 (oral argument set for April 18, 2023).
- Section 1(B)(2), Section 3(B)(2), Section 4(B)(2), Section 5(B)(2), Section 6(B)(2)—the term "infusion site" is not defined.
- Section 1(B)(2), Section 3(B)(2), Section 4(B)(2), Section 5(B)(2), Section 6(B)(2)—the phrase "provided that an insurer may communicate" is unclear. Does "provided" mean if the insurer makes this communication, then it is exempt from (B)(2)?
- Section 1(G), Section 3(G), Section 4(G), Section 5(G), and Section 6(G)—the terms "catastrophic plan" and "tax-favored plans" are not defined.
- Section 2—the term "pharmaceutical drug cost-sharing protections" is not defined.

Finally, GSD makes the following point:

> The sponsor may consider amending Subsection G in each Section to clarify that only the provisions of Subsection A do not apply, as it appears that the provisions of Subsections

B through E might have general application, regardless of whether the plan is provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, is a catastrophic plan, tax-favored plan, or high-deductible health plan with a health savings account.

LAC/RBT/al/hg/rl/ne