# Multiple Agency Fiscal Note Summary

| **Bill Number:** 1465 HB | **Title:** Prescription cost-sharing |
|---|---|

## Estimated Cash Receipts

| Agency Name | 2023-25 | | | 2025-27 | | | 2027-29 | | |
|---|---|---|---|---|---|---|---|---|---|
| | GF-State | NGF-Outlook | Total | GF-State | NGF-Outlook | Total | GF-State | NGF-Outlook | Total |
| Washington State Health Care Authority | Non-zero but indeterminate cost and/or savings. Please see discussion. | | | | | | | | |
| **Total $** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

## Estimated Operating Expenditures

| Agency Name | 2023-25 | | | | 2025-27 | | | | 2027-29 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FTEs | GF-State | NGF-Outlook | Total | FTEs | GF-State | NGF-Outlook | Total | FTEs | GF-State | NGF-Outlook | Total |
| Washington State Health Care Authority | .0 | 0 | 0 | 3,955,000 | .0 | 0 | 0 | 7,820,000 | .0 | 0 | 0 | 7,820,000 |
| Washington State Health Care Authority | In addition to the estimate above,there are additional indeterminate costs and/or savings. Please see individual fiscal note. | | | | | | | | | | | |
| Office of Insurance Commissioner | .8 | 0 | 0 | 244,048 | 1.8 | 0 | 0 | 455,159 | 1.2 | 0 | 0 | 293,782 |
| **Total $** | **0.8** | **0** | **0** | **4,199,048** | **1.8** | **0** | **0** | **8,275,159** | **1.2** | **0** | **0** | **8,113,782** |

## Estimated Capital Budget Expenditures

| Agency Name | 2023-25 | | | 2025-27 | | | 2027-29 | | |
|---|---|---|---|---|---|---|---|---|---|
| | FTEs | Bonds | Total | FTEs | Bonds | Total | FTEs | Bonds | Total |
| Washington State Health Care Authority | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| Office of Insurance Commissioner | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| **Total $** | **0.0** | **0** | **0** | **0.0** | **0** | **0** | **0.0** | **0** | **0** |

## Estimated Capital Budget Breakout

| Prepared by: Jason Brown, OFM | Phone: (360) 742-7277 | Date Published: Final 2/ 7/2023 |
|---|---|---|

# Individual State Agency Fiscal Note

| Bill Number: 1465 HB | Title: Prescription cost-sharing | Agency: 107-Washington State Health Care Authority |
|---|---|---|

## Part I: Estimates

☐ **No Fiscal Impact**

**Estimated Cash Receipts to:**

**Non-zero but indeterminate cost and/or savings. Please see discussion.**

**Estimated Operating Expenditures from:**

| | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|
| **Account** | | | | | |
| Uniform Medical Plan Benefits Administration Account-Non-Appropriated 439-6 | 750,000 | 1,653,750 | 2,403,750 | 3,615,000 | 3,615,000 |
| School Employees' Insurance Account-Non-Appropriated 493-6 | 0 | 375,000 | 375,000 | 1,500,000 | 1,500,000 |
| School Employees' Benefits Board Medical Benefits Administrative Account-Non-Appropriated 494-6 | 250,000 | 551,250 | 801,250 | 1,205,000 | 1,205,000 |
| Public Employees' and Retirees Insurance Account-Non-Appropriated 721-6 | 0 | 375,000 | 375,000 | 1,500,000 | 1,500,000 |
| **Total $** | 1,000,000 | 2,955,000 | 3,955,000 | 7,820,000 | 7,820,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**Estimated Capital Budget Impact:**

NONE

*The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.*

Check applicable boxes and follow corresponding instructions:

[X] If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

[ ] If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

[ ] Capital budget impact, complete Part IV.

[ ] Requires new rule making, complete Part V.

| | | | |
|---|---|---|---|
| Legislative Contact: | Kim Weidenaar | Phone: 360-786-7120 | Date: 01/24/2023 |
| Agency Preparation: | Sara Whitley | Phone: 360-725-0944 | Date: 01/30/2023 |
| Agency Approval: | Tanya Deuel | Phone: 360-725-0908 | Date: 01/30/2023 |
| OFM Review: | Marcus Ehrlander | Phone: (360) 489-4327 | Date: 02/03/2023 |

# Part II: Narrative Explanation

**II. A - Brief Description Of What The Measure Does That Has Fiscal Impact**

*Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.*

See attached narrative.

HCA: Indeterminate fiscal impact
HBE: No fiscal impact

**II. B - Cash receipts Impact**

*Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.*

See attached narrative.

HCA: No cash receipts
HBE: Indeterminate cash receipts impact

**II. C - Expenditures**

*Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.*

See attached narrative.

HCA: Indeterminate fiscal impact
HBE: No fiscal impact

# Part III: Expenditure Detail

**III. A - Operating Budget Expenditures**

| Account | Account Title | Type | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|---|---|
| 439-6 | Uniform Medical Plan Benefits Administration Account | Non-Appropriated | 750,000 | 1,653,750 | 2,403,750 | 3,615,000 | 3,615,000 |
| 493-6 | School Employees' Insurance Account | Non-Appropriated | 0 | 375,000 | 375,000 | 1,500,000 | 1,500,000 |
| 494-6 | School Employees' Benefits Board Medical Benefits Administrative Account | Non-Appropriated | 250,000 | 551,250 | 801,250 | 1,205,000 | 1,205,000 |
| 721-6 | Public Employees' and Retirees Insurance Account | Non-Appropriated | 0 | 375,000 | 375,000 | 1,500,000 | 1,500,000 |
| | | **Total $** | 1,000,000 | 2,955,000 | 3,955,000 | 7,820,000 | 7,820,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**III. B - Expenditures by Object Or Purpose**

| | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|
| FTE Staff Years | | | | | |
| A-Salaries and Wages | | | | | |
| B-Employee Benefits | | | | | |
| C-Professional Service Contracts | | | | | |
| E-Goods and Other Services | | | | | |
| G-Travel | | | | | |
| J-Capital Outlays | | | | | |
| M-Inter Agency/Fund Transfers | | | | | |
| N-Grants, Benefits & Client Services | 1,000,000 | 2,955,000 | 3,955,000 | 7,820,000 | 7,820,000 |
| P-Debt Service | | | | | |
| S-Interagency Reimbursements | | | | | |
| T-Intra-Agency Reimbursements | | | | | |
| 9- | | | | | |
| **Total $** | 1,000,000 | 2,955,000 | 3,955,000 | 7,820,000 | 7,820,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**III. C - Operating FTE Detail:** *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.*

NONE

**III. D - Expenditures By Program (optional)**

NONE

# Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.*

NONE

**IV. D - Capital FTE Detail:** *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

See attached narrative.

# Part V: New Rule Making Required

*Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.*

Bill Number: SB 1465 HCA Request #: 23-063

## Part II: Narrative Explanation

### II. A - Brief Description of What the Measure Does That Has Fiscal Impact

Section 2(1) adds a new section to RCW 48.43 (Insurance Reform) requiring health plans renewed on or after January 1, 2025 to calculate an enrollee's coinsurance or deductible payment for each covered prescription drug as the point of sale (POS) price reduced by an amount equal to one-hundred percent (100%) of all rebates received, or expected to be received, in connection with the dispensing or administration of the prescription drug.

Section 2(1)(b) requires a carrier to complete and provide each enrollee with an end-of-calendar year reconciliation for any cost-sharing reductions owed to the enrollee that were not passed on through via the estimated rebate amount calculated at the POS.

Section 3 adds a new section to RCW 41.05 (State Health Care Authority) with requirements for applicable health plans that are identical to those included in Section 2.

Section 4(1) adds a new section to RCW 48.200 (Health Care Benefit Managers) that does not allow a pharmacy benefit manager (PBM) to derive income from any other source other than a pharmacy benefit management fee that is set forth in contractual agreements between PBMs and a carrier or health plan.

Section 4(2) requires a PBM fee charged by or paid to a pharmacy benefit manager from a carrier not be directly or indirectly based on the following:

- The acquisition cost or any other price metric of a drug
- The amount of savings, rebates or other fees charged, collected by or generated based on the activity of the PBM.
- The amount of premiums, deductible, or other cost sharing or fees charged, realized or collected by the PBM from patient or other persons on behalf of the patient.

Section 4(3) requires PBMs to certify to the commissioner, annually by December 31st, that they are fully and completely compliant with the requirements of this legislation.

Section 4(4) requires all contracts with PBMs, and health carriers specify all forms of revenue, including PBM fees, to be paid by the carrier to the PBM.

### II. B - Cash Receipts Impact

None.

### II. C – Expenditures

Indeterminate fiscal impact, assumed to be greater than $50,000.

**Public Employee Benefits Board (PEBB) and School Employee Benefits Board (SEBB) Program Impacts**

RCW 41.05 governs the self-insured Uniform Medical Plans (UMP), which are offered by the PEBB and SEBB programs. RCW 48.43 governs the fully insured health plans offered by the PEBB and SEBB programs. Implementation of this bill could result in increased premiums for the self-insured and fully insured medical plans which may impact the state medical benefit contribution and employee contributions for health benefits.

Calculation of Rebates at the Point-of-Sale (POS)

Section 2 and Section 3 of this bill add new sections to RCW 48.43 (Insurance Reform) and RCW 41.05 (State Health Care Authority) requiring health plans renewed on or after January 1, 2025 to calculate an enrollee's coinsurance or deductible payment for each covered prescription drug as the point of sale (POS) price reduced by the amount equal to 100% of all rebates received, or expected to be received, in connection with the dispensing or administration of the prescription drug.

RCW 48.43 governs the PEBB and SEBB fully insured health plans offered through Kaiser and Premera. Kaiser has indicated that for their book of business, most prescription discounts from manufacturers are realized at the time the drugs are purchased via up-front discounts, and not as after-purchase rebates. Therefore, the assumed fiscal impact as a result of this legislation to the Kaiser PEBB and SEBB plans is minor. At this time, Premera was not able to quantify the possible impact of this legislation, but did indicate the possibility of increased premiums for all members due to rebates being passed to specific members at the POS, and not used to offset overall plan costs during rate development. At this time, we are not able to quantify the impact of this legislation for the PEBB and SEBB fully insured carriers.

RCW 41.05 governs the self-insured Uniform Medical Plans (UMP), which are offered by the PEBB and SEBB programs. The prescription drug benefit is administered by Moda, UMP's pharmacy benefit manager (PBM). This legislation would require Moda to calculate applicable member cost sharing for pharmacy coinsurance and deductibles using an amount that is net of rebates assumed to be received for a prescription drug at the POS (Table 2); this contrasts with the current practice of calculating member coinsurance and deductible amounts for prescription drugs without consideration of rebates. Currently, any projected rebate amounts received for prescription drugs in UMP are used to offset projected claims costs in the UMP each year during premium development.

UMP's pharmacy benefit design features relatively low pharmacy deductibles, and distinct medical and pharmacy maximum-out-of-pocket limits. The UMP CDHP (PEBB) and HDHP (SEBB) plans have a combined medical/pharmacy deductible and out of pocket maximum for pharmacy. The UMP pharmacy benefit is structured such that members pay any applicable coinsurance for a drug up to a capped member coinsurance (Table 1).

Table 1

| **UMP Pharmacy Benefit Tier Design** (30 day supply) | |
|---|---|
| | **Member Cost Share** |
| **Preventative Tier** | 0% coinsurance |
| **Value Tier** | 5% coinsurance up to a maximum of **$10 copay** |
| **Tier 1 Select Generic Drugs** | 10% coinsurance up to a maximum of **$25 copay** |
| **Tier 2 Preferred Drugs** | 30% coinsurance up to a maximum of **$75 copay** |

UMP's pharmacy coinsurance caps mitigate the potential impact of applying rebate dollars to specific drugs at the POS. For a high-cost specialty drug heavily discounted via application of rebate at the POS, in most cases the UMP coinsurance cap is likely to cost less than the rebate-adjusted price of the drug. For example, if a specialty drug in Tier 2 (specialty) is priced at $7,000 and the calculated rebate at the POS for that drug is $3,000, the new post-rebate drug price is $4,000. Using this post-rebate discounted price of $4,000 to calculate the member responsibility, the coinsurance cap of $75 is applied which is less than the coinsurance on the discounted price ($1,200) of the drug post-rebate (Table 2). HCA assumes that any rebates in excess of the reduction in POS costs to the member will not be owed to members during the end-of-year reconciliation.

Table 2

Example

UMP Tier 2, Specialty: 30% coinsurance up to a maximum $75 copay

| | | | |
|---|---|---|---|
| Cost of Drug | | $7,000 | A |
| Calculated Rebate at POS | | $3,000 | B |
| Net Rebate Discounted Cost of Drug | | **$4,000** | C = A-B |
| | Member pays the minimum of: | | |
| | 30% Coinsurance | $75 copay | |
| Calculated Member Cost share | C x 30% | D | |
| | $1,200 | **$75** | |

Milliman, HCA's contracted actuary, completed an analysis of historical UMP pharmacy experience for calendar years 2019, 2020 and 2021. That analysis revealed that UMP Tier 2 specialty drugs (which feature an approximate 52% average rebate) have an average unit cost of over $6,400 per 30-day supply, with 30% coinsurance and a $75 coinsurance cap. With an average initial coinsurance of approximately $1,900, it is likely that almost all cost sharing is being capped at the $75 limit. This dynamic holds true even when reducing the allowed amount by half to yield an average initial coinsurance in the $900-$1,000 range.

While members in the UMP CDHP and HDHP plans may realize the impact of rebates applied at the POS for higher cost drugs before they reach their plan deductibles, utilization of high cost drugs is less prevalent in these plans and the predicted impact of this dynamic is low.

Due to the coinsurance cap benefit design structure, if the rebate amount is greater than coinsurance cap, HCA assumes UMP would maintain the current practice of applying any projected rebate amounts received for prescription drugs as premium reductions each year during bid rate development.

Therefore, due to the underlying benefit design of the UMP pharmacy benefit, as well as the assumption that allows for the plan to receive rebates and offset plan liabilities through lower premiums, HCA assumes the annual impacts of this aspect of legislation to be approximately $1.5 million annually for the PEBB and SEBB programs combined (Table 3). Because both the state contribution via the Employer Medical Contribution (EMC) and State Index Rate (SIR) and employee contribution rates have rounding rules that round to the nearest whole dollar, these impacts would likely not be enough to move state or employee contribution rates by a dollar.

However, feedback from Moda (UMP's PBM) indicate the requirement for a significant investment in administrative resources and technological updates to systems are essential to implement this bill's requirement of calculating rebates at the POS and conducting annual reconciliation of rebates collected. Areas impacted include, but are not limited to:

- Developing and managing algorithms to calculate ingredient costs reflecting estimated rebate contributions.
- Tracking and adjusting reimbursement algorithms throughout the year as changes occur in the Wholesale Acquisition Cost (WAC) pricing.
- Developing and administering audit trails to reconcile billed and paid rebates against member cost sharing.

These updates will require the following estimated annual increases to the administrative fees paid to Moda, resulting in the following estimated fiscal impacts to the PEBB and SEBB programs. Administrative fees are currently paid to Moda on a per member per month (PMPM) basis; total amounts described below are assumed to be split between PEBB and SEBB based off of current levels of enrollment. Any increase to administrative fees could result in increased premiums for the PEBB and SEBB UMP offerings (Table 3):

Table 3

**Summary of Costs (PEBB + SEBB)**

| | FY 2024 | FY 2025 | FY 2026 | FY 2027 |
|---|---|---|---|---|
| Net Premium Change | $ - | $ 750,000 | $ 1,500,000 | $ 1,500,000 |
| Implementation Costs | $ 1,000,000 | $ 1,000,000 | $ - | $ - |
| Ongoing Costs | $ - | $ 1,050,000 | $ 2,100,000 | $ 2,100,000 |
| Assumed Interest | $ - | $ 155,000 | $ 310,000 | $ 310,000 |
| **Total** | **$ 1,000,000** | **$ 2,955,000** | **$ 3,910,000** | **$ 3,910,000** |

**Costs by Fund**

| | FY 2024 | FY 2025 | FY 2026 | FY 2027 |
|---|---|---|---|---|
| PEBB - Fund 721 | - | $ 375,000 | $ 750,000 | $ 750,000 |
| PEBB - Fund 439 | $ 750,000 | $ 1,653,750 | $ 1,807,500 | $ 1,807,500 |
| SEBB - Fund 493 | - | $ 375,000 | $ 750,000 | $ 750,000 |
| SEBB - Fund 494 | $ 250,000 | $ 551,250 | $ 602,500 | $ 602,500 |
| **Total** | **$ 1,000,000** | **$ 2,955,000** | **$ 3,910,000** | **$ 3,910,000** |

- Implementation: One-time implementation cost of approximately $2 million to implement system capacity needs and developing and algorithms to calculate allowed costs reflecting estimated rebate contributions. Implementation is assumed to begin January 1, 2024, to meet the requirements of this legislation prior to the effective date required in this bill of January 1, 2025.

- Ongoing Costs: Approximately $2.1 million ($0.50 PMPM) in annual ongoing costs related to managing algorithms to calculate ingredient costs that reflect estimated rebate contributions, tracking and adjustments of those algorithms and development and administration of audit trails.

- Additional Ongoing Costs – Interest on pre-funded amounts: It is unknown how this bill would ultimately be implemented, however, Moda would require HCA pay an annual interest rate of 15.5% on any rebate amounts that Moda is required to prefund to members at POS. HCA intends to fund all rebates paid to members at the POS and assumes this interest provision

would not be necessary. Should implementation not allow for HCA to prefund rebates, ultimately leading to interest owed on amounts paid by Moda, HCA estimates an approximate annual impact of $310,000 for both PEBB and SEBB programs. HCA also assumes this additional income required by Moda is acceptable based on the requirements set forth in Section 4 of the bill.

End-of-Year Reconciliation

Section 2(1)(b) and Section 3(1)(b) include the requirement for a carrier to complete and provide each enrollee with an end-of-calendar year reconciliation for any cost-sharing reductions owed to the enrollee that were not passed on through via the estimated rebate amount calculated at the POS.

At this time, HCA has not received assumed estimates of any fiscal impacts resulting from this aspect of the legislation from the PEBB and SEBB fully insured carriers Kaiser and Premera.

Feedback received from UMP's PBM Moda indicates the possibility of significant impacts to the underlying systems that inform the administration of the UMP pharmacy benefit, resulting in increased contracted administrative fees. The calculated rebate amount for any drug is provided by third-party references often change throughout the year. To perform an annual reconciliation of paid rebates versus rebate estimates that are calculated at POS will add considerable administrative and reporting overhead that will affect the total cost to provide benefit administration for PEBB and SEBB plans.

The underlying complexities of billing, calculating, and receiving rebates from drug manufactures often requires up to 18 months of "lag". Therefore, the annual reconciliation required by this legislation may not capture the full scope of rebates incurred and paid throughout the calendar year. HCA assumes that any rebate amounts not captured during this end-of-year reconciliation for costs incurred during the plan year are not required to be re-reconciled in any future period.

Income for Pharmacy Benefit Managers (PBMs)

Section 4 of this bill adds a new section to RCW 48.200 (Health Care Benefit Managers) that does not allow a pharmacy benefit manager (PBM) to derive income from any other source other than a pharmacy benefit management fee that is set forth in contractual agreements between PBMs and a carrier or health plan. RCW 48.200.020 (Health care benefit managers, Definitions) defines pharmacy benefit managers as a person that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug consortium established under RCW 70.14.060, but excluding health care service contractors as defined in 48.44.010.

The current structure of UMP's contractual relationship with Moda requires that 100 percent of all rebates received for drug utilized by UMP members are passed through to the plan, Moda does not retain any rebate amounts. Furthermore, the administrative fees paid to Moda are negotiated amounts based on the underlying requirements for administering the pharmacy portion of UMP's benefit. Therefore, there are no assumed impacts to UMP as a result of this aspect of the legislation.

**Assumptions:**

- HCA assumes potential rebates apply to only brand-name and specialty pharmacy claims handled by a pharmacy benefit manager (PBM) under a prescription drug benefit. Claims for prescription drugs filled at retail pharmacies, mail order pharmacies, and specialty pharmacies.

- HCA did not consider potential rebates associated with physician-office administered drugs and other drugs paid for through medical benefits and assume these drugs and any associated rebates are not included under the scope of the legislation.
- HCA assumes UMP would still be able to receive rebates, when not applied at the POS for member costs, maintaining the current practice of applying any projected rebate amounts received for prescription drugs to offset projected claims costs in the UMP each year during bid rate development.
- HCA utilized the Milliman Pharmacy Rating Model (RXRM) to size the potential impacts to UMP based on the current pharmacy benefit design and cost sharing by tier for the UMP. This analysis was limited to claims incurred in the UMP non-Medicare and Medicare risk pool. Any impacts on the UMP Classic Medicare plan premiums are assumed to be borne by the member, as UMP Classic Medicare currently realizes the full value of the Medicare Explicit Subsidy.
- It is assumed the benefit coverage requirements under this legislation do not apply to the fully insured Medicare Advantage (MA) plans offered to Medicare eligible PEBB retirees because state laws are pre-empted by Federal laws for MA and Part D offerings.
- Ongoing cost estimates from Moda do not account for any assumed growth in UMP.
- HCA assumes the OIC regulatory authority in Section 3 is intended to only apply to the PEBB & SEBB fully insured health plans, as OIC does not have existing regulatory authority over any self-insured plans (including the Uniform Medical Plan).

**Medicaid**

No fiscal impact.

No impacts on the Medicaid lines of business because this legislation places the requirements under RCW 48.43 and 41.05.

## Part IV: Capital Budget Impact

None.

## Part V: New Rule Making Required

None.

# HBE Fiscal Note

Bill Number: 1465 HB HBE Request #: 23-07-01

## Part II: Narrative Explanation

### II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

This bill would require health plans issued or renewed on/after January 1, 2025, to decrease cost sharing for prescription drugs by passing savings through to the enrollee at the point of sale.

### II. B - Cash Receipts Impact

Indeterminate. New mandated benefits typically increase premiums, but the expected premium increase amount attributable to just this new benefit is unknown at this time.

### II. C - Expenditures

No fiscal impact, changes that require inclusion of this health care benefit in qualified health plans offered in the Exchange marketplace are not expected to require significant operational or Healthplanfinder system changes.

## Part IV: Capital Budget Impact

None.

## Part V: New Rule Making Required

None.

# Individual State Agency Fiscal Note

| Bill Number: 1465 HB | Title: Prescription cost-sharing | Agency: 160-Office of Insurance Commissioner |
|---|---|---|

## Part I: Estimates

☐ **No Fiscal Impact**

**Estimated Cash Receipts to:**

NONE

**Estimated Operating Expenditures from:**

| | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|
| FTE Staff Years | 0.1 | 1.6 | 0.9 | 1.8 | 1.2 |
| **Account** | | | | | |
| Insurance Commissioners Regulatory Account-State 138-1 | 6,285 | 237,763 | 244,048 | 455,159 | 293,782 |
| **Total $** | 6,285 | 237,763 | 244,048 | 455,159 | 293,782 |

**Estimated Capital Budget Impact:**

NONE

*The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.*

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

| | | | |
|---|---|---|---|
| Legislative Contact: | Kim Weidenaar | Phone: 360-786-7120 | Date: 01/24/2023 |
| Agency Preparation: | Jane Beyer | Phone: 360-725-7043 | Date: 01/24/2023 |
| Agency Approval: | Michael Wood | Phone: 360-725-7007 | Date: 01/24/2023 |
| OFM Review: | Jason Brown | Phone: (360) 742-7277 | Date: 02/01/2023 |

## Part II: Narrative Explanation

**II. A - Brief Description Of What The Measure Does That Has Fiscal Impact**

*Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.*

Section 2(1) requires health plans issued or renewed on or after January 1, 2025, to ensure that an enrollee's coinsurance or deductible payment for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.

Section 2(1)(a) requires a carrier or subcontractor to pass through to each enrollee at the point of sale a good faith estimate of the enrollee's decrease in cost sharing required.

Section 2(1)(b) requires that in addition to the pass-through at the point of sale described in (1)(a), the carrier shall provide the enrollee with an end-of-calendar year reconciliation for any cost-sharing reductions owed to the enrollee that were not passed on to the enrollee through the estimated amount at the point of sale.

Section 2(2) states a carrier or subcontractor may decrease an enrollee's coinsurance or deductible payment by an amount greater than required under subsection (1) above.

Section 2(3) provides that pharmacies may not be penalized for failure to comply if the pharmacy did not have sufficient information to follow the law. Carrier and subcontractors may not withhold payment if the pharmacy engaged in good faith efforts to comply.

Section 2(4) authorizes OIC to adopt rules to implement the law.

Section 2(5) authorizes OIC to take appropriate enforcement action against a carrier and its subcontractors to enforce the chapter by imposing a civil penalty of up to $1,000 per violation.

Section 2(6) requires carriers to disclose to OIC upon request information sufficient to show compliance with the law. The OIC may audit the information a health carrier provides for accuracy.

Section 4(1) prohibits a pharmacy benefit manager (PBM) from deriving income from pharmacy benefit management services provided to a carrier except for income derived from a pharmacy benefit management fee. The amount of any pharmacy benefit management fees must be set for the in the agreement between the PBM and the carrier.

Section 4(3) requires each PBM, by December 31st of each year, to certify to the OIC that it has fully and completely complied with the requirements of this section throughout the prior calendar year.

Section 4(4) requires a PBM contract, entered into on or after the effective date of this section, with a carrier to specify all forms of revenue, including pharmacy benefit management fees, to be paid by the carrier to the PBM.

Section 4(5) provides that in addition to any other civil or criminal penalty authorized by law, OIC may take appropriate action to enforce the law by imposing a civil penalty not to exceed $1,000 per violation.

**II. B - Cash receipts Impact**

*Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.*

**II. C - Expenditures**

*Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.*

Section 2(1) requires health plans issued or renewed on or after January 1, 2025, to ensure that an enrollee's coinsurance or deductible payment for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.

Section 2(1)(a) requires a carrier or subcontractor to pass through to each enrollee at the point of sale a good faith estimate of the enrollee's decrease in cost sharing required.

Section 2(1)(b) requires that in addition to the pass-through at the point of sale described in (1)(a), the carrier shall provide the enrollee with an end-of-calendar year reconciliation for any cost-sharing reductions owed to the enrollee that were not passed on to the enrollee through the estimated amount at the point of sale.

Section 2(2) states a carrier or subcontractor may decrease an enrollee's coinsurance or deductible payment by an amount greater than required under subsection (1) above.

Section 2(3) provides that pharmacies may not be penalized for failure to comply if the pharmacy did not have sufficient information to follow the law. Carrier and subcontractors may not withhold payment if the pharmacy engaged in good faith efforts to comply.

Section 2 will require additional review of health plan form filings to ensure plans have updated the change in their prescription drug benefit language. The Office of Insurance Commissioner (OIC) will require one-time costs, in FY2025, of 6 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions, train staff, and educate issuers. The OIC receives approximately 312 health plan form filings each year and assumes the new review standards will result in an additional 20 minutes of review per form filing requiring 104 hours (312 form filings x 20 minutes) of a Functional Program Analyst 3 (FPA3) beginning in FY2025.

Section 2(1) and 2(1)(a) will generate a significant number of additional written inquiries, calls, and complaints to the OIC. Although self-funded health plans and Medicare Advantage plans are not subject to this new law, based upon past experience, it is anticipated to result in potential confusion between plans the OIC regulates versus those it does not. The OIC receives an average of 695 informational cases and 256 complaint cases regarding prescription drug issues each year. As a result of this bill, consumer contacts related to prescription drug issues are expected to double. For purposes of this fiscal note, it is assumed that informational cases will take 10 minutes per case and complaint cases will take 3.25 hours per case requiring a total of 948 hours (695 info cases x 10 minutes + 256 complaint cases x 3.25 hours) of a Functional Program Analyst 3 each year beginning in FY2025.

Section 2(1)(b) will produce surges in consumer informational inquiries and calls as large groups of insureds receive their notices for the first time in 2025 and then at a much lower rate annually. Assuming conservatively that only 0.2% of enrollees in plans regulated under Title 48 contact the OIC, it is anticipated that 2,400 additional consumer contacts in FY2025 reduced to 240 additional consumer contacts each year thereafter will be received requiring 200 hours (2,400 info cases x 5 minutes) in FY2025 and 20 hours (240 info cases x 5 minutes) in FY2026 and thereafter of an Insurance Technician 3.

Section 2(4) authorizes OIC to adopt rules to implement the law. There are substantial financial consequences of this legislation for carriers and pharmacy benefit managers, and substantial impact on consumer prescription drug cost sharing. In addition, several important terms in the legislation are not clearly defined, necessitating rulemaking on at least these components of the law. There will be very heightened interest in this rulemaking by all affected individuals and entities. For these reasons, the rulemaking will be 'complex' rulemaking in FY2025.

Section 2(6) requires carriers to disclose to OIC, upon request, information sufficient to show compliance with the law. The OIC may audit the information a health carrier provides for accuracy. Carriers must quickly implement significant changes to their point-of-sale pharmacy claim administration systems to include rebates at point of sale. There were 22 carriers that received pharmacy rebates in 2021. The OIC assumes that in FY2026, a preliminary market conduct examination effort must be made to show compliance. The OIC assumes it will need to conduct an additional 22 market conduct examinations (MCEs) in FY2026 reduced to 5 additional MCEs each year thereafter requiring 2,640 hours (22 MCEs x 120 hours) in FY2026 and 600 hours (5 MCEs x 120 hours) in FY2027 and thereafter of a Functional Program Analyst 3.

Section 4(1) prohibits a pharmacy benefit manager (PBM) from deriving income from pharmacy benefit management services provided to a carrier except for income derived from a pharmacy benefit management fee. The amount of any pharmacy benefit management fees must be set for the in the agreement between the PBM and the carrier.

Section 4(3) requires each PBM, by December 31st of each year, to certify to the OIC that it has fully and completely complied with the requirements of this section throughout the prior calendar year.

Section 4(4) requires a PBM contract, entered into on or after the effective date of this section, with a carrier to specify all forms of revenue, including pharmacy benefit management fees, to be paid by the carrier to the PBM.

Section 4 will require additional review of all pharmacy provider contracts to ensure contracts have addressed PBM fees and certification. The OIC will require one-time costs, in FY2024, of 4 hours of a Functional Program Analyst 4 to update filing review standards, update checklist documents and filing instructions and train staff. The OIC receives approximately 175 pharmacy provider contract filings each year and assumes the new review standards will result in an additional 30 minutes of review per contract requiring 88 hours (175 contract filings x 30 minutes) of a Functional Program Analyst 3 beginning in FY2024.

The provisions in Sections 2 and 4 will lead to an increase in enforcement actions. The OIC anticipates an average of three additional enforcement action per year to address allegations specific to payment for prescription drugs. Enforcement actions require the equivalent of approximately 40 hours per case requiring 120 hours (3 cases x 40 hours) of an Insurance Enforcement Specialist beginning in FY2026.

Ongoing Costs:
Salary, benefits and associated costs for 1.07 FTE Functional Program Analyst 3, .07 FTE Insurance Enforcement Specialist, and .01 FTE Insurance Technician 3.

# Part III: Expenditure Detail

**III. A - Operating Budget Expenditures**

| Account | Account Title | Type | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|---|---|
| 138-1 | Insurance Commissioners Regulatory Account | State | 6,285 | 237,763 | 244,048 | 455,159 | 293,782 |
| | | **Total $** | 6,285 | 237,763 | 244,048 | 455,159 | 293,782 |

**III. B - Expenditures by Object Or Purpose**

| | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|
| FTE Staff Years | 0.1 | 1.6 | 0.9 | 1.8 | 1.2 |
| A-Salaries and Wages | 3,663 | 141,578 | 145,241 | 263,980 | 171,672 |
| B-Employee Benefits | 1,365 | 48,632 | 49,997 | 97,747 | 63,354 |
| C-Professional Service Contracts | | | | | |
| E-Goods and Other Services | 1,257 | 47,553 | 48,810 | 90,432 | 58,756 |
| G-Travel | | | | | |
| J-Capital Outlays | | | | 3,000 | |
| M-Inter Agency/Fund Transfers | | | | | |
| N-Grants, Benefits & Client Services | | | | | |
| P-Debt Service | | | | | |
| S-Interagency Reimbursements | | | | | |
| T-Intra-Agency Reimbursements | | | | | |
| 9- | | | | | |
| **Total $** | 6,285 | 237,763 | 244,048 | 455,159 | 293,782 |

**III. C - Operating FTE Detail:** *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

| Job Classification | Salary | FY 2024 | FY 2025 | 2023-25 | 2025-27 | 2027-29 |
|---|---|---|---|---|---|---|
| Functional Program Analyst 3 | 73,260 | 0.1 | 0.7 | 0.4 | 1.7 | 1.1 |
| Functional Program Analyst 4 | 80,952 | | 0.2 | 0.1 | | |
| Insurance Enforcement Specialist | 99,516 | | | | 0.1 | 0.1 |
| Insurance Technician 3 | 48,156 | | 0.1 | 0.1 | 0.0 | 0.0 |
| Senior Policy Analyst | 108,432 | | 0.7 | 0.3 | | |
| **Total FTEs** | | 0.1 | 1.6 | 0.9 | 1.8 | 1.2 |

**III. D - Expenditures By Program (optional)**

NONE

# Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.*

NONE

**IV. D - Capital FTE Detail:** *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

# Part V: New Rule Making Required

*Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.*

Section 2(4) authorizes OIC to adopt rules to implement the law. There are substantial financial consequences of this legislation for carriers and pharmacy benefit managers, and substantial impact on consumer prescription drug cost sharing. In

addition, several important terms in the legislation are not clearly defined, necessitating rulemaking on at least these components of the law. There will be very heightened interest in this rulemaking by all affected individuals and entities. For these reasons, the rulemaking will be 'complex' rulemaking in FY2025.