AN ACT

RELATING TO HEALTH CARE COVERAGE; CALCULATING COST-SHARING CONTRIBUTIONS FOR PRESCRIPTION DRUG COVERAGE; ENACTING A NEW SECTION OF THE NEW MEXICO INSURANCE CODE TO PROHIBIT DISCRIMINATION AGAINST ENTITIES PARTICIPATING IN THE FEDERAL 340B DRUG PRICING PROGRAM.

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:

"CALCULATING AN ENROLLEE'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may

communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum amount;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 2. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"HEALTH BENEFITS PLAN DISCLOSURE.--Each producer, plan administrator or pharmacy benefits manager licensed in this state shall not produce a health benefits plan for sale or pharmacy benefits services for contract without prior disclosure to the purchaser of the plan or services of the option to contract for pharmaceutical drug cost-sharing protections."

SECTION 3. A new section of Chapter 59A, Article 22

NMSA 1978 is enacted to read:

"CALCULATING AN INSURED'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to 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, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 4. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"CALCULATING AN INSURED'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to a group health plan other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may

communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"CALCULATING AN ENROLLEE'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third

parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"CALCULATING A SUBSCRIBER'S COST-SHARING OBLIGATION FOR

PRESCRIPTION DRUG COVERAGE.--

A. When calculating a subscriber's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health insurance policy, health care plan or certificate of health insurance issued for delivery or renewed in this state, the insurer shall credit the subscriber for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription

drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to

excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 7. A new section of the New Mexico Insurance Code is enacted to read:

"PROHIBITION ON DISCRIMINATION AGAINST A COVERED ENTITY.--

A. As used in this section:

(1) "340B drug" means a drug that is purchased at a discount in accordance with the 340B program requirements;

(2) "340B program" means the federal drug pricing program created pursuant to 42 U.S.C. Section 256b;

(3) "covered entity" means an entity participating in the 340B program; and

(4) "pharmacy benefits manager" means an entity that provides pharmacy benefits management services.

B. A pharmacy benefits manager or a third party shall not discriminate against a covered entity on the basis of its participation in the 340B program by:

(1) reimbursing a covered entity for a 340B drug at a rate lower than that paid for the same drug to pharmacies, similar in prescription volume, that are non-

covered entities;

(2) assessing a fee, chargeback or other adjustment to the covered entity that is not assessed to non-covered entities;

(3) imposing a provision that prevents or interferes with a person's choice to receive 340B drugs from a covered entity; or

(4) imposing terms or conditions that differ from terms or conditions imposed on a non-covered entity, including:

(a) restricting or requiring participation in a pharmacy network;

(b) requiring more frequent auditing or a broader scope of audit for inventory management systems using generally accepted accounting principles;

(c) requiring a covered entity to reverse, resubmit or clarify a claim after the initial adjudication, unless these actions are in the normal course of pharmacy business and not related to the 340B program; or

(d) charging an additional fee or provision that prevents or interferes with an individual's choice to receive a 340B drug from a covered entity."