

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

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

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

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

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

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

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

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

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

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

1 F. For purposes of this section, "cost sharing"  
2 means any:  
3 (1) copayment;  
4 (2) coinsurance;  
5 (3) deductible;  
6 (4) out-of-pocket maximum amount;  
7 (5) other financial obligation, other than a  
8 premium or share of a premium; or  
9 (6) combination thereof.

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

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

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

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

1 NMSA 1978 is enacted to read:

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

4 A. When calculating an insured's cost-sharing  
5 obligation for covered prescription drugs, pursuant to an  
6 individual or group health insurance policy, health care plan  
7 or certificate of health insurance that is delivered, issued  
8 for delivery or renewed in this state, the insurer shall  
9 credit the insured for the full value of any discounts  
10 provided or payments made by third parties at the time of the  
11 prescription drug claim.

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

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

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

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

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

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

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

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

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

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

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

- 20 (1) copayment;  
21 (2) coinsurance;  
22 (3) deductible;  
23 (4) out-of-pocket maximum;  
24 (5) other financial obligation, other than a  
25 premium or share of a premium; or

1 (6) combination thereof.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 F. For purposes of this section, "cost sharing"  
2 means any:  
3 (1) copayment;  
4 (2) coinsurance;  
5 (3) deductible;  
6 (4) out-of-pocket maximum;  
7 (5) other financial obligation, other than a  
8 premium or share of a premium; or  
9 (6) combination thereof.

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

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

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

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



1 parties at the time of the prescription drug claim.

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

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

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

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

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

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

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

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

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

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

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

- 10                   (1) copayment;
- 11                   (2) coinsurance;
- 12                   (3) deductible;
- 13                   (4) out-of-pocket maximum;
- 14                   (5) other financial obligation, other than a  
15 premium or share of a premium; or
- 16                   (6) combination thereof.

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

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

25           "CALCULATING A SUBSCRIBER'S COST-SHARING OBLIGATION FOR

1 PRESCRIPTION DRUG COVERAGE.--

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (1) copayment;

19 (2) coinsurance;

20 (3) deductible;

21 (4) out-of-pocket maximum;

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

24 (6) combination thereof.

25 G. The provisions of this section do not apply to

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

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

8 "PROHIBITION ON DISCRIMINATION AGAINST A COVERED  
9 ENTITY.--

10 A. As used in this section:

11 (1) "340B drug" means a drug that is  
12 purchased at a discount in accordance with the 340B program  
13 requirements;

14 (2) "340B program" means the federal drug  
15 pricing program created pursuant to 42 U.S.C. Section 256b;

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

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

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

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

1 covered entities;

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

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

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

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

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

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

20 (d) charging an additional fee or  
21 provision that prevents or interferes with an individual's  
22 choice to receive a 340B drug from a covered entity.”\_\_\_\_\_

23

24

25