HB 1380-FN - AS AMENDED BY THE SENATE

28Mar2024... 0872h
05/15/2024 1826s
05/23/2024 2119s

2024 SESSION

24-2339
08/05

HOUSE BILL ***1380-FN***

AN ACT relative to brew pub licenses, relative to insurance cost-sharing calculations, and relative to receipt of pharmaceutical rebates by insurers and pharmacy benefits managers.

SPONSORS: Rep. Hunt, Ches. 14

COMMITTEE: Commerce and Consumer Affairs

AMENDED ANALYSIS

This bill:

I. Allows a brew pub licensee to also hold an on-premises or off-premises license.

II. Provides that, when calculating an enrollee's contribution to cost-sharing requirements, the insurer or pharmacy benefits manager shall include any amount paid by the enrollee or paid on their behalf.

III. Includes a limited exception for health savings account-qualified high deductible health plans if application of the requirement would result in account ineligibility under the Internal Revenue Code.

IV. Revises the annual reporting requirement for pharmacy benefits managers regarding pharmaceutical rebates.

V. Revises the percentage of rebates insurers are required to make available to enrollees, increases the fine for noncompliance, and removes prospective repeal of RSA 415-A:7, relative to insurer cost sharing of rebates.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Four

AN ACT relative to brew pub licenses, relative to insurance cost-sharing calculations, and relative to receipt of pharmaceutical rebates by insurers and pharmacy benefits managers.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraph; Brew Pub; On-Premise and Off-Premise Licenses. Amend RSA 178:13 by inserting after paragraph XIV the following new paragraph:

XV. Notwithstanding the provisions of RSA 179:11 Holders of Beverage Manufacturer, Wholesale Distributor, Beverage Vendor, and Other Licenses; Prohibited Interests, nothing in that section shall prevent a holder of a brew pub license from holding an on-premises or off-premises license under this chapter, provided that:

(a) The brew pub licensee does not hold any other type of manufacturing license under this title; and

(b) Brew pub licensees holding one or more on-premises or off-premises licenses shall be limited to self- distributing to not more than one on-premises license owned by the brew pub licensee and shall not exceed 2,500 barrels of beer and/or cider during their licensing period. Nothing in this section shall authorize the holder of multiple brewpub licenses to self- distribute to more than one commonly owned on- premises or off- premises license.

2 New Section; Accident and Health Insurance; Fairness in Cost-Sharing Calculations. Amend RSA 415 by inserting after section 27 the following new section:

415:28 Fairness in Cost-Sharing Calculations.

I. In this section, "cost-sharing requirements" means any coinsurance, copayment, deductible or out-of-pocket maximum.

II. When calculating an enrollee's overall contribution to any cost-sharing requirements under an individual or group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, the insurer or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee. This requirement shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. If under federal law, application of this requirement would result in health savings account ineligibility with section 223 of the federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with

respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

III. When applying paragraph II to the calculation of an enrollee or insured's contribution to the annual limitation on cost-sharing set forth in 42 U.S.C. sections 18022(c) and 300gg-6(b), an individual or group policy, plan, or contract of accident or health insurance, or pharmacy benefit manager shall include expenditures for any item or service covered by such insurer or pharmacy benefit manager and included within a category of essential health benefits as described in 42 U.S.C. section 18022(b)(1).

IV. This section shall apply to a group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses delivered, issued for delivery, or renewed on or after January 1, 2025.

3 New Section; Health Service Corporations; Fairness in Cost-Sharing Calculations. Amend RSA 420-A by inserting after section 32 the following new section:

420-A:33 Fairness in Cost-Sharing Calculations.

I. "Cost-sharing requirements" has the same meaning as in RSA 415:28.

II. Every health service corporation and every similar corporation licensed under the laws of another state that issues or renews any policy, plan, or contract of individual or group accident or health insurance providing benefits for medical or hospital expenses, or pharmacy benefit manager when calculating an enrollee's overall contribution to any cost-sharing requirements shall include any amounts paid by the enrollee or paid on behalf of the enrollee. This requirement shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. If under federal law, application of this requirement would result in health savings account ineligibility with section 223 of the federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

III. When applying paragraph II to the calculation of an enrollee or insured's contribution to the annual limitation on cost-sharing set forth in 42 U.S.C. sections 18022(c) and 300gg-6(b), an individual or group policy, plan, or contract of accident or health insurance, or pharmacy benefit manager shall include expenditures for any item or service covered by such insurer or pharmacy benefit manager and included within a category of essential health benefits as described in 42 U.S.C. section 18022(b)(1).

4 New Section; Health Maintenance Organizations; Fairness in Cost-Sharing Calculations. Amend RSA 420-B by inserting after section 26 the following new section:

420-B:27 Fairness in Cost-Sharing Calculations.

I. "Cost-sharing requirements" has the same meaning as in RSA 415:28.

II. Every health maintenance organization and every similar corporation licensed under the laws of another state that issues or renews any policy, plan, or contract of individual or group health insurance providing benefits for medical or hospital expenses, or pharmacy benefit manager when calculating an enrollee's overall contribution to any cost-sharing requirements shall include any amounts paid by the enrollee or paid on behalf of the enrollee. This requirement shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. If under federal law, application of this requirement would result in health savings account ineligibility with section 223 of the federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

III. When applying paragraph II to the calculation of an enrollee or insured's contribution to the annual limitation on cost-sharing set forth in 42 U.S.C. sections 18022(c) and 300gg-6(b), an individual or group policy, plan, or contract of accident or health insurance, or pharmacy benefit manager shall include expenditures for any item or service covered by such insurer or pharmacy benefit manager and included within a category of essential health benefits as described in 42 U.S.C. section 18022(b)(1).

5 Pharmacy Benefits Manager Reporting. Amend RSA 402-N:6, I to read as follows:

I. Each pharmacy benefits manager shall submit an annual ***or quarterly*** report to the commissioner containing a list of health benefit plans it administered[~~,~~] and the [~~aggregate amount of all~~] rebates it collected from pharmaceutical manufacturers that were attributable to patient utilization in the state of New Hampshire during the prior calendar year. ***This paragraph shall not apply to Medicaid, the Medicaid Care Management Program, the Ryan White HIV/AIDS Program administered by the department of health and human services, or self-funded plans such as the state employee health benefit plan. The report submitted to the commissioner shall include the following information:***

(a) The aggregate number of rebates and total value received by the pharmacy benefit manager;

(b) The aggregate number of rebates and total value distributed to the appropriate health care insurer;

(c) The aggregate number of rebates and total value passed on to an insured of each health care insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount;

(d) The individual and aggregate amount paid by the health care insurer to the pharmacy benefit manager for pharmacist services itemized by pharmacy, by product (at the unique NDC level), and by goods and services; and

(e) The individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

6 Pharmaceutical Rebates. Amend RSA 415-A:7, II-IV to read as follows:

II. All rebates remitted by or on behalf of a pharmaceutical manufacturer, developer, or labeler, directly or indirectly, to an insurer, or to a pharmacy benefits manager under contract with an insurer, related to its prescription drug benefits shall be remitted in [~~one or both of~~] the following ways:

(a) ***At least 50 percent of all rebates shall be*** remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular ***or specific*** prescription drug;

(b) Remitted to, and retained by, the insurer. ***The remainder of the*** rebates remitted to the insurer shall be applied by the insurer in its plan design and in future plan years to offset the premium for covered persons.

III. Beginning [~~November 1, 2020~~] ***March 1, 2025*** and annually thereafter, an insurer shall file with the commissioner a report in the manner and form determined by the commissioner demonstrating the manner in which the insurer ***and/or its contracted entity for pharmacy benefit services*** has complied with this section. ***The report shall include at least the following:***

(a) An actuarial certification attesting:

(1) All discounts and rebates received by health insurers were used to reduce costs for policyholders in compliance with paragraph II .

(2) How rebates were remitted in the individual, small, and large group market.

(3) If applied pursuant to subparagraph II(b), an explanation of how remittance was applied to both plan design, based on estimated rebates, and in future plan years to offset premium.

(4) A description of the methodology employed to calculate the estimated rebate amount, for the purpose of applying to plan design.

(b) Methodology for determining estimated rebate amount:

(1) Insurers shall employ actuarial and analytical methodologies to estimate the total rebate amount expected to be received from drug manufacturers over a defined period.

(2) The determination of the estimated rebate amount shall account for factors such as historical rebate data, anticipated changes in drug utilization, formulary modifications, and other pertinent variables.

(3) The calculated estimated rebate amount shall adhere to generally accepted actuarial principles and industry best practices to ensure precision and dependability.

(4) The calculation shall be documented and made available for review by the insurance commissioner, upon request.

III-a. This section shall not apply to Medicaid, the Medicaid Care Management Program, the Ryan White HIV/AIDS Program administered by the department of health and human services, or self-funded plans such as the state employee health benefit plan.

IV. Any insurer that violates any provision of this section may, at the discretion of the commissioner, be subject to subparagraph (a) or (b), or both:

(a) Its certificate of authority may be indefinitely suspended or revoked.

(b) A civil fine not to exceed [~~$2,500~~] ***$10,000*** may be imposed for each violation. Repeated violations of the same provision shall constitute separate civil offenses.

7 Repeal. 2020; 15:2, relative to the prospective repeal of RSA 415-A:7, is repealed.

8 Effective Date.

I. Section 1 of this act shall take effect July 1, 2024.

II. Section 7 of this act shall take effect June 30, 2024.

III. The remainder of this act shall take effect 60 days after its passage.

LBA
24-2339
Amended 5/29/24

HB 1380-FN- FISCAL NOTE

AS AMENDED BY THE SENATE (AMENDMENT #2024-2119s)

AN ACT relative to brew pub licenses, relative to insurance cost-sharing calculations, and relative to receipt of pharmaceutical rebates by insurers and pharmacy benefits managers.

FISCAL IMPACT: [X] State [X] County [X] Local [ ] None

Estimated State Impact - Increase / (Decrease)				
	FY 2024	**FY 2025**	**FY 2026**	**FY 2027**
Revenue	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Revenue Fund(s)	General Fund Insurance Premium Tax, Liquor Fund			
Expenditures	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source(s)	Liquor Fund			
Appropriations	$0	$0	$0	$0
Funding Source(s)	None			

- Does this bill provide sufficient funding to cover estimated expenditures? [X] N/A
- Does this bill authorize new positions to implement this bill? [X] No

Estimated Political Subdivision Impact - Increase / (Decrease)				
	FY 2024	**FY 2025**	**FY 2026**	**FY 2027**
County Revenue	$0	$0	$0	$0
County Expenditures	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Local Revenue	$0	$0	$0	$0
Local Expenditures	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase

METHODOLOGY:

Section 1 of **t**his bill allows a brew pub licensee to also hold an on-premises or off-premises license. The Liquor Commission states this provision of the bill would allow a licensed brewpub to hold an additional on-premise or off-premise license as long as the licensee does not hold any other type of manufacturing license. The bill restricts a licensee holding 2 or more brewpub licenses from selling more than 2,500 barrels of beer or cider to any NH licensed retailer. The Commission provided the following information and assumptions concerning the fiscal impact of the bill:

- The bill will require the commission to audit licensees holding 2 or more brewpub licenses to ensure compliance with the sales limitation in the bill. The Commission anticipates this will increase the number of audits performed by the Commission to ensure compliance with the law.

- Currently there are 33 brewpubs licensed by the Commission. The Commission is unable to provide an accurate estimate of how many, if any, of the current brewpubs would seek an additional license.

- The Commission assumes it is likely that existing licensees with other license types will switch to the Brew Pub licenses, since they would now be allowed an additional on-premises or off-premises license. This would result in additional revenue from new licensing fees and additional beer tax revenue.

The remaining sections relate to insurance cost-sharing calculations, the bill provides that, when calculating an enrollee's contribution to cost-sharing requirements, the insurer or pharmacy benefits manager shall include any amount paid by the enrollee or paid on their behalf. It includes a limited exception for health savings account-qualified high deductible health plans if application of the requirement would result in account ineligibility under the Internal Revenue Code. The Insurance Department states this bill would mandate that when insurers or pharmacy benefit managers calculate an enrollee's contribution to cost-sharing requirements that both the amount paid by the enrollee and amounts paid on behalf of the enrollee are included. This requirement may result in decreased enrollee cost-sharing contributions and increased costs to insurance carriers and pharmacy benefit managers for system updates. The insurers may respond with increased premium rates to reflect higher costs. Policyholders, including county and local governments, may have increased expenditures resulting from increased premiums. This may have an impact on general fund premium tax revenue collected by the State.

In addition the bill revises the annual reporting requirement for pharmacy benefits managers regarding pharmaceutical rebates, revises the percentage of rebates insurers are required to make available to enrollees, increases the fine for noncompliance, and removes prospective repeal of RSA 415-A:7, relative to insurer cost sharing of rebates. Regarding these changes, the Insurance Department states the bill would require insurers to remit at least 50% of product specific rebates directly to the consumer at the point of sale, and the remaining value of negotiated rebates would be remitted to the insurer, be applied to the insurer's plan design to offset future years' premiums. Currently insurers attest to the Department that the entire value of PBM-negotiated rebates are remitted to insurers to offset future years' premiums. The Department assumes approximately 50% of the nominal value of prescription drug rebates may be redirected to consumers at the point of sale. In plan year 2022, the estimated value of rebates was $90 million. Under this bill 50% or $45 million may not be available to offset future

premiums. The Department assumes the changes to carrier reporting requirements will result in a "trivial, but non-zero" fiscal impact to insurance carriers from increased administrative costs. The Insurance Department assumes, if this portion of the bill were to become law, there would be a potentially significant upward pressure on premiums for the commercial, fully insured plans including county and municipal employers purchasing these plans and increased general fund premium tax revenues, however the extent of such increases is indeterminable at this time.

AGENCIES CONTACTED:

Insurance Department and New Hampshire Liquor Commission