wakely.com

State of New Mexico: Office of the Superintendent of Insurance

House Bill 292: Potential Impact of Establishing Cost-Sharing Limits for Select Categories of Drugs

October 1, 2020

Prepared by:
Wakely Consulting Group, LLC

Julie Peper, FSA, MAAA
Principal and Senior Consulting Actuary

Maris Hayes
Senior Actuarial Analyst

Table of Contents

Introduction and Background

The State of New Mexico's Office of the Superintendent of Insurance ("OSI" or "New Mexico") retained Wakely Consulting Group, LLC ("Wakely") to analyze the impact of imposing limits on member cost sharing in the commercial markets and for the state employee plans, pursuant to House Bill 292 (HB 292).[1] In particular, HB 292 mandates a study that "shall examine, at a minimum, the benefits to New Mexico consumers and the potential costs of setting cost-sharing limitations for the following categories of drugs:

A. inhaled prescription drugs used to control asthma;
B. oral medications to treat or control diabetes;
C. injectable epinephrine devices for severe allergic reactions;
D. opioid reversal agents;
E. medications used to treat hypertension;
F. antidepressant medications;
G. antipsychotic medications;
H. lipid-lowering agents; and
I. anticonvulsants."

Value-based insurance design is gaining traction in the commercial markets.[2] In CMS' Notice of Benefit and Payment Parameters for 2021[3], they recommended reduced or no cost sharing for several categories of drugs, of which many overlap with the categories in HB 292. CMS' recommendation was based on a study performed by the Center for Value-based Insurance Design at the University of Michigan[4] that estimated that lower cost sharing for select drugs and services could be offset by higher cost sharing for drugs and services with minimal clinical value. The goal of lower cost sharing for clinically proven services was to improve access to high-value care and reduce cost-related non-adherence. In the study, the cost sharing for low-value services was increased to offset the cost of the high-value services and drugs. Thus, CMS proposed that it might be possible that lower cost sharing could be offered without an increase to premiums.

New Mexico is also making efforts to lower consumer drug costs. One of the goals of HB 292 is to increase the accessibility of drugs to consumers. While HB 292 doesn't contemplate the

[1] https://www.nmlegis.gov/Sessions/20%20Regular/final/HB0292.pdf

[2] Commercial markets included in the analysis include the individual and small group Affordable Care Act (ACA) markets and the large group fully insured market.

[3] https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021

[4] https://vbidcenter.org/initiatives/vbid-x/

possibility of offsetting potential costs of lower drug cost sharing with higher cost sharing on less clinically proven services, the insurers would be able to determine how to offset potential cost increases if the lower cost sharing is ultimately implemented. The most likely options for insurers to offsetting increased plan costs would be to increase premiums or increase cost sharing for other services.

This report documents the results of the analysis as required under HB 292, including the methodology and assumptions. This document has been prepared for the sole use of New Mexico. This report documents the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Executive Summary

In order to determine which scenarios to analyze, Wakely first summarized the data to understand the current cost sharing (i.e., out of pocket costs) and prevalence of scripts (i.e., prescriptions filled). The table below provides the 2019 average insurer paid costs (i.e., costs for which insurers are liable) per script, the average cost share per member, and the percent of scripts represented by each drug category, which indicates how much each drug category could impact the overall analyses. The data is shown separately for the commercial and the state employee plans.

Table 1: 2019 Data Metrics by Drug Category

Drug Category	Commercial Plans			State Employees Plan		
	Paid Claims per Script	Cost Share per Script	% of HB 292 Scripts	Paid Claims per Script	Cost Share per Script	% of HB 292 Scripts
Anticonvulsants	$31.98	$9.20	8.8%	$57.38	$8.36	8.5%
Antidepressant Medications	$12.71	$4.95	20.7%	$13.36	$7.50	22.1%
Antipsychotic Medications	$96.86	$16.19	2.0%	$133.50	$13.99	2.2%
Inhaled Prescription Drugs Used To Control Asthma	$141.13	$37.39	6.6%	$133.03	$58.05	5.9%
Injectable Epinephrine Devices For Severe Allergic Reactions	$271.92	$36.05	0.2%	$324.56	$17.60	0.2%
Lipid-Lowering Agents	$15.46	$4.55	16.0%	$10.80	$5.14	14.0%
Medications Used To Treat Hypertension	$7.16	$3.79	33.1%	$4.58	$4.97	34.0%
Opioid Reversal Agents	$60.73	$22.75	0.3%	$82.01	$25.38	0.3%
Oral Medications To Treat Or Control Diabetes	$80.03	$11.57	12.3%	$79.96	$22.59	12.8%

As can be seen in the above table, the cost share per script is already relatively low for many of the drug categories. This is mostly driven by a high generic dispensing rate (GDR) where drug costs and member cost sharing are typically lower. All of the drug categories, except Inhaled Prescription Drugs Used To Control Asthma, Injectable Epinephrine Devices For Severe Allergic Reactions, and Opioid Reversal Agents, have a generic dispensing rate that exceeds 80%, with many drug categories in the high 90%. The three categories with the lowest GDR have the highest member cost share.

Based on the historical data, the State of New Mexico's Office of the Superintendent of Insurance requested several scenarios be analyzed to assess the impact of different cost-sharing limits for the specified drug categories. For each scenario, only drugs in the generic and preferred brand[5] drug tiers will have the limits apply in the commercial markets.[6] For the state employee plan, two scenarios were considered. In the first, only the generic and multi-source brand drug tiers will have the limits apply (hereinafter called State Employee Plan Scenario 1). In the second, the limits will apply to all drug tiers, including the single-source brand drug tier (hereinafter called State Employee Plan Scenario 2).

Wakely analyzed the following cost-sharing limit scenarios. These scenarios are not the only cost-sharing limits that could be considered but were identified as a reasonable range of options for the state to determine what, if any, cost-sharing limits to consider for each of the nine drug categories.

1. $10 maximum cost share for a 30 days' supply of a generic or brand preferred/brand multi-source drug (indicated in the reports as the $10/$10 scenario)[7]
2. $25 maximum cost share for a 30 days' supply of a generic or brand preferred/brand multi-source drug (indicated in the report as the $25/$25 scenario)
3. $10 maximum cost share for a 30 days' supply of a generic drug and a $25 maximum cost share for a 30 days' supply of a brand preferred/brand multi-source drug (indicated in the report as the $10/$25 scenario)
4. $0 maximum cost share for a 30 days' supply of a generic drug and a $10 maximum cost share for a 30 days' supply of a brand preferred/brand multi-source drug (indicated in the report as the $0/$10 scenario)

---

[5] Generic drugs are drugs created to be the same as the original brand-name version but at a cheaper cost.

[6] For the commercial markets, the insurers have a wide range of drug tiers they use in their products and plan designs. Wakely attempted to consolidate the insurer tiers into the most common tiers, but it will not be exact. More details on the tier mapping and assumptions are included in Appendix B.

[7] For the State Employee Plan Scenario 2, the second listed cost share will also be applied to single-source brand drugs as the state only has the three tiers: generic, multi-source brand, and single-source brand. The state employee plan considers different tiers than commercial given they have a different tier structure than the commercial markets.

When member cost sharing is lowered, it decreases the out of pocket costs for consumers and increases the paid claim liability for insurers. Table 2 shows the estimated increase to insurer paid claims[8] based on lowering the cost sharing and using 2019 claims data from the New Mexico markets. In order to understand the impact on the overall plan costs, the calculation divides the change in cost sharing for the nine drug categories by the current total paid medical and drug claims for the plans. **The impact to paid claims does not incorporate the potential increase in utilization if adherence is improved or the potential savings from lower medical costs due to increased adherence.** Lower medical costs could result, for example, if emergency department visits and/or hospitalizations are avoided due to the increased adherence. Other important considerations, such as cost-shifting, may also ultimately impact the actual increase to paid claims. The list of additional considerations is discussed later in the report.

Table 2: Estimated Increase on Paid Claims for the Cost-Sharing Limit Scenarios

Scenario	Commercial Plans	State Employee Plan Scenario 1	State Employee Plan Scenario 2
$10/$10	0.3%	0.0%	0.4%
$25/$25	0.2%	0.0%	0.3%
$10/$25	0.2%	0.0%	0.3%
$0/$10	0.5%	0.3%	0.7%

The impact for the first three scenarios is relatively small, due in large part to the fact that there is a high generic dispensing rate for most of the drug categories and most insurers already offer low or no cost sharing for many of the drugs in the nine categories in HB 292. For example, for a plan with an average current paid claims of $400 per member per month (PMPM) and a 0.3% impact, this would equate to an increase to the insurer's liability of $1.20 PMPM or $14.40 per member per year. While the overall impact is modest for most scenarios, the impact does vary notably by drug category, with the largest impacts typically being in the categories with the highest current cost share, as noted in Table 1.

The impacts also vary by line of business within commercial (individual, small group, and large group) as well as by plan type or richness (for example, a gold plan versus a bronze plan), and insurer. Some insurers already have robust programs with low or no cost share for maintenance drugs, so the impact on these insurers will be significantly smaller than the average. For example, even though the overall impact for the $10/$10 scenario for commercial plans is 0.3%, the majority of the impacts by insurer and line of business range from 0.1% to approximately 0.7%. Similarly,

[8] Insurers may choose to offset the increased liability by increasing cost sharing for other services. If not, the additional cost could be absorbed by consumers through higher premiums. If insurers choose to increase premiums, the overall impact will likely be less than the impact to paid claims given fixed non-benefit related costs.

when looking at various plan designs, the impact could be negligible for a platinum plan[9] and closer to 0.7% impact for a bronze plan.

The following two tables show the percent of members impacted and the percent of prescription drug scripts that will be impacted based on the various cost-sharing limits. A member is considered impacted if they have a drug that was filled in one of the nine drug categories and the cost sharing would have been lower based on the cost-sharing limit as defined in each scenario.

Table 3: Estimated Portion of Members Impacted for the Cost-Sharing Limit Scenarios*

Scenario	Commercial Plans	State Employee Plan Scenario 1	State Employee Plan Scenario 2
$10/$10	9.7%	3.7%	10.4%
$25/$25	5.4%	0.0%	7.6%
$10/$25	8.8%	3.7%	10.4%
$0/$10	25.8%	24.6%	27.4%

*Percent of members impacted will vary by line of business, insurer, and plan.

Roughly 30% of the commercial members have a drug that is included in the nine drug categories defined in HB 292. The vast majority of these members have claims that are impacted in the $0/$10 scenario, with a lesser but still significant portion of members being impacted for most of the other scenarios.

A script is considered impacted if the drug was defined as being in one of the nine drug categories, and the cost sharing would have been lower based on the cost-sharing limit as defined in each scenario.

Table 4: Estimated Portion of Scripts Impacted for the Cost-Sharing Limit Scenarios*

Scenario	Commercial Plans	State Employee Plan Scenario 1	State Employee Plan Scenario 2
$10/$10	3.8%	2.0%	4.2%
$25/$25	1.5%	0.0%	2.2%
$10/$25	3.4%	2.0%	4.2%
$0/$10	22.7%	25.4%	27.6%

* Percent of scripts impacted will vary by line of business, insurer, and plan.

Roughly a third of all scripts are for drugs included in the specified nine drug categories. Drugs on the non-preferred and specialty drug tiers are assumed to not be impacted by HB 292 and not

[9] Under the Affordable Care Act, a platinum plan has an actuarial value of around 90%, or the insurer pays on average 90% of all of the cost of care incurred by the members. The gold, silver, and bronze plans have actuarial values of 80%, 70% and 60%, respectively.

all scripts have cost sharing over the scenario limits. As expected, the scenario with the $0 generic limit has the largest portion of scripts impacted with a notably smaller percent for the other scenarios.

The preceding two tables show the portion of members and scripts impacted. The following table shows the average cost share per script before and after the cost-sharing limit is included. Only cost sharing for the nine drug categories specified in HB 292 are included. The impact on the various drug categories varies significantly (shown in the Detailed Results Section).

Table 5: Estimated Cost Share per Script for Consumers Baseline and by Scenario

Scenario	Commercial Plans	State Employee Plan Scenario 1	State Employee Plan Scenario 2
Baseline	$8.18	$11.52	$11.52
$10/$10	$4.58	$11.01	$5.32
$25/$25	$6.01	$11.39	$7.11
$10/$25	$5.59	$11.02	$6.74
$0/$10	$1.57	$6.65	$0.97

In summary, most of the current cost sharing for the drug categories in HB 292 is already relatively low with a high proportion of scripts being filled with generic drugs. However, the average cost sharing varies by insurer, plan, and drug category. Establishing cost-sharing limits could significantly lower out of pocket costs for a notable portion of members, but with some impact to overall insurer liability, which would need to be offset through higher premiums or higher cost sharing for other services or drugs.

There are other qualitative implications and considerations that should also be noted. For example, the same exact drug can be used to treat multiple conditions. Any cost-sharing limits that the state would impose cannot be limited to a specific condition. Thus, the state can either include these drugs, recognizing additional conditions may be helped, or multi-use drugs can be removed from the list of drugs included in any policy recommendation. Also, some plans (high deductible health plans and catastrophic plans) have regulatory requirements on which services can be offered before the deductible. Limiting cost sharing for these plans may violate these requirements and as such, any policy should allow for exceptions where needed. Finally, the actual impact to insurers could vary from the estimates in this report due to induced demand, cost shifting, and potential long-term savings. More details on these factors are included in the Additional Considerations section of this report.

The remainder of this document presents the current cost sharing for the various drug categories, detailed results of each of the various scenarios, as well as the associated methodology and assumptions underlying the analysis.

Detailed Results

The first step in the analysis was to understand what the current cost sharing and tier distribution are for each of the nine drug categories in HB 292. The following table shows the 2019 average cost share for a 30-day prescription and the generic dispensing rate (GDR, or percent of scripts filled that are generic) for each of the nine drug categories for both commercial and the state employee plan. The generic dispensing rate includes drugs listed under preventive drug tiers, which are offered at no cost sharing.

Table 6: 2019 Average Cost Share and Generic Dispensing Rate by Drug Category Commercial Lines of Business and State Employee Plan

Drug Category	Commercial Plans		State Employee Plan	
	Average Cost Share per 30-day Script	Generic Dispensing Rate	Average Cost Share per 30-day Script	Generic Dispensing Rate
Anticonvulsants	$8.09	95.7%	$6.92	96.7%
Antidepressant Medications	$4.00	98.9%	$5.77	99.4%
Antipsychotic Medications	$14.51	87.3%	$11.90	91.3%
Inhaled Prescription Drugs Used To Control Asthma	$35.21	17.3%	$46.86	16.2%
Injectable Epinephrine Devices For Severe Allergic Reactions	$35.67	68.6%	$17.32	89.6%
Lipid-Lowering Agents	$3.43	98.2%	$3.27	99.2%
Medications Used To Treat Hypertension	$2.89	98.9%	$3.48	99.6%
Opioid Reversal Agents	$21.56	51.3%	$23.50	52.9%
Oral Medications To Treat Or Control Diabetes	$9.13	86.5%	$16.00	84.2%

As can be seen in the table, the majority of the drug categories in HB 292 already have a relatively low average cost-share amount per 30-day supply. Many of these categories have a low cost per drug and high generic dispensing rate. When more scripts are filled at the brand (or other) tier, the cost of the drug and the consumer cost sharing tend to be higher. For example, for Commercial Inhaled Prescription Drugs Used To Control Asthma, the average cost share is around $15 per generic script, but almost 75% of scripts are filled under the Preferred Brand tier where the average cost share is over $40 per script. The detailed percent of scripts and cost sharing per script by drug tier for each drug category can be found in Appendix A.

Given the disparity of the average cost share by script by drug tier, the distribution of cost share for each drug category was analyzed. The following tables show the portion of scripts that have

a 30 days' supply cost-sharing amount in the specified ranges, first for the commercial plans and then for the state employee plan.

Table 7a: 2019 Distribution of Cost Share per Script by Drug Category
Commercial Lines of Business

	Commercial Plans			
Drug Category	**$0**	**($0,$10]**	**($10,$25]**	**$25+**
Anticonvulsants	27.8%	58.0%	10.0%	4.2%
Antidepressant Medications	50.5%	41.5%	7.0%	1.1%
Antipsychotic Medications	37.9%	39.8%	14.0%	8.4%
Inhaled Prescription Drugs Used To Control Asthma	13.9%	12.9%	13.0%	60.2%
Injectable Epinephrine Devices For Severe Allergic Reactions	9.4%	46.9%	19.4%	24.3%
Lipid-Lowering Agents	66.3%	26.2%	6.4%	1.1%
Medications Used To Treat Hypertension	46.4%	49.0%	3.9%	0.7%
Opioid Reversal Agents	25.0%	19.9%	21.6%	33.5%
Oral Medications To Treat Or Control Diabetes	41.6%	44.0%	2.2%	12.2%
Total	45.7%	41.3%	6.1%	6.8%

Table 7b: 2019 Distribution of Cost Share per Script by Drug Category
State Employee Plan

	State Employee Plan			
Drug Category	**$0**	**($0,$10]**	**($10,$25]**	**$25+**
Anticonvulsants	7.5%	82.7%	6.9%	2.9%
Antidepressant Medications	2.3%	77.6%	19.5%	0.6%
Antipsychotic Medications	7.6%	78.2%	7.0%	7.2%
Inhaled Prescription Drugs Used To Control Asthma	4.7%	15.4%	3.4%	76.6%
Injectable Epinephrine Devices For Severe Allergic Reactions	4.0%	82.3%	3.4%	10.4%
Lipid-Lowering Agents	28.6%	55.1%	15.8%	0.5%
Medications Used To Treat Hypertension	2.0%	83.5%	14.1%	0.3%
Opioid Reversal Agents	15.8%	44.4%	5.3%	34.5%
Oral Medications To Treat Or Control Diabetes	1.8%	74.4%	8.4%	15.4%
Total	6.6%	72.7%	13.4%	7.4%

Both tables show a large portion of the current cost sharing is less the $10 per script. Due to some insurers having robust $0 cost-sharing programs for maintenance drugs, the commercial lines of business have over 45% of scripts already with no member cost share. In total, the commercial plans have around 87% of scripts with a cost share of $10 or less, but with wide variation by drug category. While the state employee plan has significantly fewer scripts with no member cost share, similar to commercial, almost 80% of scripts have a cost share of $10 or less.

Due to the variations by drug category, the impact of the cost-sharing limits also varies significantly by drug category. The following table shows the impact by drug category for the $10/$10 cost-sharing limit scenario. These paid claims impacts are based on the impact of paid claims in the specific drug category only and not on the overall plan costs.

Table 8: Estimated Changes in Member Cost Share and Insurer Paid Claims by Drug Category for the $10/$10 Cost-Sharing Limit Scenario

Drug Category	Commercial Plans		State Employee Plan Scenario 1		State Employee Plan Scenario 2	
	Cost Share	Paid Claims	Cost Share	Paid Claims	Cost Share	Paid Claims
Anticonvulsants	-32.9%	9.5%	-4.4%	0.6%	-36.0%	5.3%
Antidepressant Medications	-20.8%	8.1%	-15.1%	8.5%	-24.5%	13.7%
Antipsychotic Medications	-49.2%	8.2%	-0.1%	0.0%	-56.0%	5.9%
Inhaled Prescription Drugs Used To Control Asthma	-66.7%	17.7%	-0.3%	0.1%	-81.4%	35.5%
Injectable Epinephrine Devices For Severe Allergic Reactions	-68.6%	9.1%	-1.1%	0.1%	-63.7%	3.5%
Lipid-Lowering Agents	-27.2%	8.0%	-4.6%	2.2%	-13.3%	6.3%
Medications Used To Treat Hypertension	-16.9%	9.0%	-10.2%	11.0%	-16.0%	17.4%
Opioid Reversal Agents	-53.1%	19.9%	-0.5%	0.1%	-72.9%	22.6%
Oral Medications To Treat Or Control Diabetes	-56.9%	8.2%	-0.6%	0.2%	-73.5%	20.8%
Total	-44.0%	11.2%	-4.5%	1.6%	-53.8%	18.8%

As expected, for drug categories with a lower percent of generic use and higher current member cost sharing (for example, inhaled drugs to control asthma), the impact to both cost sharing and insurer paid claims is higher than in categories where current member cost sharing is already relatively low (for example, lipid-lowering agents).

By Commercial Line of Business and Insurer

In addition to analyzing the average impact for each scenario, Wakely also looked at the average impact by lines of business within commercial and by insurer. As noted previously, some insurers already have robust programs that have low or no cost sharing for maintenance drugs. The impact to these insurers will be less than the average. There may also be differences by line of business within commercial to the extent the demographic and risk profiles differ or that the drug cost-sharing structure in the plan designs is different. The table below shows the paid claims impact based on the average, median, 10% percentile, and 90% percentile for each cost-sharing scenario.

Table 9: Range of Potential Impacts by Insurers and Line of Business by Scenario

Scenario	Average Impact	Median	10% Percentile	90% Percentile
$10/$10	0.3%	0.2%	0.1%	0.7%
$25/$25	0.2%	0.1%	0.1%	0.4%
$10/$25	0.2%	0.2%	0.1%	0.5%
$0/$10	0.5%	0.5%	0.3%	1.3%

The table indicates that while the impact may be notably larger than average for an insurer or line of business within an insurer, the majority of the data points are closer to or below the average based on the median impact. The large group market does tend to have a larger impact than the individual and small group markets.

By Plan Type

Plan type, or the richness of the plan design, also factors into the impact of the cost-sharing limits. For individual and small group, the impacts were segmented by metal level, including the cost-sharing reduction (CSR) variations for silver plans. For large group, the plans were separated into high actuarial value and low actuarial value plans. The following table shows the same statistics but is based on the various impacts by plan richness.

Table 10: Range of Potential Impacts by Plan Type by Scenario

Scenario	Average Impact	Median	10% Percentile	90% Percentile
$10/$10	0.3%	0.2%	0.0%	0.4%
$25/$25	0.2%	0.1%	0.0%	0.2%
$10/$25	0.2%	0.2%	0.0%	0.3%
$0/$10	0.5%	0.6%	0.2%	1.1%

As expected, the richer plan designs (such as the platinum plans and 94% CSR plans) have the lowest impact, typically aligning with the 10% percentile, while bronze plans tend to have the

highest impact, typically represented by the 90% percentile. Because we are looking at the 90% percentile, it is possible there will be some plans where the impact could be larger.

It is hard to fully show just the impact by plan type and just the impact by insurer/line of business given they are related. For example, if an insurer has a low impact and has a large portion of the market's bronze plans, it might impact the overall impact to bronze plans. Thus the tables should be considered as general ranges that may be experienced by the various plans, insurers, and lines of business, but impacts outside of these data points are likely.

Additional Considerations

The results of the analysis outlined the impact to paid claims, which could translate to an increase in premiums for the respective markets or higher cost sharing for other services. However, there are additional factors that may impact how much premiums or other services are ultimately impacted, as well as other considerations as the state contemplates a cost-sharing limit policy. The following discusses some of these factors.

Evolving Prescription Drug Market

The drugs available to consumers are dynamic. Using 2019 data provides a recent data point for the impact of the various cost-sharing limits, but the impact could change significantly if there are new drugs to the market between 2019 and the implementation year. For example, if there are new generics in the drug categories, especially for categories that currently have a lower generic dispensing rate, it could lower the impact to insurer paid claims. If there are new higher-cost preferred brand drugs, it could conversely increase the impact on insurer paid claims.

Similarly, insurers change the tier placement of drugs regularly so it is possible, for example, that drugs that were on a non-preferred brand drug tier in the analysis could be moved to a preferred brand drug tier in the future. Additionally, the drug tier categories were not consistent among the insurers and assumptions were made to map the current tiers to a condensed set of consistent drug tiers. This mapping could potentially impact the results. The state may want to consider having any cost-sharing limits apply to specific drugs, which could be based on price and/or typical tier placement, rather than insurer tiers.

Drugs with Multiple Uses

For the analysis, Wakely requested all utilization for the identified drugs. In reality, many of these drugs can be used to treat multiple conditions, including conditions not targeted by HB 292. The state may choose to exclude some of these drugs based on guidance from pharmacists or other knowledgeable clinicians. To the extent that some drugs are removed from the list, the impact may be smaller than what is stated in this report.

Regulatory Considerations

High Deductible Health Plans (HDHP), or Health Savings Account Qualified (HSAQ) plans can only offer certain services before the deductible, such as preventive services and drugs.[10] Based on the data provided by the insurers, the lipid-lowering agents drug category currently include preventive drugs. To the extent that there are drugs covered under HB 292 that do not qualify for the deductible to be waived under HDHP regulations, the cost-sharing limits cannot be applied to HDHPs without the plans losing their HSAQ status. A similar requirement exists for the Affordable Care Act's (ACA) Catastrophic plans. Thus, the state may need to make an exception for any cost-sharing limits for these plans.

It should be noted that regardless of the reason for cost-sharing changes, whether required by state or at the discretion of the insurer, the impact of the change does not necessarily mean that premiums will increase. Insurers may choose to instead offset the impact of decreasing cost sharing on for the specified drugs by increasing cost sharing for other services. For individual and small group ACA plans, plan designs must fall within specified ranges of actuarial value (AV, or paid to allowed claims ratio). Consequently, some plans may be required to increase cost sharing on other services in order to maintain compliance with Federal AV requirements.

Changes to Overall Services

Changing the cost sharing for prescription drugs could have several downstream effects depending on the final cost-sharing limits that are established.

- Cost Shifting – If the same cost-sharing limits are applied to both generic and preferred brand (or multi-source brand), there could be shifting from generic drugs to higher-cost preferred brand drugs if the insurers do not voluntarily create a distinction.[11] Most of the drug categories listed in HB 292 currently have a high proportion of the drug claims as generic. If members are not incentivized, through lower cost sharing, to use generic drugs, some shifting may occur to preferred brand drugs, which could increase the cost to insurers and ultimately back onto consumers.
- Induced Demand and Potential Savings – For the scenarios where the proposed cost-sharing limits are significantly lower than the current cost sharing per script, members could be incentivized to fill more scripts and thereby increase utilization. While this is likely

[10] https://www.irs.gov/pub/irs-drop/n-19-45.pdf

[11] In the stakeholder meetings, at least one insurer indicated a preference for a flat cost sharing limit so that the insurers had flexibility on how they wanted to incent generic utilization. For example, if a $25 cost sharing limit were implemented, insurers could apply this limit to preferred brand drugs but voluntarily include a lower cost share for the generic drugs.

an intent of HB 292 (to get members with chronic conditions to be more compliant with their maintenance medication), this still could increase prescription drug costs to insurers more than just the cost of the lower cost sharing. If that occurs, the hope would be for longer-term savings as these members avoid higher-cost medical services such as emergency department visits and hospitalizations. These savings could potentially offset, either partially or fully, the impact of the lower cost sharing and induced demand. However, when and the extent of the savings and if and when the insurers factor these savings into the premiums, is uncertain.

Deductible and Maximum Out of Pocket Accumulations

High deductible plans are becoming more common as health care costs rise. For plan designs where there is a drug deductible, especially when combined with a medical deductible, or the member's maximum out of pocket comes into play, the actual impact of the cost-sharing limit may be less than assumed in this analysis. For example, consider a member who has $20,000 in total claim costs, $5,000 for prescription drugs, and $15,000 for medical services, and has a plan design that has a $5,000 combined medical and drug deductible and out of pocket maximum. Thus, the member pays for all claims up to $5,000, and then the insurer pays for any claims above that amount. If they have monthly prescriptions that are impacted by HB 292, it will lower the most they can pay for the specified drugs, but they will still have to pay the full $5,000 out of pocket maximum given their medical claims. The data did not allow for an analysis into the frequency that this could occur, but it could overstate the impact of cost-sharing limits.

Appendix A: Additional Exhibits

The numeric results of the analyses were also included in an Excel document titled “NM HB292 Data Summary Exhibits_20200930-To Post”. The exhibits in this file can be referenced for further detail that is not in this report. This appendix includes some of the key additional data points. Exhibits not included in this appendix but in the Excel file, include but are not limited to the top 10 drugs for each drug category based on scripts, allowed claims, and cost sharing.

Table 11: Key Metrics for the Commercial Lines of Business

Drug Category	30 Day Scripts per Member per Year	Insurer Paid per Script	Member Cost Sharing per Script
Anticonvulsants	5.98	$31.98	$9.20
Antidepressant medications	7.51	$12.71	$4.95
Antipsychotic medications	6.02	$96.86	$16.19
Inhaled prescription drugs used to control asthma	3.45	$141.13	$37.39
Injectable epinephrine devices for severe allergic reactions	1.20	$271.92	$36.05
Lipid-lowering agents	7.43	$15.46	$4.55
Medications used to treat hypertension	9.46	$7.16	$3.79
Opioid reversal agents	1.55	$60.73	$22.75
Oral Medications to Treat or Control Diabetes	9.34	$80.03	$11.57

Table 12: Key Metrics for the State Employee Plan

Drug Category	30 Day Scripts per Member per Year	Insurer Paid per Script	Member Cost Sharing per Script
Anticonvulsants	6.42	$57.38	$8.36
Antidepressant medications	8.20	$13.36	$7.50
Antipsychotic medications	6.48	$133.50	$13.99
Inhaled prescription drugs used to control asthma	3.14	$133.03	$58.05
Injectable epinephrine devices for severe allergic reactions	1.08	$324.56	$17.60
Lipid-lowering agents	8.57	$10.80	$5.14

Drug Category	30 Day Scripts per Member per Year	Insurer Paid per Script	Member Cost Sharing per Script
Medications used to treat hypertension	10.78	$4.58	$4.97
Opioid reversal agents	1.27	$82.01	$25.38
Oral Medications to Treat or Control Diabetes	10.67	$79.96	$22.59

Table 13: Drug Categories by Drug Tier for Commercial Lines of Business

Drug Category	Drug Tier	Scripts - % of the Drug Category	Paid - % of the Drug Category	Avg Cost Sharing per Script	Avg Paid per Script
Anticonvulsants	Generic	95.7%	39.6%	$6.15	$13.25
	Brand Preferred	3.1%	48.6%	$65.74	$495.09
	Brand Non-Preferred	1.0%	10.2%	$97.57	$320.54
	Specialty	0.1%	1.0%	$279.27	$397.60
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.1%	0.5%	$28.65	$162.34
Antidepressant medications	Generic	98.9%	83.1%	$4.16	$10.67
	Brand Preferred	0.5%	10.6%	$87.09	$259.05
	Brand Non-Preferred	0.4%	4.9%	$63.79	$140.76
	Specialty	0.0%	0.8%	$167.50	$383.78
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.1%	0.7%	$70.30	$125.09
Antipsychotic medications	Generic	87.3%	23.8%	$7.33	$26.35
	Brand Preferred	8.9%	56.3%	$74.42	$612.72
	Brand Non-Preferred	3.5%	17.2%	$78.28	$481.94
	Specialty	0.1%	1.7%	$176.76	$1,151.83
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.2%	1.0%	$116.47	$573.55
Inhaled prescription	Generic	17.3%	9.3%	$15.07	$75.64
	Brand Preferred	74.5%	80.6%	$40.86	$152.58
	Brand Non-Preferred	7.9%	9.9%	$52.73	$176.42

Drug Category	Drug Tier	Scripts - % of the Drug Category	Paid - % of the Drug Category	Avg Cost Sharing per Script	Avg Paid per Script
drugs used to control asthma	Specialty	0.0%	0.0%	$51.40	$0.00
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.3%	0.3%	$57.51	$137.19
Injectable epinephrine devices for severe allergic reactions	Generic	68.6%	63.5%	$29.01	$251.79
	Brand Preferred	26.7%	31.5%	$50.11	$321.57
	Brand Non-Preferred	2.6%	3.5%	$42.47	$360.60
	Specialty	1.6%	1.1%	$82.71	$192.09
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.5%	0.3%	$67.00	$174.77
Lipid-lowering agents	Generic	75.0%	67.7%	$4.55	$13.95
	Brand Preferred	1.4%	9.9%	$55.81	$107.68
	Brand Non-Preferred	0.2%	1.2%	$61.59	$98.87
	Specialty	0.1%	2.0%	$213.60	$358.76
	Preventive	23.2%	19.1%	$0.12	$12.72
	No Mapping	0.1%	0.1%	$18.33	$25.04
Medications used to treat hypertension	Generic	98.9%	95.1%	$3.31	$6.88
	Brand Preferred	0.8%	4.1%	$46.20	$38.61
	Brand Non-Preferred	0.3%	0.7%	$56.62	$17.74
	Specialty	0.0%	0.0%	$112.31	$0.00
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.1%	0.1%	$10.37	$13.82
Opioid reversal agents	Generic	51.3%	22.2%	$11.56	$26.30
	Brand Preferred	39.1%	55.1%	$33.22	$85.61
	Brand Non-Preferred	9.4%	22.2%	$36.83	$144.30
	Specialty	0.1%	0.3%	$500.00	$300.34
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.2%	0.2%	$46.80	$42.63
Oral Medications to	Generic	86.5%	14.0%	$3.31	$12.95
	Brand Preferred	12.1%	73.5%	$60.72	$485.61

Drug Category	Drug Tier	Scripts - % of the Drug Category	Paid - % of the Drug Category	Avg Cost Sharing per Script	Avg Paid per Script
Treat or Control Diabetes	Brand Non-Preferred	1.2%	3.7%	$82.69	$242.32
	Specialty	0.0%	8.3%	$818.20	$23,299.82
	Preventive	0.0%	0.0%	$0.00	$0.00
	No Mapping	0.1%	0.6%	$82.83	$331.39

Table 14: Drug Categories by Drug Tier for State Employee Plan

Drug Category	Drug Tier	Scripts - % of the Drug Category	Paid - % of the Drug Category	Avg Cost Sharing per Script	Avg Paid per Script
Anticonvulsants	Generic	96.7%	49.2%	$5.45	$29.19
	Brand Multi-Source	0.1%	1.4%	$76.55	$710.89
	Brand Single-Source	3.2%	49.4%	$93.67	$883.89
Antidepressant medications	Generic	99.4%	77.5%	$6.74	$10.43
	Brand Multi-Source	0.0%	1.6%	$130.00	$2,155.27
	Brand Single-Source	0.6%	20.8%	$126.80	$445.59
Antipsychotic medications	Generic	91.3%	10.9%	$5.83	$16.01
	Brand Multi-Source	0.0%	0.0%	$0.00	$0.00
	Brand Single-Source	8.7%	89.1%	$99.81	$1,367.75
Inhaled prescription drugs used to control asthma	Generic	16.2%	3.9%	$6.55	$31.82
	Brand Multi-Source	3.4%	15.2%	$11.49	$600.95
	Brand Single-Source	80.5%	81.0%	$70.34	$133.86
Injectable epinephrine devices for severe allergic reactions	Generic	89.6%	93.1%	$6.15	$337.23
	Brand Multi-Source	0.0%	0.0%	$0.00	$0.00
	Brand Single-Source	10.4%	6.9%	$116.68	$214.93
Lipid-lowering agents	Generic	99.2%	48.6%	$4.60	$5.29
	Brand Multi-Source	0.3%	21.2%	$22.85	$869.91
	Brand Single-Source	0.6%	30.2%	$91.71	$586.92
	Generic	99.6%	84.3%	$4.63	$3.87
	Brand Multi-Source	0.0%	0.0%	$31.40	$3.55

Drug Category	Drug Tier	Scripts - % of the Drug Category	Paid - % of the Drug Category	Avg Cost Sharing per Script	Avg Paid per Script
Medications used to treat hypertension	Brand Single-Source	0.3%	15.7%	$105.98	$218.06
Opioid reversal agents	Generic	52.9%	17.9%	$6.70	$27.69
	Brand Multi-Source	0.0%	0.0%	$0.00	$0.00
	Brand Single-Source	47.1%	82.1%	$46.37	$143.07
Oral Medications to Treat or Control Diabetes	Generic	84.2%	2.8%	$4.81	$2.63
	Brand Multi-Source	0.0%	0.0%	$8.88	$0.56
	Brand Single-Source	15.8%	97.2%	$117.16	$491.38

Appendix B: Methodology and Assumptions

Wakely took the following steps to identify the specific drugs included in HB 292 and to conduct the analysis presented in this report.

1. The first step was to identify the specific drugs to include in the analysis based on the drug categories included in HB 292. This process included identifying the National Drug Codes (NDCs) that map to the nine drug categories. Wakely used the MediSpan database to identify the GPIs (generic product identifier) for the drugs that correspond to the nine drug categories. The GPI and the route of administration were then used to identify the specific NDCs. One of the insurers provided a list of included NDCs that may be used for multiple conditions. These NDCs represent around a quarter of the scripts in the analysis. All scripts were included if they were for the identified NDC, regardless of the condition for which the member was being treated. This list of NDC codes is what was included in the analysis but does not necessarily need to represent the specific drugs that are included in any policy implemented by the state.
2. Based on the identified NDCs, Wakely sent out a data request to all insurers with significant market share in each of the individual, small group and large group fully insured commercial markets. We requested similar data from the state employee plan administrator. The insurers and state employee plan provided pharmacy claims detail data for the 2019 benefit year (incurred 1/1/2019-12/31/2019) for pharmacy claims with an NDC that was identified as being included in one of the 9 drug categories for HB 292 (the list of NDC codes in included in the Excel document referred earlier). Claims were only provided for the largest plans in each market based on enrollment and also ensuring that all metal levels were represented for the individual and small group markets.
    a. For Individual ACA plans, the largest plans for each metal level and CSR variant (73%, 87%, 94%), based on enrollment were requested.
    b. For Small Group ACA, the largest 5 plans, based on enrollment were requested. If the top 5 plans did not include one of each metal level, a plan from each missing metal was requested.
    c. For Large Group, the largest ten fully insured plans, based on enrollment, were requested.
    d. For the State Employee plan, all plans were requested.

    In addition to the detailed data, the total scripts, paid and allowed medical and drug claims for the plans included in the detailed request, as well as the market totals, was requested.
3. Once the data was received, the data was checked for reasonability. In some instances, revised data was collected from the insurers. The following describes some of the assumptions or adjustments that were made to the final versions of the data.

a. For some insurers, the allowed cost of the drug did not equal the paid amount plus cost sharing. Wakely worked with the insurers to develop a process to make sure we accurately captured the paid cost and cost-sharing amounts for the drugs. In most instances, the default was to set the cost sharing to equal allowed less paid amounts.

b. Drug tier mapping provided by each carrier was specific to the carrier's plan design and was not consistent across carriers. In order to summarize results by drug tier, Wakely grouped each carrier's drug tier into one of the following categories for commercial plans: Generic, Brand Preferred, Brand Non-Preferred, Specialty, and Preventative. Claims not mapped to a tier represent 0.1% of claims. The state employee plan was summarized by Generic, Brand Single-Source, and Brand Multi-Source drug tiers. The below lists the drug tier mapping applied by Wakely.

Commercial Plans Provided Drug Tier	Mapped Drug Tier
Preventive	Preventive
Zero Cost-Share Preventive Drugs	Preventive
Generic	Generic
Generic Non-Specialty	Generic
Lower Cost	Generic
Non-Preferred Generic	Generic
Preferred Generic	Generic
Brand Non-Specialty	Brand Preferred
Mid-Range Cost (Tier 2)	Brand Preferred
Preferred Brand	Brand Preferred
Mid-Range Cost (Tier 3)	Brand Non-Preferred
Non-Preferred Brand	Brand Non-Preferred
Non-Preferred Generic, Non-Preferred Brand	Brand Non-Preferred
Brand Specialty	Specialty
Highest Cost	Specialty
Non Preferred Specialty	Specialty
Preferred Specialty	Specialty

State Employee Plan Provided Drug Tier	Mapped Drug Tier
Generic	Generic
Multi Source Brand	Brand Multi-Source
Single Source Brand	Brand Single-Source

c. Once the data was summarized for all insurers into drug tiers and drug categories, a couple of the categories had a small amount of scripts. Wakely checked the key metrics, such as average scripts per member and allowed and cost sharing per scripts against Wakely's national database and determined the insurer data to be reasonable.

4. The data was then summarized into the exhibits in this report and the accompanying Excel document. In additional, the cost-sharing limit logic was applied for the various scenarios. While most summarizations and calculations were directly from the data, some adjustments were made:

    a. Bucketing of scripts into the days' supply categories. The days supplies was bucketed into a few buckets for easier comparison. Specifically, we used 0 to 45 days (assumed to be a 30 days' supply), 46 to 75 days (assumed to be a 60 days' supply), and 76 and more (assumed to be a 90 days' supply). The vast majority of scripts are either 30 or 90 days' supply.

    b. For days' supply greater than 30 days, the cost-sharing limit was adjusted to mirror a 30 day supply. For example, if the cost share was $30 for a 90 days' supply and the maximum cost share scenario is $10 for a 30 day supply, the cost share limit for the 90 days' supply would be $30 ($10 x (90/30)).

    c. For days' supply that are less than 30 days' supply, no adjustments were made.

5. The estimated portion of scripts and members impacted by the cost-sharing limit scenarios were calculated as follows:

    a. The estimated portion of scripts impacted by each cost-sharing limit scenario was calculated by first counting the scripts (distinct number of claim identifiers) in the carrier provided detailed pharmacy data that had a changed cost-sharing value under the scenario. The sum of these scripts was then divided by the number of scripts as provided by carriers in the 2019 total scripts for the plans included in the detailed data request.

    b. The estimated portion of members impacted by each cost-sharing limit scenario was calculated by first identifying the number of members (distinct number of members identifiers) in the carrier provided detailed pharmacy data with a changed cost-sharing value under the scenario for any of the nine drug categories. This number was then divided by the members in the plans associated with the detailed data request. Note that the total number of distinct members was not requested in the 2019 Market Information by Plan Level data request. To estimate distinct members, Wakely used the provided member months in the data request and divided by the average duration enrolled in the corresponding line of business. Average duration metrics were developed from Wakely's internal national database.

c. For both script and member calculations, data was only included where the plan name identifier provided in the detailed pharmacy data mapped to a plan name identifier provided in the 2019 Market Information by Plan Level data request.

Appendix C: Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- 2019 data from the commercial insurers and state employee plan
    - Detailed prescription drug data for the drugs (identified by NDC), including allowed, paid, and cost-sharing amounts, drug tier, days' supply, and other information
    - Summary of scripts and medical and drug claims for the plans included in the analysis
    - Summary of scripts and medical and drug claims for all plans in the corresponding line(s) of business
    - Summary of benefit descriptions for the plans where detailed drug data was provided

The following caveats in the analysis should be considered when relying on the results.

- **Data Limitations.** As discussed in the body of this report, the WACA database is comprised of EDGE server data. There are some variances in the EDGE data compared to other data sources that may be used to check the reasonability of the EDGE data; however, the variances were reasonable and not expected to impact the results. Additionally, it is possible that some portion of the data used may have been truncated due to state-specific EHB limits that are stricter than New Mexico's current limits. Our analysis indicated any potential impact of such truncation to be low, if not negligible.
- **Enrollment Uncertainty.** This report was produced based on 2019 experience data. To the extent that the risk profile, mix of services utilized, size, or any other significant characteristic or combination of characteristics of the insured population changes significantly between 2019 and any year for which cost-sharing limitations would apply, the data on which this report is based may no longer be applicable.
- **Mental Health Parity and Discriminatory Testing.** Some drugs are used to treat different conditions. If these drugs are included in the final list of drugs where cost-sharing limits apply, then it is our understanding that the cost-sharing limits would apply regardless of the condition the drug is treating. The state should ensure compliance with all discriminatory regulations.
- **Issuer Conformity.** The estimated impacts of removing coverage for specific benefits assumes that any changes to the New Benchmark plan will be adopted by all issuers present in the state, with respect to their covered benefits offered to members. All

estimates are Wakely's estimate of the change in insurer paid claims costs. Actual paid costs and premium impacts may vary by insurers, based on their internal data and utilization, formularies, their internal modeling, and their approach to addressing potential increased costs.

Appendix D: Disclosures and Limitations

Responsible Actuaries. Julie Peper is the actuary responsible for this communication. She is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report. Maris Hayes contributed significantly to this report.

Intended Users. This information has been prepared for the sole use of New Mexico. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that New Mexico or its insurers will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the state of New Mexico.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the ‘Methodology and Assumptions’ and ‘Reliances and Caveats’ sections identifies the key data and reliances.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding benefits and cost-sharing levels may have a material impact on the results included in this report. Material changes as a result of Federal or state regulations may also have a material impact on the results. In addition, the impacts may vary if the economy and COVID

change the market composition. There are no other known relevant events subsequent to the date of engagement that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication