HB 22-1370

Legislative Council Staff
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Fiscal Note

Drafting Number:	LLS 22-0251	**Date:**	April 19, 2022
Prime Sponsors:	Rep. Jodeh; Sirota Sen. Winter; Buckner	**Bill Status:**	House Health & Insurance
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Bill Topic: **COVERAGE REQUIREMENTS FOR HEALTH-CARE PRODUCTS**

Summary of Fiscal Impact:

☐ State Revenue
☒ State Expenditure
☒ State Diversion
☐ TABOR Refund
☐ Local Government
☐ Statutory Public Entity

The bill modifies prescription drug coverages, prohibits changes in a carrier's prescription drug coverage formulary during the plan year, and requires reporting and analysis on prescription drug rebates by the Division of Insurance and the Department of Health Care Policy and Financing. It increases state expenditures and diversions on an ongoing basis beginning in FY 2022-23.

Appropriation Summary: For FY 2022-23, the bill requires an appropriation of $420,226 to multiple state agencies.

Fiscal Note Status: The fiscal note reflects the introduced bill. This analysis is preliminary and will be updated following further review and any additional information received.

Table 1
State Fiscal Impacts Under HB 22-1370

		Budget Year FY 2022-23	Out Year FY 2023-24
Revenue		-	-
Expenditures	General Fund	$118,321	$82,870
	Cash Funds	$252,667	$183,782
	Federal Funds	$49,238	$49,238
	Centrally Appropriated	$55,213	$53,748
	Total Expenditures	**$475,439**	**$369,638**
	Total FTE	**1.7 FTE**	**2.0 FTE**
Diversions	General Fund	($307,880)	($237,530)
	Cash Funds	$307,880	$237,530
	Net Diversion	**$0**	**$0**
Other Budget Impacts	General Fund Reserve	$17,748	$12,431

Summary of Legislation

Beginning January 1, 2023, the bill requires health insurance carriers that offer an individual or small group health benefit plan to Coloradans to offer at least 25 percent of its plans on the Colorado Health Benefit Exchange and at least 25 percent of its plans not on the exchange in each bronze, silver, gold, and platinum benefit levels in each service area as copayment-only payment structures for all prescription drug cost tiers. The Commissioner of Insurance in the Department of Regulatory Agencies (DORA) may promulgate rules to implement and enforce this policy.

Also beginning in 2023, the bill requires the Department of Health Care Policy and Financing (HCPF), in collaboration with the administrator of the All-Payer Claims Database, to conduct an annual analysis of the prescription drug rebates received in the previous calendar year, by carrier and prescription drug tier, and make the analysis available to the public.

Starting in 2024, a carrier or pharmacy benefit manager is prohibited from modifying or applying a modification to the current prescription drug formulary during the current plan year, such as eliminating a prescription drug from the formulary or moving a prescription drug to a higher cost-sharing tier.

For each health benefit plan issued or renewed on or after January 1, 2024, the bill requires each carrier or pharmacy benefit manager demonstrate to the Division of Insurance that:

- 100 percent of the estimated rebates received or to be received in connection with dispensing or administering prescription drugs included in the carrier's prescription drug formulary are used to reduce costs for the employer or individual purchasing the plan;
- for small group and large employer health benefit plans, all rebates are used to reduce employer and individual employee costs; and
- for individual health benefit plans, all rebates are used to reduce consumers' premiums and out-of-pocket costs for prescription drugs to the extent practicable.

The Commissioner of Insurance is required to promulgate rules to implement prescription drug pass-through requirements for carriers. Each carrier or pharmacy benefit manager is required to report annually specified prescription drug rebate information to the commissioner.

Finally, the bill repeals and reenacts the current requirements for step therapy and requires a carrier to use clinical review criteria to establish the step-therapy protocol.

State Diversions

This bill diverts about $310,000 from the General Fund in FY 2022-23 and about $240,000 in FY 2023-24 and ongoing. This revenue diversion occurs because the bill increases costs in DORA, Division of Insurance, which is funded with premium tax revenue that would otherwise be credited to the General Fund.

State Expenditures

The bill increases state cash fund expenditures in DORA by about $310,000 in FY 2022-23 and about $240,000 in FY 2023-24 and ongoing from the Division of Insurance Cash Fund. It will also increase state expenditures in the Department of Health Care Policy and Financing by about $170,000 in FY 2022-23 and by about $130,000 in FY 2023-24 from the General Fund and federal funds. Expenditures are shown in Table 2 and detailed below.

Table 2
Expenditures Under HB 22-1370

	FY 2022-23	FY 2023-24
Department of Regulatory Agencies		
Personal Services	$157,972	$181,082
Operating Expenses	$2,295	$2,700
Capital Outlay Costs	$12,400	$0
Contractor Costs	$80,000	$0
Centrally Appropriated Costs[1]	$55,213	$53,748
FTE – Personal Services	1.7 FTE	2.0 FTE
DORA Subtotal *(DOI Cash Fund)*	**$307,880**	**$237,530**
Department of Health Care Policy and Financing		
Personal Services	$91,809	$56,358
Operating Expenses	$75,750	$75,750
HCPF Subtotal	**$167,559**	**$132,108**
General Fund	*$118,321*	*$82,870*
Federal Funds	*$49,238*	*$49,238*
Total Cost	**$475,439**	**$369,638**
Total FTE	**1.7 FTE**	**2.0 FTE**

[1] *Centrally appropriated costs are not included in the bill's appropriation.*

Department of Regulatory Agencies. The Division of Insurance in DORA will have new staffing and contractor costs to monitor and enforce provisions against carriers and to collect and audit compliance data. First-year staffing costs are prorated for a September 1 start date. Standard operating and capital outlay costs are included.

- **Staff.** The division requires 1.0 FTE rate and financial analyst to create a template for formulary review and to review changes in prescription drug formularies for roughly 100 drugs lists for the individual and small group market and roughly 200 drugs lists for the large group market. The position will also provide support to carriers in correcting errors to their submissions. In addition, the bill's rebate provision requires the division to collect data from carriers and perform an analysis to determine the feasibility of applying rebates to reduce a person's cost sharing at the point of sale, which necessitates 1.0 FTE actuary to review data submissions from carriers, perform

research to verify carrier attestations regarding rebates, and to review filings submitted by carriers indicating they are in compliance and using rebates to reduce consumers' costs. Finally, the division requires 0.1 FTE rate and financial analyst for rulemaking related to regulations regarding carriers offering copayment-only plans, changes in step therapy protocol, and to create a step therapy protocols exception request form.

- **Contractor costs.** The division requires 200 hours of a contractor at $400 per hour to assist in evaluating how rebates may be applied to reduce a covered persons defined cost sharing for each prescription drug at the point of sale and determine how rebates may be applied to reduce defined cost sharing and the impact on premiums.

- **Legal services.** Preliminarily, legal services costs for rulemaking are assumed to be accomplished within the division's existing legal services budget.

Health Care Policy and Financing. HCPF will have contract costs for the Center for Improving Value in Health Care (CIVHC), the administrator of the All-Payer Claims Database, to conduct prescription drug rebate analyses each year, estimated at $91,809 in FY 2022-23, and $56,358 in FY 2023-24 and ongoing, paid from the General Fund. In addition, since CHP+ is operated as a carrier and health benefit plan subject to the Colorado Insurance Code, HCPF will require contractor services to reevaluate CHP+ parity compliance, specifically related to cost-sharing requirements and treatment limits, estimated at a one-time cost $151,500, paid over two years ($75,750 per year), with 65 percent federal funds and 35 percent General Fund.

Centrally appropriated costs. Pursuant to a Joint Budget Committee policy, certain costs associated with this bill are addressed through the annual budget process and centrally appropriated in the Long Bill or supplemental appropriations bills, rather than in this bill. These costs, which include employee insurance and supplemental employee retirement payments, are shown in Table 2.

Statutory Public Entity

Because the bill codifies into statute existing regulations on the plan types and designs the Health Benefit Exchange must offer, there is no fiscal impact to Connect for Health Colorado.

Effective Date

The bill takes effect 90 days following adjournment of the General Assembly sine die, assuming no referendum petition is filed. Section 1 of the bill applies to health benefit plans issued or renewed on or after January 1, 2023. Sections 2 through 6 of this act apply to health benefit plans issued or renewed on or after January 1, 2024.

State Appropriations

For FY 2022-23, the bill requires the following appropriations totaling $420,226:

- $252,667 to the Department of Regulatory Agencies from the Division of Insurance Cash Fund and 1.7 FTE; and
- $167,559 to the Department of Health Care Policy and Financing of which $118,321 is General Fund and $49,238 is federal funds.

State and Local Government Contacts

Connect for Health Colorado
Information Technology
Regulatory Agencies

Health Care Policy and Financing
Law