SENATE JUDICIARY COMMITTEE SUBSTITUTE FOR
SENATE CORPORATIONS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR
SENATE BILL 415

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

AN ACT

RELATING TO HEALTH CARE; AMENDING AND ENACTING SECTIONS OF THE PHARMACY BENEFITS MANAGER REGULATION ACT; PROVIDING FOR RENEWAL OF PHARMACY BENEFITS MANAGER LICENSURE; REQUIRING DISCLOSURE OF DOCUMENTS DURING AN INVESTIGATION; PROVIDING FOR CONFIDENTIALITY; PROVIDING FOR CHANGES TO THE REIMBURSEMENT PROCESS; PROVIDING FOR AN APPEALS PROCESS; REQUIRING THE PROVISION OF CERTAIN DOCUMENTS OR INFORMATION UPON REQUEST; REQUIRING CERTAIN CONTRACTUAL PROVISIONS; LIMITING PHARMACY BENEFITS MANAGER CHARGES TO THOSE ITEMIZED IN A CONTRACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 59A-61-2 NMSA 1978 (being Laws 2014, Chapter 14, Section 2) is amended to read:

"59A-61-2. DEFINITIONS.--As used in the Pharmacy Benefits Manager Regulation Act:

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[~~A. "covered entity" means a nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization; a health program administered by the state as a provider of health coverage; any type of group health care coverage, including any form of self-insurance offered, issued or renewed pursuant to the Health Care Purchasing Act; or an employer, labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state. "Covered entity" does not include a self-funded plan that is exempt from state regulation pursuant to the federal Employee Retirement Income Security Act of 1974; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts;~~

~~B. "covered individual" means a member, participant, enrollee, contract holder, policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity and includes a dependent or other person provided health coverage through a policy, contract or plan for a covered individual;~~

~~C. "medicare advantage plan" or "MA-PD" means a prescription drug program authorized pursuant to Part C of~~

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~~Title 18 of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that provides qualified prescription drug coverage;~~]

A. "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug;

B. "maximum allowable cost list" means a searchable, electronic and internet-based listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist is made;

C. "obsolete" means a product that is listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured;

D. "pharmacist" means an individual licensed as a pharmacist by the board of pharmacy;

E. "pharmacy" means a licensed place of business where drugs are compounded or dispensed and pharmacist services are provided;

F. "pharmacy benefits management" means [~~the service provided to a health benefit plan or health insurer, directly or through another person, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits,~~

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~~including:~~

~~(1) mail service pharmacies; and~~

~~(2) claims processing, retail network management or payment of claims to pharmacies for dispensing dangerous drugs, as those drugs are defined in the New Mexico Drug, Device and Cosmetic Act~~] a service provided to or conducted by a health plan as defined in Section 59A-16-21.1 NMSA 1978 or health insurer that involves:

(1) prescription drug claim administration;

(2) pharmacy network management;

(3) negotiation and administration of prescription drug discounts, rebates and other benefits;

(4) design, administration or management of prescription drug benefits;

(5) formulary management;

(6) payment of claims to pharmacies for dispensing prescription drugs;

(7) negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or

(8) any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity;

G. "pharmacy benefits manager" means [~~a person or a wholly or partially owned or controlled subsidiary of a person that provides claims administration, benefit design and~~

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~~management, pharmacy network management, negotiation and administration of product discounts, rebates and other benefits accruing to the pharmacy benefits manager or other prescription drug or device services to third parties, but "pharmacy benefits manager" does not include licensed health care facilities, pharmacies, licensed health care professionals, health insurers, unions, health maintenance organizations, medicare advantage plans or prescription drug plans when providing formulary services to their own patients, employees, members or beneficiaries;~~

~~H. "prescription drug plan" or "PDP" means prescription drug coverage that is offered pursuant to a policy, contract or plan that has been approved as specified in 42 CFR Part 423 and that is offered by a prescription drug plan sponsor that has a contract with the federal centers for medicare and medicaid services of the United States department of health and human services~~] an entity that provides pharmacy benefits management services;

H. "pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by or is under common ownership or control with a pharmacy benefits manager;

I. "pharmacy services administrative organization" means an entity that contracts with a pharmacy or pharmacist to

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act as the pharmacy or pharmacist's agent with respect to matters involving a pharmacy benefits manager or third-party payor, including negotiating, executing or administering contracts with the pharmacy benefits manager or third-party payor; and

[~~I.~~] J. "superintendent" means the superintendent of insurance."

SECTION 2. Section 59A-61-3 NMSA 1978 (being Laws 2014, Chapter 14, Section 3) is amended to read:

"59A-61-3. [~~LICENSE~~] LICENSURE--INITIAL APPLICATION--ANNUAL RENEWAL REQUIRED--REVOCATION.--

A. A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act and applicable federal and state laws. A licensee shall renew the licensee's pharmacy benefits manager license annually.

B. An initial application and a renewal application for licensure as a pharmacy benefits manager shall be made on a form and in a manner provided for by the superintendent, but at a minimum shall require [~~only the following information~~]:

(1) the identity of the pharmacy benefits manager;

(2) the name and business address of the contact person for the pharmacy benefits manager; [~~and~~]

(3) where applicable, the federal employer

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identification number for the pharmacy benefits manager; and

(4) any other information specified in rules promulgated by the superintendent.

C. The superintendent shall enforce and promulgate rules to implement the provisions of the Pharmacy Benefits Manager Regulation Act and may suspend or revoke a license issued to a pharmacy benefits manager or deny an application for a license or renewal of a license if:

(1) the pharmacy benefits manager is operating [~~materially~~] in contravention of its application;

(2) the pharmacy benefits manager has failed to continuously meet or [~~substantially~~] comply with the requirements for issuance or maintenance of a license; or

(3) the pharmacy benefits manager has failed to [~~substantially~~] comply with applicable state or federal laws or rules. [~~or~~

~~(4) the pharmacy benefits manager has transacted insurance in the state without authorization or has transacted insurance for a product that is not issued by an authorized insurer.~~]

D. If the license of a pharmacy benefits manager is revoked, the manager shall proceed, immediately following the effective date of the order of revocation, to [~~wind up~~] conclude its affairs, notify each pharmacy in its network and conduct no further [~~business~~] pharmacy benefits management

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services in the state, except as may be essential to the orderly conclusion of its affairs. The superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it to be in the best interest of patients [~~to obtain pharmacist services~~].

E. A person whose pharmacy benefits manager license has been denied, suspended or revoked may seek review of the denial, suspension or revocation pursuant to the provisions of Chapter 59A, Article 4 NMSA 1978.

F. Nothing in the Pharmacy Benefits Manager Regulation Act shall be construed to authorize a pharmacy benefits manager to transact the business of insurance."

SECTION 3. Section 59A-61-4 NMSA 1978 (being Laws 2014, Chapter 14, Section 4) is amended to read:

"59A-61-4. [~~MAXIMUM ALLOWABLE COST PRICING REQUIREMENTS~~] PHARMACY REIMBURSEMENT PRACTICES FOR GENERIC DRUGS--APPEALS PROCESS REQUIRED.--

A. A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources.

B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service.

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[~~A.~~] C. A pharmacy benefits manager using maximum allowable cost pricing [~~shall:~~

~~(1) to~~] may place a drug on a maximum allowable cost list [~~ensure that the drug~~] if the drug:

[~~(a)~~] (1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", [~~(b)~~] or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; [~~and~~

~~(c)~~] (2) is [~~generally~~] available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and

(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book".

D. A pharmacy benefits manager using maximum allowable cost pricing shall:

[~~(2)~~] (1) upon a network pharmacy's request, provide [~~to a~~] that network pharmacy [~~provider, at the time a contract is entered into or renewed~~] with [~~the network pharmacy provider~~] the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to

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that provider;

[~~(3)~~] (2) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;

[~~(4)~~] (3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in [~~a timely manner~~] at least seven business days to remain consistent with pricing changes and product availability in the marketplace;

[~~(5) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug and respond to a challenge not later than the fifteenth day after the date the challenge is made. If the challenge is successful, a pharmacy benefits manager using maximum allowable cost pricing shall make an adjustment in the drug price effective one day after the challenge is resolved, and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefits manager, as appropriate. If the challenge is denied, the pharmacy benefits manager using maximum allowable cost pricing shall provide the reason for the denial; and~~]

(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:

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(a) directly to the pharmacy benefits manager; or

(b) through a pharmacy services administrative organization;

(5) provide an appeals process that, at a minimum, includes the following:

(a) a dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;

(b) the ability to submit an appeal directly to the pharmacy benefits manager; and

(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;

(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;

(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the

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claim or claims that formed the basis of the appeal;

(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;

(9) within one business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision;

(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and

[~~(6)~~] (11) provide for each of its network pharmacy providers and the superintendent a process [~~for each of its network pharmacy providers~~] and mechanism to readily access the maximum allowable cost list specific to that provider.

[~~B.~~] E. A maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefits manager is confidential.

[~~C. As used in this section, "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug.~~]

F. Pursuant to Section 59A-4-3 NMSA 1978, a

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pharmacy benefits manager shall provide information contained in a maximum allowable cost list to the superintendent upon request by the superintendent."

SECTION 4. Section 59A-61-5 NMSA 1978 (being Laws 2014, Chapter 14, Section 5) is amended to read:

"59A-61-5. PHARMACY BENEFITS MANAGER CONTRACTS--CERTAIN PRACTICES PROHIBITED--CERTAIN DISCLOSURES REQUIRED UPON REQUEST.--

A. A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.

B. [~~Each~~] A pharmacy benefits manager shall provide to [~~the pharmacies~~] a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.

C. A contract between a pharmacy benefits manager and a pharmacy shall [~~provide specific time limits for the pharmacy benefits manager to pay the pharmacy for services rendered~~] identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice.

D. The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract.

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E. A pharmacy benefits manager shall not:

(1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

(2) require pharmacy validation and revalidation standards inconsistent with, more stringent than or in addition to federal and state requirements for licensure and operation as a pharmacy in this state;

(3) prohibit a pharmacy or pharmacist from:

(a) mailing or delivering drugs to a patient as an ancillary service;

(b) providing a patient information regarding the patient's total cost for pharmacist services for a prescription drug; or

(c) discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available;

(4) require or prefer a generic drug over its generic therapeutic equivalent;

(5) prohibit, restrict or limit disclosure of information by a pharmacist or pharmacy to the superintendent; or

(6) prohibit, restrict or limit pharmacies or pharmacists from providing to state or federal government

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officials general information for public policy purposes.

F. A pharmacy benefits manager or health benefit plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefit plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

G. Within seven business days of a request by the superintendent or a contracted pharmacy or pharmacist, a pharmacy benefits manager or pharmacy services administrative organization shall provide as appropriate:

(1) a contract;

(2) an agreement;

(3) a claim appeal document;

(4) a disputed claim transaction document or price list; or

(5) any other information specified by law.

H. In a time and manner required by rules promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide.

I. Pursuant to the provisions of Section 59A-4-3

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NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the information confidential."

SECTION 5. Section 59A-61-6 NMSA 1978 (being Laws 2014, Chapter 14, Section 6) is amended to read:

"59A-61-6. AUDIT--PHARMACY BENEFITS MANAGER.--A pharmacy benefits manager [~~whether~~] licensed pursuant to the Pharmacy Benefits Manager Regulation Act [~~or exempt from licensure pursuant to that act~~] shall be subject to Section 61-11-18.2 NMSA 1978. A pharmacy benefits manager shall not reduce or eliminate payment on an adjudicated claim except as permitted by Section 61-11-18.2 NMSA 1978."

SECTION 6. Section 59A-61-7 NMSA 1978 (being Laws 2017, Chapter 16, Section 2) is amended to read:

"59A-61-7. PHARMACY BENEFITS MANAGERS--PROHIBITED PHARMACY FEES.--

A. A pharmacy benefits manager shall not charge a [~~pharmacist or~~] pharmacy a fee related to the adjudication of a claim, including:

[~~A.~~] (1) the receipt and processing of a

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pharmacy claim;

[~~B.~~] (2) the development or management of a claim processing or adjudication network; or

[~~C.~~] (3) participation in a claim processing or claim adjudication network.

B. A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract."

SECTION 7. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] REGISTRATION OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS REQUIRED.--A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent."

SECTION 8. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2019.

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