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F I S C A L I M P A C T R E P O R T

SPONSOR: Campos DATE TYPED: 03/05/03 HB

SHORT TITLE: Pharmacy Benefit Managers Regulation Act SB 871

ANALYST: Geisler

REVENUE

Estimated Revenue		Subsequent Years Impact	Recurring or Non-Rec	Fund Affected
FY03	FY04			
	.01 See Narrative	.01 See Narrative	Recurring	OSF

(Parenthesis ( ) Indicate Revenue Decreases)

SOURCES OF INFORMATION

Responses Received From
Regulation and Licensing Department, Board of Pharmacy (BOP)
Public Regulation Commission (PRC), Superintendent of Insurance (SI)
Retiree Healthcare Authority (RHCA)
Public School Insurance Authority (PSIA)
General Services Department (GSD)
Human Services Department (HSD)
Health Policy Commission (HPC)

SUMMARY

Synopsis of Bill

SB 871 creates the Pharmacy Benefits Manager Regulation Act, which establishes rules, audit procedures, enforcement authority, reimbursement policies, participation fees, and prohibited practices for Pharmacy Benefits Managers (PBMs) that have New Mexico contracts. PBMs will function under and be monitored by the Superintendent of Insurance (SI). The Act would be effective July 1, 2003.

Significant Issues

1) Impact of the bill on PBM operations and the cost of the services they provide to health insurance plans in the state. See discussion below under Fiscal Implications.

2) Implementation of dual oversight proposed by the bill. The Board of Pharmacy (BOP) may adopt rules regulating PBMs with respect to public health and safety issues and the Superintendent of Insurance (SI) may adopt rules regulating PBMs with regard to business and financial issues.

   The BOP supports additional oversight over PBMs. They provided:

   - PBMs currently dictate to patients and pharmacy providers what drugs are to be used, where patients can get drugs, and how much will be paid for certain drugs. This often contradicts existing statutes regarding changing from one drug to another and affects the health and welfare of the public by causing unnecessary delay of treatment and inconvenience for the patient.
   - PBMs dictate to a highly regulated industry without any regulations of their own.

   The PRC suggests that the bill might be amended to rely more on existing regulatory and enforcement authority. See discussion below under Other Substantive Issues.

FISCAL IMPLICATIONS

The bill creates the PBM fund for deposit of fees and penalties assessed under the Act.

State agencies including HSD, PSIA, RHCA, and GSD express concern that the assessments and other costs to PBMs associated with application for certificate of authority, annual filings, examinations etc., will be passed on to clients of the PBM either as increased administration fees or less favorable discount and rebate arrangements. This could cause health insurance costs to increase.

Concerns about regulation of PBM operations proposed by the bill include:

1. HSD provides that Section 11 (Prohibited Practices) may preclude the use of a prescription drug formulary because it prohibits the PBM from influencing the provider's choice of therapy. The effects might be sufficient to reduce the ability of managed care agencies to run a cost-effective pharmacy program and lead to decreased access to pharmacy services for Medicaid clients.
2. RHCA provides that provisions in Section 10 on medication reimbursement costs and Section 11 on the use of usual and customary price information may eliminate the ability of PBMs to pay a discounted rate on many drugs.
3. PSIA provides that that the contracting language in Section 8 (PBM Contracts) that requires the PMB to first inform the pharmacy or pharmacies in writing of the number of and other relevant information concerning patients to be served by the pharmacy or pharmacist under the contract will be very difficult to comply with for PBMs.
4. RHCA provides that if the state mandates the PBM payment cycle to pharmacies this may increase costs.

ADMINISTRATIVE IMPLICATIONS

Implementation of the bill may be difficult because both the BOP and SI would have to draft regulations pertaining to PBMs. Additional staff and training will be required to enforce the provisions of the bill. Having two different agencies responsible for the enforcement of the statute could prove to be time consuming and difficult.

TECHNICAL ISSUES

HSD provides that Section 2 contains definitions that are ambiguous:

1. Multi-source drug. The term "suppliers" contained in the definition could be interpreted as a manufacturer, re-packager or wholesaler. Availability of a given product from a specific wholesaler may vary frequently, even on the same day. Wholesalers have their own priorities for allocation of limited supplies. For a drug to be both "available and stocked from three or more suppliers" has too many variables.
2. The definition of pharmacy benefits manager appear to exempt HMOs that self-manage their prescription benefit, although the activities would be identical to those health plans and managed care organizations that contract such services out.
3. Single-source drug is defined as "not a multi-source drug". A product could shift between single-source and multi-source more rapidly than the ability to keep up with.
4. Usual and customary price. The definition is arbitrary, in that pharmacies have no requirements for disclosing cash prices to the public. A pharmacy may state the usual and customary price of a prescription as whatever they want it to be on a given day. BOP regulations distinguish between "price disclosure" and "prescription drug advertising". Additionally, pharmacists are limited in their ability to engage in price discussions with one another under the Sherman Anti-trust Act.

OTHER SUBSTANTIVE ISSUES

SB 871 and Existing Regulations

The SI provides that SB 871 could be amended to rely more on the many existing regulatory and enforcement authority and remedies available under the New Mexico Insurance Code to the Superintendent. For instance, Article 4 of the New Mexico Insurance Code already provides a comprehensive framework for financial examinations, enforcement actions and administrative fines and penalties. The SI would encourage the integration of the SB 871 provisions into the Insurance Code's regulatory scheme.

Additional Background on PBMs from the Health Policy Commission

Pharmacy Benefits Managers

- While there is a movement to make prescription drugs more affordable and accessible to consumers, accountability, quality management, and distribution of prescription drugs must be maintained. SB871 would require accountability from the PBMs to ensure such accountability and quality, and may facilitate timely reimbursement to licensed pharmacies.

- In 1998, over 88% of HMOs contracted with Pharmacy Benefit Managers (managedcare-digest.com).

- PBMs are hired by health management organizations to assist them in –
  - Tracking prescriptions
  - Administering prescription drug claims
  - Establishing formularies
  - Tracking physician prescribing patterns
  - Providing education to improve efficiency and cost effectiveness
  - Provide disease management programs

  - PBMs are able to provide discounted prices and rebates through their networks with pharmaceutical companies.

  - A GAO report issued in January 2003 stated that:
  - PBMs produced savings for plans participating in the Federal Health Employees Health Benefits Program.
  - Brand name drugs were an average of 18% below the price paid for drugs paid without third-party coverage.
  - Health plan enrollees had wide access to pharmacies.
  - Retail pharmacies may have to accept discounted reimbursements from PBMs and perform additional administrative duties.

Physician and pharmacist concerns

- The primary purposes of PBMs are to assist HMOs in their efforts to be cost-effective in the area of prescription drugs. However, there has been growing concern among physicians and pharmacists that the rules and formularies put into place by PBMs are done so only on the basis of cost-effectiveness, and without proper consultation with the physician and/or pharmacist.
- Pharmacists and physicians must consult with each other regularly when changes are made in dispensing drugs for their patients to ensure that their patients are not put at risk, but PBMs do not generally follow that same process of consultation. For instance, a physician may prefer to prescribe a drug not offered by the PBM, but may not allowed to do so due to contractual agreements.

GGG/yr/njw