**Fiscal impact reports (FIRs) are prepared by the Legislative Finance Committee (LFC) for standing finance committees of the NM Legislature. The LFC does not assume responsibility for the accuracy of these reports if they are used for other purposes.**

**Current and previously issued FIRs are available on the NM Legislative Website (www.nmlegis.gov).**

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

**SPONSOR** Fajardo **ORIGINAL DATE** 02/03/21 **LAST UPDATED** 03/15/21 **HB** 129/aHHHC/aHFl#1/aSJC

**SHORT TITLE** Pharmacy Benefit Manager Reporting **SB**

**ANALYST** Chilton

## ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

| | FY21 | FY22 | FY23 | 3 Year Total Cost | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|---|---|
| **Total** | | Minimal | NFI | Minimal | Nonrecurring | General Fund |

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to numerous other statutes attempting to limit the cost of prescription drugs.

## SOURCES OF INFORMATION

LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
General Services Department (GSD)

## SUMMARY

Synopsis of SJC Amendment

The Senate Judiciary Committee amendment to House Bill 129 as twice amended, removes the entire contents of the bill and replaces most of the title of the bill, to repurpose it to "enacting a new section of the pharmacy benefit regulation act to provide for cost sharing calculations."

The amended bill has been entirely rewritten, such that most of the requirements of OSI and thus its costs have been eliminated, other than to promulgate regulations related to the amended act. Subsection 1 B of the new language defines "generic equivalent" and "health insurance carrier", as used in Section 1 A. Section 1 A states that health insurance carriers and pharmacy benefit managers, in calculating a patient's cost-sharing (copayment, deductible or out-of-pocket maximum), must include all payments by the patient or on his/her behalf. This requirement applies only to brand-name drugs with no generic equivalent and which is deemed medically necessary by the prescriber. The calculation does not take into account rebates paid by a pharmaceutical company to a pharmacy management company or health insurance carrier. Such rebates are no longer mentioned in the bill and "transparency" and "reporting" are no longer mentioned in the bill.

Synopsis of House Floor Amendment

The House Floor amendment to House Bill 129 as amended by the House Health and Human Services Committee corrects two typographical errors, a word inversion on page 7 and a substitution of a plural noun for a singular noun on page 11, without appearing to change the meaning of the bill.

Synopsis of HHHC Amendment

The House Health and Human Services Committee amendment to House Bill 129 changes the definitions for the terms "aggregate retained rebate percentage" and "rebates" used in Section 3 of the bill, which refers to items to be contained in the transparency report each pharmacy benefit manager is required to submit.

The amendment also adds health insurers, defined in a new Section 4E of the bill, to pharmacy benefit managers as being required to use rebates in reducing the cost-sharing for consumers or for other persons paying on behalf of the consumers.

Synopsis of Original Bill

House Bill 129 would amend and add new subsections to Section 59A-61 NMSA 1978 (the Pharmacy Benefit Manager Regulation Act, part of the Insurance Code) to increase transparency of operations of pharmacy benefit managers (PBMs) operating in New Mexico.

In Section 1 of the bill, a new subsection G requires a pharmacy to submit annual transparency reports.

Section 2 requires PBMs to file disclosures routinely, not just "on request." A new subsection J specifies that PBMs must file with OSI formularies for each of the insurance programs with which they contract. These must be updated in a "timely" fashion and made available to consumers through OSI's website.

Section 3 is new material that requires PBMs to submit a transparency report on the PBM's function and data from the previous year by July 1 of each year. PBMs must report on the following:

1) Aggregate rebates from manufacturers;
2) Aggregate of administrative fees received;
3) Aggregate insurer administrative fees;
4) Aggregate amount of rebates received and not passed on to insurers;
5) Retained rebate percentage; and
6) Highest, lowest and mean rebate percentage for all the PBM's relationships with insurers.

This transparency report would be published on a website accessible by the public, which would not identify the insurer to which the material applied, as information regarding individual drugs and insurers would be treated as confidential and not subject to IPRA.

Section 4, also new material, regards the pass-through to consumers of rebates received by PBMs. The value of these rebates must be passed along fully (or more than 100 percent) to consumers as a percentage of their cost sharing (copays or coinsurance). The Superintendent of Insurance would promulgate rules that would apply to all health plans entered into, amended, extended or renewed after January 1, 2022.

The effective date of this bill is July 1, 2021.

## FISCAL IMPLICATIONS

There is no appropriation in HB 129.

OSI has estimated its costs in administering the PBM transparency project as follows:

1) Managing frequent PBM formulary changes and auditing the accuracy of drug formulary changes: one full-time employee at $80 thousand per year.
2) Ensuring that nine insurance companies' 600+ plans were passing on rebates to consumers: actuarial service required at least $348 thousand per year.
3) Maintaining the webpage for the 600+ plan formularies and updating the webpage each month: one technically adept person at $95 thousand per year.
4) Dealing with anticipated consumer questions, concerns and complaints: one consumer assistance specialist at $71.5 thousand per year.

GSD, the State Group Benefits Program of GSD received approximately $18 million in rebates from pharmaceutical manufacturers in FY20, using those to offset other costs of that program. GSD does not see a likelihood of material changes in its costs due to House Bill 129.

## SIGNIFICANT ISSUES

According to the Commonwealth Fund, a private foundation that promotes access to healthcare:

> Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers. By negotiating with drug manufacturers and pharmacies to control drug spending, PBMs have a significant behind-the-scenes impact in determining total drug costs for insurers, shaping patients' access to medications, and determining how much pharmacies are paid.[1] PBMs have faced growing scrutiny about their role in rising prescription drug costs and spending.

PBMs operate in the middle of the distribution chain for prescription drugs. That's because they

- Develop and maintain lists, or formularies, of covered medications on behalf of health insurers, which influence which drugs individuals use and determine out-of-pocket costs;
- Use their purchasing power to negotiate rebates and discounts from drug manufacturers; and
- Contract directly with individual pharmacies to reimburse for drugs dispensed to beneficiaries.

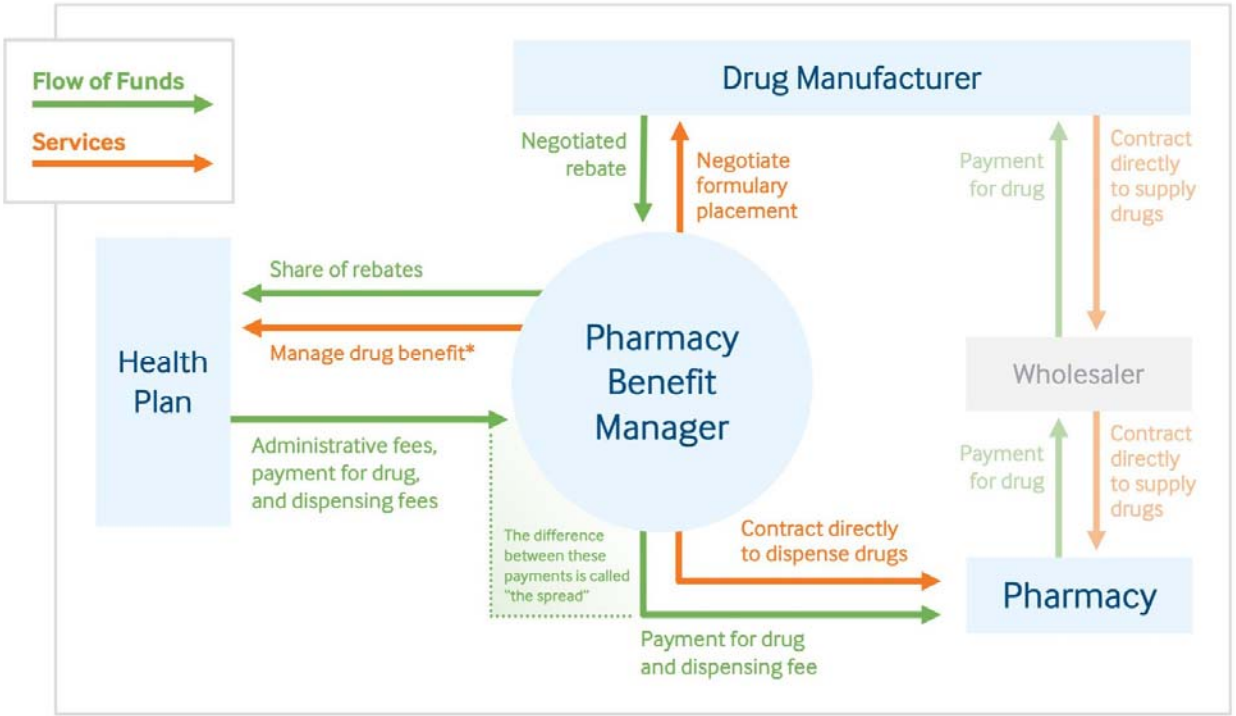
There is much debate as to whether PBMs should be able to keep the rebates they receive from drug manufacturers, which generally are not publicly disclosed. Some believe PBMs should be compelled to "pass through" all or a larger portion of these savings to health insurers and other payers. If PBMs were required to do this, insurers could use the savings to further reduce people's premiums and cost-sharing payments. A recent study found the share of rebates PBMs passed through to insurers and payers increased from 78 percent in 2012 to 91 percent in 2016. But many small insurers and employers say they do not receive this share of savings.

Policymakers have considered three principal reforms to regulate PBMS:

- Require greater transparency around rebates. Federal and state policymakers likely need more data on the rebates PBMs receive to gain a more complete understanding of pharmaceutical spending and where reforms may be needed.
- Policymakers could ban the practice of "spread pricing" to ensure that payers and employers are not overpaying PBMs for prescription drugs. A more limited proposal would mandate that PBMs update their cost schedules with pharmacies to reflect price increases for generic drugs.[7]
- Require PBMs to pass through rebates to payers or to patients. To preserve some of their incentive to negotiate price reductions with drug makers, PBMs could be required to pass through 90 percent of their rebate savings to payers. Alternatively, PBMs could be required to pass through rebates to patients. The federal government has, in fact, proposed requiring PBMs contracted with Medicare Part D plans to pass through to patients at least one-third of the rebates and price concessions they receive.

(https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending)

PBMs' role is complex, as shown in the following chart:




The National Conference of State Legislatures (NCSL) indicates states are increasingly legislating restrictions on pharmacy benefit managers in order to prevent "gag clauses" (which keep pharmacists from telling patients that it will be less expensive for them to pay out of pocket rather than using insurance), "spread pricing" (where a PBM charges an insurer more than it pays a pharmacist for a medication) and failure to pass along rebates received by the PBM to consumers.

OSI indicates that, due to the structure of rebates from pharmaceutical companies to insurers and PBMs, the requirement in Section 4 of the bill that those rebates be provided to consumers are

each dispensation of drugs is unworkable. It suggests an amendment to that provision and to several others, as indicated under "amendments", below.

**RELATIONSHIP** to other bills looking to decrease patients' exposure to high drug prices, including

- HB154, which would set up a Prescription Drug Affordability Board
- SB1 from 2020, to institute importation of drugs from Canada

**ALTERNATIVES**

OSI suggests the state consider a bill similar to Texas' 2019 pharmaceutical price transparency bill, "in which the state obtains data across the entire supply chain, including PBMs, insurers, and pharmaceutical manufacturers." The bill was lauded by one group of stakeholders, the AARP, in a 2019 article (states.aarp.org/texas):

> House Bill 2536, as amended, requires certain drug-cost information to be provided – and then shared with the public on a state website – from drug manufacturers, pharmacy benefit managers (also known PBMs) and health benefit plans. Specifically, drug manufacturers would inform the Texas Health and Human Services Commissioner if the wholesale price of certain medicines increase more than 10 percent in any given year or more than 40 percent over five years. Within 60 days of reporting the information, the HHSC would post the data to a public website.
>
> AARP Texas Director Bob Jackson said the updated bill would give consumers much-needed insights, such as how much of a drug's cost is owed to spending on advertising and marketing, and how much goes into research and development.
>
> "The Texas House of Representatives deserves a round of applause for passing House Bill 2536, which will provide older Texans and other consumers the information they need to plan for and to understand drug price increases," said Jackson. "Drug price information allows consumers to combat the high cost of the medicines they need.

**AMENDMENTS**

OSI recommends several amendments, as follows, stating, "These amendments will significantly reduce the potential negative cost impact of the bill while obtaining the information that allows New Mexico decision makers to get a transparent picture of the true cost of the pharmaceutical supply chain."

1) Delete Section 2(J) in its entirety.
2) Amend Section 3(A) to read: "The transparency report shall contain the information specified in Subsections (1) through (6), and any additional data specified in rules promulgated by the superintendent."
3) Amend Section 3(B) to delete the phrase "the prices charged for specific drugs or classes of drugs or the amount of any rebates provided for specific drugs or classes of drugs."
4) Amend section 3(C) to delete the phrase "the prices charged for a specific drug or class of drugs or the amount of any rebates provided for a specific drug or class of drugs."
5) Delete Section 4 in its entirety or revise to reflect the concerns expressed herein, including disclosure of price increases made by the manufacturers of the proposed covered drugs.
6) Add a recurring appropriation of $595,000.

LAC/al/rl