HOUSE BILL 129

55TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2021

INTRODUCED BY

Kelly K. Fajardo and Gerald Ortiz y Pino

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE
PHARMACY BENEFITS MANAGER REGULATION ACT TO PROVIDE FOR
INCREASED TRANSPARENCY; REQUIRING CERTAIN DISCLOSURES;
PROVIDING FOR COST SHARING CALCULATIONS.

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

SECTION 1. Section 59A-61-3 NMSA 1978 (being Laws 2014,
Chapter 14, Section 3, as amended) is amended to read:

"59A-61-3. LICENSURE--INITIAL APPLICATION--ANNUAL RENEWAL
REQUIRED--REVOCATION--TRANSPARENCY REPORTS.--

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.

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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:

(1) the identity of the pharmacy benefits manager;
(2) the name and business address of the contact person for the pharmacy benefits manager;
(3) where applicable, the federal employer 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 in contravention of its application;
(2) the pharmacy benefits manager has failed to continuously meet or comply with the requirements for issuance or maintenance of a license; or
(3) the pharmacy benefits manager has failed to comply with applicable state or federal laws or rules.

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 conclude its affairs, notify each pharmacy in its network and conduct no further pharmacy benefits management 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.

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.

G. A pharmacy benefits manager shall submit an annual transparency report pursuant to Section 3 of this 2021 act."

SECTION 2. Section 59A-61-5 NMSA 1978 (being Laws 2014, Chapter 14, Section 5, as amended) 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. A pharmacy benefits manager shall provide to 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 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.

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 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 .218986.2
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 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.

J. For each of a pharmacy benefits manager's contractual or other relationships with a health benefit plan or health insurance issuer, the pharmacy benefits manager shall
provide the office of superintendent of insurance with the
health benefit plan's formulary and provide timely notification
of formulary changes and product exclusions. The information
provided pursuant to this subsection shall be made available in
a centralized location on the office's website in a format that
allows for consumer access, including links to pharmacy
benefits manager websites."

SECTION 3. A new section of the Pharmacy Benefits Manager
Regulation Act is enacted to read:

"[NEW MATERIAL] TRANSPARENCY REPORTS--FORMULARIES.--

A. On or before July 1 of each year, a pharmacy
benefits manager shall submit to the superintendent a
transparency report containing data from the prior calendar
year. The transparency report shall contain the following
information for each of the pharmacy benefits manager's
contractual or other relationships with a health benefit plan
or health insurance issuer:

(1) the aggregate amount dollar of all rebates
and other payments that the pharmacy benefits manager received
from all pharmaceutical manufacturers;

(2) the aggregate dollar amount of all
administrative fees that the pharmacy benefits manager
received;

(3) the aggregate dollar amount of all insurer
administrative fees that the pharmacy benefits manager
received;

(4) the aggregate dollar amount of all rebates that the pharmacy benefits manager received from all pharmaceutical manufacturers and did not pass through to health benefit plans or health insurance issuers;

(5) the aggregate retained rebate percentage;

and

(6) across all of the pharmacy benefits manager's contractual or other relationships with all health benefit plans and health insurance issuers, the highest, lowest and mean aggregate retained rebate percentage.

B. The transparency report required pursuant to Subsection A of this section shall be published in a timely manner on a publicly available website; provided that such information is made available in a form that does not disclose the identity of a specific health benefit plan, the prices charged for specific drugs or classes of drugs or the amount of any rebates provided for specific drugs or classes of drugs.

C. A pharmacy benefits manager and its agents, an insurer and its agents and the superintendent shall not publish or disclose any information that would reveal the identity of a specific health benefit plan, 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. Any such information shall be protected from disclosure as confidential and
proprietary information and shall not be regarded as a public
record pursuant to the Inspection of Public Records Act or the
Public Records Act.

D. Within sixty days of receipt, the superintendent
shall publish on the office of superintendent of insurance's
website transparency reports submitted pursuant to this
section. The superintendent shall provide a dedicated location
on the office of superintendent of insurance's website for
pharmacy benefits manager information and links.

E. As used in this section:

(1) "aggregate retained rebate percentage"
means the percentage calculated for each prescription drug for
which a pharmacy benefits manager receives rebates under a
particular health benefit plan expressed without disclosing any
identifying information regarding the health benefit plan,
prescription drug or therapeutic class. The percentage shall
be calculated by dividing the aggregate rebates that the
pharmacy benefits manager received during the prior calendar
year from a pharmaceutical manufacturer related to utilization
of the manufacturer's prescription drug by health benefit plan
enrollees that did not pass through to the health benefit plan
or health insurance issuer by the aggregate rebates that the
pharmacy benefits manager received during the prior calendar
year from a pharmaceutical manufacturer related to utilization
of the manufacturer's prescription drug by health benefit plan
enrollees;

(2) "health benefit plan", "plan", "benefit" or "health insurance coverage" means services consisting of medical care provided directly through insurance, reimbursement or other means, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization contract or health maintenance organization contract offered by a health insurance issuer; provided that excepted benefits are not included as a "health benefit plan";

(3) "health insurance issuer" means an entity that offers health insurance coverage through a plan, policy or certificate of insurance subject to state law that regulates the business of insurance and also includes a "health maintenance organization" as defined and certified pursuant to the Health Maintenance Organization Law; and

(4) "rebates" means all rebates, discounts and other price concessions, based on utilization of a prescription drug and paid by the manufacturer or other party other than an enrollee, directly or indirectly, to the pharmacy benefits manager after the claim has been adjudicated at the pharmacy and shall include a reasonable estimate of any volume-based discount or other discounts."

SECTION 4. A new section of the Pharmacy Benefits Manager
Regulation Act is enacted to read:

"[NEW MATERIAL] PHARMACY BENEFITS MANAGER PROVISIONS RELATED TO PATIENT COST SHARING.--

A. An enrollee's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to one hundred percent of all rebates received or to be received in connection with the dispensing or administration of the prescription drug.

B. Nothing in this section shall preclude an insurer or pharmacy benefits manager from decreasing an enrollee's defined cost sharing by an amount greater than that provided for in Subsection A of this section.

C. When calculating an enrollee's contribution to any applicable cost sharing requirement, including an out-of-pocket maximum, deductible or copayment responsibility to prescription drug benefits, a pharmacy benefits manager shall include amounts paid by the enrollee or paid on the enrollee's behalf through a third-party payment, financial assistance, discount or product voucher for a prescription drug. This provisions shall apply with respect to health plans entered into, amended, extended or renewed on or after January 1, 2022.

D. In complying with the provisions of this section, an insurer or its agents, and a pharmacy benefits
manager or its agents, shall not publish or otherwise reveal
information regarding the actual amount of rebates an insurer
or pharmacy benefits manager receives on a product,
manufacturer, or pharmacy-specific basis. Any such information
shall be protected from disclosure as confidential and
proprietary information and shall not be regarded as public
record pursuant to the Inspection of Public Records Act or the
Public Records Act.

E. The superintendent shall promulgate rules
necessary to implement and carry out the provisions of this
section."

SECTION 5. EFFECTIVE DATE.--The effective date of the
provisions of this act is July 1, 2021.

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