MINUTES of the
Interagency Pharmaceuticals Purchasing Council
February 27, 2020
State Capitol, Room 322 Santa Fe, NM 87507
1:00 pm to 4:00 pm

1. CALL TO ORDER

Ken Ortiz, Director of the Interagency Pharmaceuticals Purchasing Council (IPPC) called the meeting to order at 1:04 p.m. in Room 322, of the New Mexico State Capitol. A quorum was established with roll call.

ROLL CALL

Ken Ortiz, Director IPPC
Designee, Human Services Department, Kari Armijo
Secretary, Department of Health, Kathy Kunkel
Designee, Children Youth and Families Department, Terry Locke
Secretary, Corrections Department, Alisha Tafoya Lucero
Director, Risk Management Division, General Services Department, Clinton Nicley
Executive Director, Retiree Health Care Authority, David Archuleta
Interim Director, Public School Insurance Authority, Richard Valerio
Designee, Albuquerque Public Schools, Mark Tyndall
Designee, University of New Mexico, Joey Evans
Executive Director, New Mexico Counties, Steve Kopelman

ABSENT/EXCUSED

Director Ortiz mentioned the passing of council member Bill Fulginiti of the New Mexico Municipal League. A moment of silence was observed in his honor.

2. APPROVAL OF THE AGENDA

MOTION: Mr. Nicley moved to approve the agenda with a second from Ms. Armijo which passed unanimously by voice vote.

3. APPROVAL OF MINUTES FROM NOVEMBER 14, 2019

Changes/Corrections:

a) Under Item 6 change Frank Allen to Frank Roland.
b) Second paragraph on page 3, change savings to additional expense.

MOTION: Secretary Kunkel moved to approve the minutes as amended with a second from Mr. Locke which passed unanimously by voice vote.

4. 2020 LEGISLATIVE UPDATE AND SB1 and HB 292

Jane Wishner, Executive Policy Adviser for Health and Human Services; Secretary Kathy Kunkel, Department of Health; and Russell Toal, Superintendent of Insurance

Jane Wishner thanked the General Services Department (GSD) team for their work during the Legislative session and discussed the Governor's plan for the work that was done on Senate Bill 1 (SB1) and House Bill 292 (HB292).

SB1, which was passed during the 2020 legislature, will enable New Mexico to purchase drugs from Canada at a lower rate than the manufacturer's wholesale rate in the United States. This means that the same brand name drug product from the manufacturer will be available at a much lower cost in New Mexico through drug importation.

HB292 addresses the copays paid by New Mexico patients for insulin. While the price of insulin will not change the manufacturer's or Pharmacy Benefit Manager's (PBM) cost, HB292 ensures patients in New Mexico will not have to pay more than $25 for each 30-day insulin prescription.

Secretary Kunkel thanked Ms. Wishner for her research, work, and talking points for SB1. Secretary Kunkel added that Mr. Dale Tinker, New Mexico Pharmacists Association, helped with testimony before the legislature and helped explain the bill as well.

SB1 created the opportunity for New Mexico to create a commission to create a plan to import wholesale drugs from Canada and submit the plan to the federal government by December 30, 2020. Secretary Kunkel will lead the commission and stated she has set a date for the first meeting.

In 2013 the federal government passed a statute allowing states to execute plans to begin importing drugs from other countries, but rules for this statute had not been promulgated until December 2019. These rules are still in the public comment stage and are not in effect.

Colorado, Vermont, Florida, and Maine, have begun working on their plans for drug importation; Secretary Kunkel hopes to make New Mexico the fifth state to submit plans for wholesale drug importation. So far the federal government has recognized Canada as the only country that can import to the United States, but that may change. Secretary Kunkel stated that the commission can benefit from the experience of the four states and during this year's legislature, Colorado and Vermont provided advice to Secretary Kunkel.

Small New Mexico pharmacies will be included in the planning stages and there will also be a public hearing so the legislature and members of the public can contribute to the plan. SB1 added non-recurring funding to set up the commission and Secretary Kunkel hopes to add a program manager and consultant for the initial year.

Mr. Toal discussed HB292 and thanked the Governor for helping with the high cost of insulin. There are many avoidable complications that can occur if people cannot afford their insulin. Thus, HB292 was introduced and passed. As a result, copayments for diabetes patients will be no more than $25 a month for each preferred formulary prescription insulin drug, for a maximum of $50 per month. This will be a cost savings for citizens and lead to a dramatic reduction in harm to people with diabetes.

Mr. Toal reviewed section 4 of HB292 with IPPC members, which calls for the Superintendent of Insurance to convene an advisory group by May 20, 2020 to study the cost of nine (9) drug categories to New Mexico consumers and make recommendations. The group is required to

report its findings to the legislative finance committee (LFC) and legislative health and human services committee (LHHSC) by October 1, 2020. Currently, the group is lining up an actuary before the May start date and is starting work on the design of the study. The advisory group will be working with the pharmaceutical carriers and PBM community on the study and looks forward to reporting its findings not only to the LFC and LHHSC, but to the IPPC as well. Mr. Toal stated Senator Ivey-Soto did a great job in the Senate to get HB292 passed with bipartisan support.

Secretary Ortiz thanked Superintendent Toal for his presentation and invited him back to present the advisory group's findings to the IPPC once the report is finalized.

5. PRESCRIPTION DRUG COSTS: PAYER & PURCHASER OPTIONS FOR AN IMPROVED APPROACH TO COST CONTAINMENT IN NM

Jane Horvath, Horvath Health Policy

Ms. Horvath presented her slideshow regarding Prescription Drug Costs: Payer and Purchaser Options for an Improved Approach to Cost Containment in New Mexico. (Presentation attached to the minutes).

After Ms. Horvath's presentation, Director Ortiz asked the IPPC members for questions and/or comments.

Ms. Armijo asked about the Ms. Horvath's Medicaid supplemental rebates recommendation and wanted to know if the recommendation was for fee for service specifically or for the Medicaid delivery system. Ms. Horvath said the recommendation was for the whole Medicaid program. Asked by Ms. Armijo if this recommendation would require a unified formulary or PBL (Preferred Brand List) for Medicaid fee for service, Ms. Horvath said it would not. However, Ms. Horvath thinks a unified formulary would be better because the program may get a better deal for driving market share. Ms. Armijo asked if there would be any issues with pursing supplemental rebates for Medicaid managed care only. Ms. Horvath stated that pursuing supplemental rebates only on Medicaid managed care would not pose any initial problems.

Mr. Archuleta asked about the reverse auction process and whether New Mexico will need to modify its procurement laws. Ms. Horvath explained that reverse auction is a market based approach rather than regulatory. PBMs that wish to bid must review and agree to the initial and general terms of a contract before they are eligible to bid. Then PBMs look at claims data from the health plans and submit a bid based on the data they have reviewed.

Mr. Nicley stated he was also thankful for the presentation. Mr. Nicley asked for some success stories about reverse auctions. Ms. Horvath stated she will gather some information on the New Jersey (NJ) bill that amended procurement laws since NJ awarded a PBM contract in 2017 through the reverse auction process.

Mr. Locke thanked Ms. Horvath for her presentation and asked about the sustainability of savings and the market's response to drug importation. Ms. Horvath stated it is price competition and that, in fact, Florida's Governor has publicly stated that pharmaceutical manufacturers have been approaching him to try to offer purchasing rebates as a way to match drug importation prices.

Director Ortiz offered "next step" options to further research Ms. Horvath's recommendations and the priorities on which to focus. He suggested a subcommittee be formed to explore the recommendations and report at the next meeting to be held in May. Another option he suggested was for the Risk Management Director, Ms. Trujillo, and himself to meet with each entity to gather data on the pharmaceutical programs and the recommendations each would like to focus on.

Mr. Tyndall suggested testing the waters to look at the amount of covered lives of other self-funded pharmaceutical purchasers such as City of Albuquerque, Central New Mexico Community College (CNM), and Bernalillo County. He would like to see who would participate in pharmaceutical purchasing consolidation voluntarily as early as they can. He would also like to have a conversation on the 340B pricing. Mr. Tyndall stated that according to data, half of the specialty pharmaceutical spending comes from the medical plans and when looking at payer reports, it is difficult to ascertain the difference between the medical cost and the facility cost. Sometimes, the health plan is owned by the medical facility. So not only is there a copay cost for pharmaceuticals, patients are oftentimes paying a facility markup for the medical drug. APS would also be interested in the risk sharing pools moving forward.

Secretary Kunkel stated that members learn more in subcommittees and would move to have a subcommittee.

After more discussion it was suggested to have two subcommittees; one for purchasers and one for payers to assure they talk to each other and possibly invite other public local bodies. Director Ortiz stated that he and Ms. Trujillo will attend both meetings and that IPPC members can be on both subcommittees.

MOTION: Mr. Tyndall moved to create two subcommittees with a second from Mr. Valerio which passed unanimously by voice vote.

IPPC members have until Friday, March 6, 2020 to reply to Ms. Trujillo via email on who will be volunteering for the subcommittees.

6. PUBLIC COMMENT

Dale Tinker thanked the Council and watched the process of the SB1 and HB292. The New Mexico Pharmacists Association spoke on behalf of each one and supported the bills. Specifically, SB1 requires a chain of custody to assure safety. In Canada they have a law that allows pharmacies to import drugs anywhere in the world without regard to the FDA process. In addition, Mr. Tinker knows the IPPC agencies and entities will be impacted by the lower drug pricing with SB1 and wants to make sure council members are mindful not to short the pharmacies. One pharmacy's contract has pharmaceuticals selling at break-even market rates with zero dispensing fees. Without dispensing fees, pharmacies do not have funds for operations. Community pharmacies are struggling now.

7. NEXT STEPS FOR IPPC

The next IPPC meeting will be on May 14, 2020.

8. ADJOURN

MOTION: Mr. Valerio moved to adjourn at 2:47 p.m. with a second from Mr. Nicley. The motion passed unanimously.

Ken Ortiz, Director

6/11/20

Date

SENATE BILL 1

54TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2020

INTRODUCED BY

Mary Kay Papen and Deborah A. Armstrong

This document incorporates amendments that have been adopted during the current legislative session. The document is a tool to show the amendments in context and is not to be used for the purpose of amendments.

AN ACT

RELATING TO HEALTH; ENACTING THE WHOLESALE PRESCRIPTION DRUG IMPORTATION ACT; PROVIDING POWERS AND DUTIES; CREATING A PROGRAM; CREATING A COMMITTEE; REQUIRING FEDERAL CERTIFICATION; CREATING A FUND; **SFC→~~MAKING AN APPROPRIATION~~←SFC**; DECLARING AN EMERGENCY.

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

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Wholesale Prescription Drug Importation Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the

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Wholesale Prescription Drug Importation Act:

A. "Canadian supplier" means a manufacturer, wholesale distributor or pharmacy that is appropriately licensed or permitted under Canadian federal or provincial laws and rules to manufacture, distribute or dispense prescription drugs;

B. "committee" means the prescription drug importation advisory committee;

C. "department" means the department of health;

D. "eligible prescription drug" means a drug eligible for importation that:

(1) meets the United States federal food and drug administration's standards related to safety, effectiveness, misbranding and adulteration;

(2) does not violate federal patent laws;

(3) is expected to generate cost savings; and

(4) is not a controlled substance;

E. "program" means the wholesale prescription drug importation program; and

F. "state drug wholesaler" means a licensed **SFC→wholesale←SFC** drug **SFC→~~wholesale~~←SFC** distributor that contracts with the state to import eligible prescription drugs from a Canadian supplier.

SECTION 3. [NEW MATERIAL] ADVISORY COMMITTEE CREATED--MEMBERSHIP--DUTIES.--

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A. The "prescription drug importation advisory committee" is created as an interagency advisory committee of the department. The committee consists of:

(1) the secretary of health, who shall serve as the chair of the committee;

(2) the executive director of the board of pharmacy;

(3) the superintendent of insurance;

(4) the secretary of human services; and

(5) the secretary of general services.

B. Members may appoint designees.

C. The committee shall advise the department in developing and implementing the program. The committee shall consult with interested stakeholders and appropriate federal officials as necessary in shaping its advice to the department. SPAC→The department shall hold a public hearing on the proposed program prior to submitting the program for federal approval.←SPAC

SECTION 4. [NEW MATERIAL] WHOLESALE PRESCRIPTION DRUG IMPORTATION PROGRAM CREATED.--The department, in consultation with the committee, shall design a "wholesale prescription drug importation program" that complies with the applicable requirements of 21 U.S.C. Section 384, including the requirements regarding safety and cost savings. The department shall explore all potential mechanisms, to the extent allowable

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under law, for the importation of eligible prescription drugs. The program design shall:

A. contract with SFC→~~a licensed drug wholesaler~~←SFC SFC→one or more state drug wholesalers←SFC to seek federal certification and approval to import safe, eligible prescription drugs from Canadian suppliers and provide significant prescription drug cost savings to New Mexico consumers;

B. allow the importation of eligible prescription drugs sold by Canadian suppliers;

C. ensure that only eligible prescription drugs meeting the United States food and drug administration's safety, effectiveness and other standards are imported by or on behalf of the state;

D. import only those eligible prescription drugs expected to generate substantial savings for New Mexico consumers;

E. ensure that SPAC→, with respect to eligible prescription drugs to be imported pursuant to the program,←SPAC the program and the state drug wholesaler comply with the tracking SPAC→~~and~~←SPAC SPAC→,←SPAC tracing SPAC→, verification and identification←SPAC requirements of 21 U.S.C. Sections 360eee and 360eee-1 SPAC→;←SPAC SPAC→~~prior to the importation of eligible prescription drugs into the state and that the program and state drug wholesaler comply fully with~~

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~~federal requirements after eligible prescription drugs are in the possession of the state drug wholesaler;~~ SPAC

F. prohibit the distribution, dispensing or sale of eligible prescription drugs imported pursuant to the Wholesale Prescription Drug Importation Act outside the exterior boundaries of the state;

G. recommend a charge per prescription or another method of support to ensure that the program is funded adequately in a manner that does not jeopardize significant consumer savings; and

H. include an audit function.

SECTION 5. [NEW MATERIAL] MONITORING FOR ANTI-COMPETITIVE BEHAVIOR.--The department shall consult with the attorney general to identify the potential, and to monitor, for anti-competitive behavior in industries that would be affected by the program.

SECTION 6. [NEW MATERIAL] FEDERAL COMPLIANCE.--On or before December 15, 2020, the department shall submit a formal request to the secretary of the United States department of health and human services for certification of the state's program.

SECTION 7. [NEW MATERIAL] IMPLEMENTATION.--Upon certification of approval by the secretary of the United States department of health and human services, the department shall begin implementing the program and begin operating the program

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within six months of that approval. As part of the implementation process, the department shall:

A. enter into contracts in accordance with the Procurement Code with one or more **SFC→~~New Mexico licensed~~←SFC** **SFC→state←SFC** drug wholesalers and New Mexico licensed drug distributors and contract with one or more approved Canadian suppliers;

B. consult with interested stakeholders, including the committee, the legislature, health insurance plans, employers, pharmacies, health care providers and consumers;

C. develop a registration process for health insurance plans, pharmacies and prescription drug administering health care providers who choose to participate in the program;

D. make a list of imported eligible prescription drugs and their prices and make that list available to all participating entities and the general public;

E. create an outreach and marketing plan to generate program awareness;

F. create and staff a helpline to answer questions and address the needs of consumers, employers, health insurance plans, pharmacies, health care providers and other affected sectors;

G. require annual and special audits of the program; and

H. carry out other duties in accordance with the

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Wholesale Prescription Drug Importation Act that the department SPAC→, in consultation with the board of pharmacy,←SPAC determines to be necessary for successful implementation of the program.

SECTION 8. [NEW MATERIAL] ANNUAL REPORTING.--Annually, after implementation, the department shall report to the governor and the legislature regarding the operation of the program during the previous year, including:

A. which eligible prescription drugs and Canadian suppliers are included in the program;

B. the number of participating pharmacies, health care providers and health insurance plans;

C. the number of prescriptions dispensed through the program;

D. the estimated savings to consumers, health plans, employers and the state during the previous year and to date;

E. information regarding implementation of the audit plan and the correction plans for audit findings; and

F. any other information requested by the governor or the legislature or that the secretary of health deems relevant.

SECTION 9. [NEW MATERIAL] WHOLESALE PRESCRIPTION DRUG IMPORTATION FUND.--The "wholesale prescription drug importation fund" is created as a nonreverting fund in the state treasury.

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The fund consists of money received by the state through the implementation of the program pursuant to the Wholesale Prescription Drug Importation Act and appropriations, gifts, grants, donations to the fund and income from investment of the fund. SFC→~~The state investment officer shall invest the fund in the same manner as the land grant permanent funds are invested.~~←SFC The department shall administer the fund, and money in the fund is SFC→~~appropriated to the department to carry out the purposes of that act~~←SFC SFC→**subject to appropriation by the legislature and shall be expended only as provided in the appropriation**←SFC. Expenditures shall be by warrant of the secretary of finance and administration pursuant to vouchers signed by the secretary of health or the secretary's authorized representative.

SECTION 10. [NEW MATERIAL] COUNTRIES OTHER THAN CANADA ALLOWED BY FEDERAL LAW.--The provisions of the Wholesale Prescription Drug Importation Act may be extended to any other country allowed by federal law to import prescription drugs into the United States, at the discretion of the department.

SFC→~~SECTION 11. APPROPRIATION.--Three hundred fifty thousand dollars ($350,000) is appropriated from the general fund to the wholesale prescription drug importation fund for expenditure in fiscal year 2021 and subsequent fiscal years to administer the provisions of the Wholesale Prescription Drug Importation Act. Any unexpended or unencumbered balance~~

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~~remaining at the end of a fiscal year shall not revert to the general fund.~~←SFC

SECTION SFC→~~12~~←SFC SFC→11←SFC. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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SECTION 4. TEMPORARY PROVISION--STUDY AND REPORT.— The superintendent of insurance shall convene an advisory group to include the secretary of human services, the secretary of health and the secretary of general services or their designees and the dean of the university of New Mexico college of pharmacy or the dean's designee to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility of prescription drugs. The report shall be submitted to the legislative health and human services committee and the legislative finance committee no later than October 1, 2020. The study shall examine, at a minimum, the benefits to New Mexico consumers and the potential costs of setting cost-sharing limitations for the following categories of drugs:

A. inhaled prescription drugs used to control asthma;

B. oral medications to treat or control diabetes;

C. injectable epinephrine devices for severe allergic reactions;

D. opioid reversal agents;

E. medications used to treat hypertension;

F. antidepressant medications;

G. antipsychotic medications;

H. lipid-lowering agents; and

I. anticonvulsants.

SECTION 5. EFFECTIVE DATE.—

A. The effective date of the provisions of Sections 1 through 3 of this act is January 1, 2021.

B. The effective date of the provisions of Section 4 of this act is May 20, 2020.

HOUSE BILL 292

54TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2020

INTRODUCED BY

Micaela Lara Cadena and Daniel A. Ivey-Soto

This document incorporates amendments that have been adopted during the current legislative session. The document is a tool to show the amendments in context and is not to be used for the purpose of amendments.

AN ACT

RELATING TO HEALTH CARE PLANS; ESTABLISHING LIMITS ON COST SHARING FOR CERTAIN PRESCRIPTION DRUGS; REQUIRING A REPORT RECOMMENDING ADDITIONAL DRUGS AND SERVICES FOR COST-SHARING LIMITATIONS; REQUIRING A STUDY OF THE COST OF PRESCRIPTION DRUGS FOR NEW MEXICO CONSUMERS AND MAKING RECOMMENDATIONS ON INCREASING ACCESSIBILITY OF PRESCRIPTION DRUGS; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

SECTION 1. A new section of the Health Care Purchasing

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Act is enacted to read:

"[NEW MATERIAL] INSULIN FOR DIABETES--COST-SHARING CAP.--Group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall cap the Hfl→~~total~~ ←Hfl amount an insured is required to pay for Hfl→~~HSEIC→preferred formulary←HSEIC~~ ←Hfl Hfl→~~prescription insulin drugs~~←Hfl Hfl→a preferred formulary prescription insulin drug or a medically necessary alternative ←Hfl Hfl→~~HSEIC→or medically necessary alternatives←HSEIC~~←Hfl at an amount not to exceed a total of Hfl→~~fifty dollars ($50.00)~~←Hfl Hfl→twenty-five dollars ($25.00)←Hfl per thirty-day supply Hfl→."←Hfl Hfl→~~,~~ ~~regardless of the amount, number of prescription drugs or types of insulin prescribed to meet the covered person's insulin health needs; provided that nothing in this section shall prevent an insurer from reducing an insured's cost sharing by an amount greater than the amount specified in this section."~~←Hfl

SECTION 2. Section 59A-22-41 NMSA 1978 (being Laws 1997, Chapter 7, Section 1 and also Laws 1997, Chapter 255, Section 1) is amended to read:

"59A-22-41. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

A. Each individual and group health insurance policy, health care plan, certificate of health insurance and managed health care plan delivered or issued for delivery in

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this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care benefit and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as otherwise provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same policy, plan or certificate, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given policy. The Hfl→~~total~~←Hfl amount an individual with diabetes is required to pay for Hfl→~~HSEIC→preferred formulary←HSEIC~~←Hfl Hfl→~~prescription insulin drugs~~←Hfl Hfl→a preferred formulary prescription insulin drug or a medically necessary alternative ←Hfl Hfl→~~HSEIC→or medically necessary alternatives←HSEIC~~←Hfl is an amount not to exceed a total of Hfl→~~fifty dollars ($50.00)~~←Hfl Hfl→twenty-five dollars ($25.00)←Hfl per thirty-day supply Hfl→.←Hfl Hfl→~~, regardless of the amount, number of prescription drugs or types of insulin prescribed to meet the covered person's insulin health needs; provided that~~

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~~nothing in this subsection shall prevent an insurer from reducing an insured's cost sharing by an amount greater than the amount specified in this subsection.~~ Hfl

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and

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treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled in health policies described in that subsection shall be entitled to the following basic health care benefits:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the food

and drug administration, all individual or group health insurance policies as described in Subsection A of this section shall:

(1) maintain an adequate formulary to provide these resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. The provisions of Subsections A through E of this section shall be enforced by the superintendent.

G. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified disease policies.

H. For purposes of this section:

(1) "basic health care benefits":

(a) means benefits for medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services; and

(b) does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment; and

(2) "managed health care plan" means a health

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benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in the plan through its own employed health care providers or by contracting with selected or participating health care providers. A managed health care plan includes only those plans that provide comprehensive basic health care services to enrollees on a prepaid, capitated basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations."

SECTION 3. Section 59A-46-43 NMSA 1978 (being Laws 1997, Chapter 7, Section 3 and Laws 1997, Chapter 255, Section 3) is amended to read:

"59A-46-43. COVERAGE FOR INDIVIDUALS WITH DIABETES.--

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A. Each individual and group health maintenance organization contract delivered or issued for delivery in this state shall provide coverage for individuals with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage shall be a basic health care service and shall entitle each individual to the medically accepted standard of medical care for diabetes and benefits for diabetes treatment as well as diabetes supplies, and this coverage shall not be reduced or eliminated.

B. Except as provided in this subsection, coverage for individuals with diabetes may be subject to deductibles and coinsurance consistent with those imposed on other benefits under the same contract, as long as the annual deductibles or coinsurance for benefits are no greater than the annual deductibles or coinsurance established for similar benefits within a given contract. The Hfl➔~~total~~⬅Hfl amount an individual with diabetes is required to pay for Hfl➔~~HSEIC➔preferred formulary⬅HSEIC~~⬅Hfl Hfl➔~~prescription insulin drugs~~⬅Hfl Hfl➔a preferred formulary prescription insulin drug or a medically necessary alternative⬅Hfl Hfl➔~~HSEIC➔or medically necessary alternatives⬅HSEIC~~⬅Hfl is an amount not to exceed a total of Hfl➔~~fifty dollars ($50.00)~~⬅Hfl Hfl➔twenty-five dollars ($25.00)⬅Hfl per thirty-day supply Hfl➔.⬅Hfl Hfl➔~~, regardless of the amount, number of~~

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~~prescription drugs or types of insulin prescribed to meet the covered person's insulin health needs; provided that nothing in this subsection shall prevent an insurer from reducing an insured's cost sharing by an amount greater than the amount specified in this subsection.~~ Hfl

C. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance organization contract shall be entitled to the following equipment, supplies and appliances to treat diabetes:

(1) blood glucose monitors, including those for the legally blind;

(2) test strips for blood glucose monitors;

(3) visual reading urine and ketone strips;

(4) lancets and lancet devices;

(5) insulin;

(6) injection aids, including those adaptable to meet the needs of the legally blind;

(7) syringes;

(8) prescriptive oral agents for controlling blood sugar levels;

(9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional

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orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(10) glucagon emergency kits.

D. When prescribed or diagnosed by a health care practitioner with prescribing authority, all individuals with diabetes as described in Subsection A of this section enrolled under an individual or group health maintenance contract shall be entitled to the following basic health care services:

(1) diabetes self-management training that shall be provided by a certified, registered or licensed health care professional with recent education in diabetes management, which shall be limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; and

(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and

(2) medical nutrition therapy related to diabetes management.

E. When new or improved equipment, appliances,

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prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the food and drug administration, each individual or group health maintenance organization contract shall:

(1) maintain an adequate formulary to provide these resources to individuals with diabetes; and

(2) guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this subsection within the limits of the health care plan, policy or certificate.

F. The provisions of Subsections A through E of this section shall be enforced by the superintendent.

G. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified disease policies."

SECTION 4. TEMPORARY PROVISION--STUDY AND REPORT.--The superintendent of insurance shall convene an advisory group to include the secretary of human services, the secretary of health and the secretary of general services or their designees and the dean of the university of New Mexico college of pharmacy or the dean's designee to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility of prescription drugs. The report shall be submitted to the legislative health and human services committee and the legislative finance

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committee no later than October 1, 2020. The study shall examine, at a minimum, the benefits to New Mexico consumers and the potential costs of setting cost-sharing limitations for the following categories of drugs:

A. inhaled prescription drugs used to control asthma;

B. oral medications to treat or control diabetes;

C. injectable epinephrine devices for severe allergic reactions;

D. opioid reversal agents;

E. medications used to treat hypertension;

F. antidepressant medications;

G. antipsychotic medications;

H. lipid-lowering agents; and

I. anticonvulsants.

SECTION 5. EFFECTIVE DATE.--

A. The effective date of the provisions of Sections 1 through 3 of this act is January 1, 2021.

B. The effective date of the provisions of Section 4 of this act is May 20, 2020.

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Jane Horvath

February 27, 2020

Report to the New Mexico Interagency Pharmaceutical Purchasing Council
slide 11 revised 3/1/2020 for new Medicaid rebate amount analysis

Policy Recommendations for IPPC Consideration

Revised for new Medicaid rebate data on slide 11

Horvath Health Policy, *Innovations in Healthcare Financing Policy*

Why have drugs become so expensive?

- No serious constraint on manufacturer price setting or price increases
  - **Patent thickets**
  - **Unrelenting pressure on stock price**
  - **Focus on small population treatments (rare diseases)**
  - **Unparalleled political power**
  - **Price increases help competitors**
  - **General market disfunction**
- Misaligned incentives and policies in the market
  - **Rebates instead of on-invoice discounts**
  - **From academic bench science to the supply chain to PBMs –**
    - **Everyone benefits from higher prices because revenue is a percentage of price**
- Who doesn't benefit from high drug prices
  - **Patients**
  - **Health plans**
  - **Government programs**

Context

- Other states share New Mexico's concern about prescription drug spending
- NM SB131 gave the IPPC an agenda consistent with what other states are working on:
  - **Align state (and local) government funded healthcare for more market leverage**
  - **Consolidate drug procurement for state (and local) government purchasers**
  - **Try value-based contracting for high cost drugs**
  - **Understand the role of 340B discount drug program in state healthcare systems**
  - **Evaluate multi-state purchasing strategies**
  - **Bring private and public sectors together for new drug financing or drug procurement strategies**

IPPC Member Distinctions

- Payers/Health Plans
  - **Reimburse pharmacies, physicians, facilities for drugs dispensed or administered (ingredient cost reimbursement)**
  - **Reimbursement pharmacies, physicians, facilities for professional services required to dispense or administer**
- Purchasers
  - **Buy and take ownership of the drug product**
  - **Resale to institutions that dispense or administer the product**
  - **Dispense or administer product to patient**
  - **Bill payer for ingredient cost and professional services**
- Hybrids
  - **Hospitals and other facilities that purchase but also run [employee] health plans**

Traditional Payer Cost Control Tools

- Benefit design tools
  - **Formulary – Open/Closed**
  - **Preferred Drugs/Tiering**
  - **Prior Authorization**
  - **Step Therapy**
  - **Quantity Limits**
- Use benefit design tools to move market share
  - **Basis of manufacturer rebate agreements**

Purchaser Market-Based Cost Control Tools

- Wholesaler purchasing
  - **Volume**
- Manufacturer Negotiations
  - **Prefer the product**
  - **Exclude competitors (move market share for manufacturer)**
  - **Manufacturer agreements are fulfilled by wholesalers**

Initial Payer Data

10 IPPC Payer PBM Contractors

- The 10 health plans represented by IPPC members include 3 Medicaid MCOs and Medicaid Fee for Service
- 5 Express Scripts contracts (ES is owned by the health insurer, Cigna)
  - **All 5 Express Scripts contracts are with New Mexico government employee health plans**
- 1 Optum Rx contract (Optum is owned by the health insurer, UnitedHealth)
  - **Medicaid managed care plan**
- 2 Prime Therapeutics contracts (Prime has been purchased by Express Scripts)
  - **UNM employee health plan**
  - **Medicaid managed care plan**
- 1 Envolve Pharmacy Services contract
  - **Medicaid managed care plan**
- 1 Conduent contract
  - **Medicaid fee for service**

COSTLIEST DISEASE STATES REPORTED BY IPPC PLANS	# OF IPPC PLANS REPORTING DISEASE STATE AS ONE OF 5 MOST COSTLY	HIGHEST SPEND RX ASSOCIATED WITH TOP SPEND DISEASE CONDITIONS	
DIABETES	10	Trulicity (3 plans) Humalog (1 plans) Novolog (2 plans)	Lantus (1 plan) Levemir (1 plan) Basaglar (2 plans)
CANCER	8	Revlimid (4 plans) Imbruvica (2 plans)	Imbrance (1 plan)
INFLAMMATORY	8	Humira Pen (9 plans) Enbrel SureClick (1plan)	Stelara (2 plans)
HIV	7	No HIV Rx was reported in top 5 highest spend Rx for any plan	
MULTIPLE SCLEROSIS	5 (all employer plans)	Gilenya (2 plans) Tecfidera (2 plans)	Aubagio (1 plan)
HEPATITIS C	3 (all Medicaid)	Mavyret (4 plans)	
SUBSTANCE ABUSE TREATMENT	3 (Medicaid)	Suboxone (3 plans)	
ASTHMA	2 (all Medicaid)	No asthma/COPD Rx was reported in top 5 highest spend Rx for any plan	
BLOOD THINNERS	1 (employer)	Xarelto (1 plan) Eliquis (1 plan)	
HEMOPHILIA	1 (employer)	Kovaltry (1 plan) Idelvion (1 plan)	Adynovate (1 plan)
PAIN	1 (Medicaid)	No pain Rx was reported in top 5 highest spend Rx for any plan	
SEIZURES	1 (Medicaid)	No anti-convulsant Rx was reported in top 5 highest spend Rx for any plan	
INFECTIONS	1 (employer)	No anti-infective Rx was reported in the top 5 highest spend Rx for any plan	

IPPC Payer Average Rebates as % of Pharmacy Spend

- Express Scripts Plans (employer plans) -- 23.7% to 32.6%
- Prime Therapeutics (employer plan) – 10.7%
- Average rebate percentage is not correlated to size of plan/number of covered lives
- All 6 Employer plans all had the following diseases in their 5 most costly medical conditions
  - **Diabetes**
  - **Autoimmune**
  - **Cancer**
- 5 Employer plans reported these diseases in their top 5 most costly medical conditions:
  - **Multiple Sclerosis**
- Common PBM contractor, common highest spend diseases, but diverse average rebate percentages

Medicaid Average Rebate Percentages

- Medicaid managed care plans have low average rebates amounts
  - **MCO Rx utilization is submitted to State and used to bill for federal law rebates.**
  - **Manufacturers are not inclined to provide significant price concessions for the same drugs twice**
- Medicaid Fee for Service (FFS)
  - **Average rebate is 54% of total pharmacy spend**
  - **Nationally, rebates offset ~50% of the pharmacy spend**
  - State data is consistent with federal rebate data

Purchaser Data

Department of Health

- Purchaser
  - For outpatient health clinics
    - Accesses federal deep discount 340B program
      - 340B pricing are probably the lowest prices in the country
    - Operates a warehouse
    - Cardinal Health wholesaler supplier via MMCAP
  - Residential facilities (veterans, behavioral health, substance abuse treatment)
    - In-house pharmacy services
    - Cardinal health is wholesaler via MMCAP
  - Additional notes:
    - Veterans facility can access US VA pricing
    - Sequoyah facility uses Pharmerica for prescriptions/billing residents with health coverage, and Diamond pharmacy for in-house Rx stocking
    - Turquoise Lodge stocks about 300 drugs for common conditions. No HIV or specialty meds
    - Los Lunas community facility contracts for pharmacy services – Rx Innovations based in NM

Children Youth and Families Department

- Juvenile Justice residential facilities
  - In-house pharmacy services
  - Sapphire Pharmacy via MMCAP
  - Off-patent drugs are the major expense
    - Skin conditions, infections, asthma

Department of Corrections

- Wexford Health contracted for all medical care
  - Boswell Pharmacy is Wexford subcontractor
  - Boswell stocks some on-site medicines
  - Boswell does prescription fulfillment for medicines not stocked on site
- Hepatitis C, diabetes and inflammatory conditions are highest spend drugs.

Recommendations

Payers

Pharmacy Benefit Manager Contract

1. Independent review existing PBM contracts
    1. Formulary and formulary structure
    2. Contract provisions that may disadvantage a payer
    3. Contract termination provisions
    4. Pharmacy network participation requirements and reimbursement methodology
2. Independent review of financial performance of each contract
3. Review/compare procurement rules of different departments/agencies
4. Evaluate feasibility and benefits of consolidated PBM contracting
    1. Consider a 'reverse auction'
    2. Consider Northwest Consortium
5. Ensure that PBM provisions do not punish lower cost drug offerings

340B Implications for Public Payers

1. Understand which facilities and commercial pharmacies participate in 340B program
2. Understand how much of payer outpatient pharmacy spend is the result of a medical service at a 340B entity
3. Determine if the there is an opportunity for government payers to share in the savings of government 340B providers
    1. 300 hospital 340B outpatient specialty medicine clinics in New Mexico
    2. 366 community health centers in New Mexico

Pharmacy Reimbursement

- Do payers reimburse national chain pharmacies and independent pharmacies the same for brand and/or generic drugs?
- Can government payers create differential payments based on actual acquisition costs?
- Independent pharmacies and regional chains have higher drug acquisition costs than national chains.
- If national chains were reimbursed less and independents reimbursed more, there could be a savings
  - Even if the reimbursement change is budget neutral, there would be greater fairness in the reimbursement system.

Selected Providers for Administration of Specialty Drugs

- Explore whether government payers could/should collectively establish 'centers of excellence' for the administration of certain drug treatments?
- Centers of excellence would be 340B participating facilities
  - Centers of excellence would share in the savings of the 340B drug products
  - Centers of excellence would benefit from service volume
- Payers may make other concessions to centers of excellence such as increased procedure reimbursement, fewer utilization management protocols applied to the treatment

Track Development of Non-Profit Drug Manufacturing

- CivicaRX
  - Private label distributor
  - Intent to become a manufacturer
  - Generic drugs important for inpatient care that are in recurring shortage
- 18 Blue Cross Blue Shield plans will support retail generic drugs
  - Affiliated with CivicaRx
  - Retail generic drug manufacture
  - Private label distribution
  - New Mexico BCBS?
- State of California, Office of Pharmaceutical Acquisition Services

Recommendations

Medicaid

Medicaid Considerations

- Establish supplemental rebate agreements
- Participate in a consolidated IPPC PBM procurement structured as a supplemental rebate agreement for Medicaid
- Participate in any Centers of Excellence program established by the IPPC
- Determine compliance with federal 340B billing rules
- Assess financial implications of generic dispensing
- Evaluate whether to carve out pharmacy from managed care contracts

Recommendations

Facilities

Off-Site Pharmacy Services

- IPPC purchasers use 3 different pharmacy services
  - Boswell Pharmacy (Corrections)
    - Supply on-site stock and individual prescription fulfillment
    - Hep C treatments, Humira, Lantus
  - Innovations Rx (Dept of Health Los Lunas residential facility)
    - Prescription fulfillment
    - Top spend Rx?
  - Sapphire Pharmacy (CYFD Juvenile Justice)
    - Supply on-site stock
    - Symbicort, generics for asthma and skin disorders
- Compare contracts, dispensing fees/stocking fees, ingredient costs
- Compare with Cardinal Health wholesaler contract with current pharmacy services contracts
  - Can DoC stock high spend medicines on-site if Cardinal represents savings?

340B Drug Discount Program

- Are State purchasers maximizing 340B participation?
  - Review 340B eligibility
  - Check status of all Department of Health clinics
- Can residential facilities have residents treated at any of the 366 health clinics or 300 hospital outpatient specialty clinics in New Mexico?
  - "Regular" patients of a 340B clinic can be treated with 340B discount drugs

Recommendations

Broad-based Ideas

Multi-Agency Ideas

- Create Statewide office of prescription drug procurement and negotiations
  - Unified multi-agency contracting for off-site pharmacy services
  - Unified PBM contracting
  - Negotiate with 340B providers on behalf of state payers and residential facilities
  - Could include commercial plans and ERISA plans
- Washington State Healthcare Authority – unified formulary
  - Medicaid, state employee and retirees, school employees, workers comp
- Massachusetts State Office of Pharmacy Services
- California General Services Office of Pharmaceutical Services

Multi-Agency Ideas

- High Risk Insurance Pool for Rare Disease Treatments
  - Coverage of high cost, rare condition treatments
  - Express Scripts/Cigna offering to ERISA plans
  - Could include commercial plans and ERISA plans
- Incentivize enrollees to purchase from Canada or Mexico
  - Utah
  - CanaRx

Create a Prescription Drug Affordability Board

- Analogous to state oversight of public services
- Focus on drugs with costs that impede patient access and payer ability to finance
- Statewide upper payments limits for certain drugs
- 2 states enacted, 12 state bills this year, MN Governor's Healthcare Task Force recommendation

States have been here before

- MMCAP (renamed infuse-mn), 1985
- 1980's manufacturer refusal to negotiate with Medicaid lead to the Medicaid drug rebate program, 1990
- State supplemental Medicaid rebate contract pools 2003, 2005, 2005
- Northwest Consortium, 2006
- State interagency collaboration
  - **MA State Office of Pharmacy Services 1992**
  - **Washington Health Care Authority (unified formulary Medicaid, state employees, school employees and workers comp)**
  - **CA Pharmaceutical Collaborative/Office of Pharmaceutical Acquisition Services**

States Then and Now

- Many state efforts in early 2000's faded
  - PBM offerings started to fill the need states had
  - PBM consolidation created the market strength states were trying create
- State efforts that persist today address both purchasers and payers
- States and others are innovating in this space again

Thank You!

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