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To: New Mexico Governor's Office
From: Health Policy Team | Center for American Progress
Date: June 28, 2019
Re: Policies to reduce prescription drug spending

The Office of the Governor has asked the Center for American Progress (CAP) to prepare this background memorandum on potential state strategies to lower prescription drug costs for members of the State's Interagency Pharmaceuticals Purchasing Council (Council). The Council, which was created as part of New Mexico Senate Bill 131 (SB 131), is charged with reviewing and evaluating a variety of strategies for lowering prescription drug costs for the State and its residents. CAP is an independent, non-partisan think tank based in Washington, D.C.*

This memorandum provides an overview of each of the cost-containment strategies listed in SB 131 and describes lessons learned from other states' efforts to lower drug prices. After providing background information on prescription drug spending, the memorandum is organized into the following three sections:

- Medicaid-specific reforms
- Combined purchasing and negotiations
- Other state reforms

Appendix 1 of this memorandum is a crosswalk table with the policies listed for consideration in SB 131 and the corresponding discussion in this document.

* The technical assistance CAP is providing to New Mexico was made possible in part by a grant from the Peter G. Peterson Foundation. The statements and the views expressed in this memorandum are solely the responsibility of CAP.

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Executive Summary

Prescription drug spending continues to rise steadily across the United States, including in New Mexico. Reducing state expenditures will require a variety of complementary approaches that account for both the complexity of the pharmaceutical supply chain and different state agencies that purchase or pay for prescription drugs. This memorandum discusses policy options available to New Mexico that can lower the state's drug spending.

First, this memorandum considers options limited solely to New Mexico's Medicaid program: negotiating supplemental rebates and enhancing drug utilization review.

- Drug manufacturers are required to pay rebates to the federal and state government as a condition of coverage under the Medicaid program, and many states have negotiated additional rebates. These supplemental rebates can significantly reduce state's drug spending.
- By expanding the state's drug utilization review program to include drugs paid for through Medicaid managed care organizations and physician-administered drugs, New Mexico can ensure that, when medically appropriate, the lowest cost drugs are being prescribed at all times. New Mexico's current savings through drug utilization review are about one-fourth of the national average, so expanding this program offers a large opportunity for savings.

Second, this memorandum discusses reforms that seek to improve the state's negotiating power: consolidating purchasing across state programs or with other states, establishing a common formulary across state programs, the common procurement of PBM and other plan management services, and negotiating rebates with entities other than drug manufacturers.

- Consolidating purchasing across programs and with other states is an area of significant savings potential. States that have consolidated their purchasing with each other have accrued hundred of millions of dollars in savings, and California expects to save around $150 million annually through consolidating its purchasing across its state programs.
- Establishing a common formulary for Medicaid managed care organizations and other state programs is a complementary reform that allows for consistency across the state, increasing the state's leverage when negotiating discounts.
- New Jersey has consolidated its PBM procurement through the use of a "reverse auctioning" system in which PBM candidates bid against each other for the state contract. The practice is expected to save over $1.6 billion over three years and could also be applied by New Mexico to other plan management services such as medical direction, utilization review, and actuarial services.
- Additionally, New Mexico could negotiate additional rebates with PBMs. These rebates can be used to reduce the negative impact of spread pricing – essentially, marking up drugs – by PBMs. Few states have implemented this approach, allowing New Mexico to lead on this issue.

Finally, this memorandum discusses the following additional reforms: establishing a drug affordability review board, reference pricing, maximizing 340B participation, promoting the use of generics, reducing the cost of physician-administered drugs, and importing drugs from Canada.

- Establishing a drug affordability board is a relatively new approach to reducing drug spending. The concept is based on similar state regulatory bodies for electricity and other utility rates. The boards are able to regulate the price of drugs that are expected to cause significant affordability issues for states and will be most effective if they are empowered to regulate all drugs, not just drugs purchased by the states.
- Under reference pricing, a state determines a maximum price that it will pay for drugs within a class. The approach reduces price variation.
- The 340B drug discount program allows safety net hospitals and clinics to purchase drugs at steep discounts. New Mexico can work with eligible facilities to promote participation in the program, as well as ensure that state regulations do not interference with a facility's participation.
- By maximizing the use of generic drugs, New Mexico can ensure that more expensive drugs are not being prescribed when there is no medical need. Requiring, rather than permitting, generic substitution is the most effective way to promote generic use. Policymakers should include a robust appeals process to avoid medically contraindicated substitution.
- The first step to addressing the high cost of physician-administered drugs is information collection. Requiring more granular information on claims for these drugs is critical. In addition, other states have lowered costs by requiring physicians treating Medicaid patients or enrollees in other state health plans to purchase physician-administered drugs through a contracted specialty pharmacy.
- Multiple states are exploring ways to import drugs from Canada. Vermont, Colorado, and Florida are trying to implement policies to import drugs including insulin, contraceptives, and treatments for HIV and multiple sclerosis. Contracting and safety issues are two considerations to keep in mind, although proponents believe that these concerns are exaggerated.

Background

States that wish to lower their prescription drug expenditures face a number of challenges. Federal law preempts states from enacting sweeping, comprehensive reforms. Moreover, the complexity of the prescription drug supply chain and the myriad of interactions different state agencies have with different parts of the supply chain require a multi-faceted approach. However, given the budgetary pressure that drug prices put on states and harm to residents' health and finances, states such as New Mexico are considering various policy changes.

Before discussing the different policy options identified in SB 131, this section provides an overview of national and New Mexico spending trends as well as of the prescription drug supply chain.

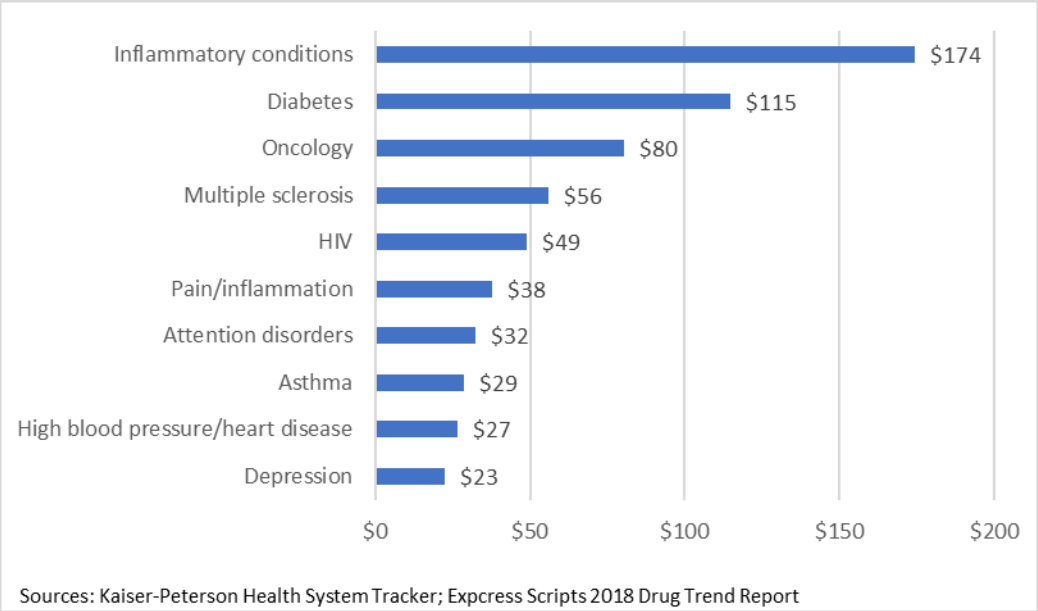
National Prescription Drug Spending Trends

Drug spending has risen significantly in recent years.[1] This is due not only to manufacturers setting prices of new drugs at extraordinarily high levels but also to price increases on existing drugs, some of which have been on the market for years.[2] While estimates vary, the Pew Charitable Trusts estimates that U.S. drug spending exceeds $450 billion annually.[3] This increase in spending represents a significant challenge to state budgets—CMS data shows that average Medicaid spending from 2013-2017 on prescription drugs has increased by over 13 percent.[4]

Prices of brand name prescription drugs continue to rise across classes, contributing to increased health care spending. A report by the Health Care Cost Institute found that, while the number of filled days for brand name drugs declined by 38 percent between 2012 and 2016, prices increased by 110 percent over the same period.[5] At the same time, utilization of generic drugs increased by 15 percent, but their prices only increased by 4 percent between 2012 and 2016.[6] These disparities are even greater for specialty drugs.

Specialty drugs – defined by Medicare as medications that cost more than $670 per month in 2019– account for a large portion of prescription drug expenditures in all parts of the health care system.[7] These are typically medications that treat complex, chronic, or life-threatening conditions, such as inflammatory conditions, multiple sclerosis, HIV, and many cancers. In addition to being more complex to manufacture than other prescription drugs, they often require special handling or ongoing monitoring and clinical support.[8] Data from Express Scripts, a PBM, show that commercial spending is driven mostly by conditions treated with specialty drugs.[9] (See Figure 4) Separately, a CalPERS analysis shows that among both current employees and its Medicare drug plans, specialty drugs account for about 1 percent of prescriptions but about 30 percent of prescription drug expenditures.[10]

Figure 1: Express Scripts per member per year spend on the top therapy class drugs in 2018



New Mexico Prescription Drug Spending Overview

Ten different New Mexico state agencies purchase prescription drugs; in fiscal year 2016, these agencies spent over $680 million, an increase of roughly 54 percent from fiscal year 2014.[11] These increased expenditures are driven by some of the same factors as national drug spending, including rising enrollment and more spending on high-priced specialty drugs. [12]

Seven of the 10 state agencies pay for prescription drugs as part of state health plans: the Human Services Department, which administers Medicaid; the University of New Mexico (UNM) employee and UNM Hospital employee health plans; and the agencies whose employees and retirees receive coverage under the state's Interagency Benefits Advisory Council (IBAC) plans – the Albuquerque Public Schools, the General Services Department, the NM Public School Insurance Authority, and the Retiree Health Care Authority.[13] The four IBAC agencies each run their own self-funded plans with different plan benefit designs. [14] However, state law requires the four agencies to issue joint requests for proposals for health care and pharmacy benefit management services to bolster their negotiating power. [15]

The other three state agencies pay for prescription drugs through systems in state facilities – the Corrections Department, the Department of Health, and the Children, Youth and Families Department.

Medicaid Prescription Drug Spending[†]

Of the $680 million spent by state agencies on prescription drugs in fiscal year (FY) 2016, $423 million was in the state's Medicaid program, which covers over 800,000 New Mexicans. [16] The state's Medicaid drug spending patterns are similar to other state Medicaid programs, with the top conditions for drug spending as follows: Hepatitis C, diabetes, asthma, and mental health. [17] In the Centennial Care managed care Medicaid program, which enrolls about 80 percent of New Mexico's Medicaid population, the

[†] CAP has not received data from the state on Medicaid prescription drug spending; this discussion is based on reports published by third parties.

Department of Human Services negotiates a capitated per member per month payment with each managed care organization (MCO), and pharmaceutical costs are generally included in this capitated payment amount.[18,‡] The MCOs each contract with separate PBMs, and the MCOs must report the additional discounts each negotiates with drug manufacturers to the state.

Other State Entities Prescription Drug Spending

The four agencies that comprise the IBAC spent about $220 million on prescription drugs in FY 2016 for about 175,000 school and state government employees, state retirees, and eligible dependents.[19] Express Scripts is the PBM that administers the IBAC plans' drug benefit.[20]

The University of New Mexico and the UNM Hospital together cover over 18,700 employees and their dependents, spending about $24 million on prescription drugs in FY 2016. The UNM health plan contracts with Express Scripts for PBM services, and the UNM Hospital health plan's PBM is Prime Therapeutics.[21]

The New Mexico Corrections Department contracts with Centurion Correctional Healthcare of New Mexico to provide health care to inmates; however, this organization does not provide pharmacy services.[22] Pharmacy services are managed by Boswell Pharmacy Services, with a budgeted $6,983,400 towards the contract for FY 2019.[23] The NMCD has unique challenges in addressing its drug spending; the key driver for recent spending increases has been the very expensive treatments for Hepatitis C.[24]

New Mexico's Department of Health pays for prescription drugs through the Public Health Division and at five state-owned or operated health care facilities in the state.[25] The Department does not centrally coordinate or monitor drug purchasing; most of its drug purchases are bought at 340B prices or subsidized through the Ryan White AIDS Drug Assistance Program.[26] Each of the five facilities has its own pharmacy manager, but all are members of the Minnesota Multistate Contracting Alliance for Prescriptions.[§]

The Children, Youth and Families Department (CYFD) purchases prescription drugs for about 200 children in juvenile justice treatment facilities. CYFD is also part of the Minnesota Multistate Contracting Alliance for Prescriptions.

The Prescription Drug Supply Chain

The flow of prescription drugs is very different than that of other consumer goods. First, various players throughout the system negotiate various direct or indirect discounts. Health plans or PBMs, for example, negotiate discounts and rebate amounts directly with the manufacturer at the top of the supply chain, and retail pharmacies will negotiate discounts or rebates separately with manufacturers. Wholesalers also will offer separate prompt-pay or volume discounts. In addition, insured consumers only pay for a portion of the cost of a drug; their health plan covers the rest of the cost. This means that each person who arrives at the pharmacy to purchase a drug will pay an amount that is based on insurance coverage and their cost-sharing requirements, and the pharmacy will receive the rest of the payment from a third party.

[‡] Medicaid has separate payments for prescription drug risk corridors and separate payment amounts for Hepatitis C treatments.

[§] The Minnesota Multistate Contracting Alliance for Prescriptions is a voluntary group purchasing organization. The Alliance is open to government entities and agencies that provide health care services.

The Role of Pharmacy Benefit Manufacturers

PBM contracts typically cover administration of the retail prescription drug benefit; more than 200 million Americans are covered by health plans that use PBMs, and these entities play a role in almost two-thirds of all prescriptions dispensed in the United States. These entities not only process claims but also essentially help create the plan's drug benefit. They negotiate with drug companies to obtain discounts, rebates, or other price concessions. For example, the manufacturer may give rebates to encourage the use of certain drugs, such as an additional discount if the manufacturer's drug is the most commonly prescribed drug from a class of similar medications.

Patients do not directly benefit from these discounts when they purchase the drug from the pharmacy; if their out-of-pocket costs are 20 percent of the price of the drug, they will pay 20 percent of the negotiated retail price, not 20 percent of the price after rebates are counted. But rebates may reduce health care premiums if they end up back with the insurer or employer and are used to lower health care costs.

PBMs also set up pharmacy networks that channel patients to preferred pharmacies that have lower cost sharing for patients. Most also have their own mail order and specialty pharmacy businesses that provide lower-priced prescriptions to patients. They also review clinical data to evaluate new drugs, allowing them to make contracting and coverage decisions based on this information, including lists of preferred drugs, and to create incentives to encourage the use of generics.

PBMs regularly face a variety of allegations about their business model, especially the lack of transparency about rebates from drug companies. For example, lawsuits have alleged that PBMs pocket rebates from manufacturers that should be passed along to plan sponsors.

Prescription Drugs Covered Under Plans' Medical Benefits

In addition to the drugs covered under a health plans' pharmacy benefit, plans also pay for certain drugs as part of medical benefits. Drugs included in medical spending are primarily administered by doctors in hospitals or other health care facilities. Many of these are expensive specialty drugs, such as oncology drugs and treatments for autoimmune diseases. Non-retail drugs are about 28 percent of total prescription drug spending nationally, according to a report by the Altarum Institute.[27]

Drugs that are administered in medical settings by injection or infusion are typically separately purchased by the provider. The plan then reimburses the provider for the drug as well as for the provider's services. [28] In addition, the medical claims submission process is very different from that of the retail pharmacy benefit.[29]

Policy Options to Lower Prescription Drug Prices

SB 131 established an interagency pharmaceutical purchasing council tasked with reviewing cost-containment approaches for procuring prescription drugs and pharmacy benefit services, identifying ways to maximize the purchasing power of the state, and studying other cost-savings opportunities for New Mexico residents who purchase prescription drugs in the private sector. The Council includes representatives from each of the state agencies discussed above.

The statute lists a number of strategies that the council must consider as part of its work. Below, we discuss these policy options, as well as several other approaches that states and private employers have taken to lower prescription drug costs. First, we discuss reforms that would impact solely the state's Medicaid program. Second, we discuss reforms that combine purchasing and negotiations across New

Mexico programs and that can extend to other states. Third, we discuss a variety of other state reforms. The crosswalk table in Appendix 1 lists the specific policies listed in section 1.E of SB 131 and where the discussion of those policies can be found in this memorandum.

New Mexico Medicaid-Specific Reforms

Given the unique federal-state joint financing of Medicaid and the requirements of the Medicaid statute and the Medicaid Drug Rebate Agreement, there are several policy interventions that the state may wish to consider that are specific to the Medicaid program. The following section discusses two potential options for lowering prescription drug costs in the state's Medicaid program – expanding supplemental rebates from pharmaceutical companies and enhancing drug utilization review.

Supplemental Rebates

While Medicaid coverage of prescription drugs is optional under federal law, every state – including New Mexico – currently provides this coverage.[30] When states include prescription drug coverage as part of their Medicaid programs, drug manufacturers and states must enter into a rebate agreement under the Medicaid Drug Rebate Program. The program requires states to cover all drugs of a manufacturer that enters into a rebate agreement with the US Secretary of Health and Human Services.[31] The goal of the rebate program is to ensure that Medicaid receives significant discounts for prescription drugs, and as a result, Medicaid pays some of the lowest prices for drugs in the United States.

The base rebate amount depends on the type of drug, but for "innovator drugs" (i.e. brand-name, rather than generic, drugs), the required amount is the greater of: 23.1 percent of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the drug's "best price," which is the lowest price per unit the manufacturer provides to most private purchasers, adjusted for inflation by the Consumer Price Index-Urban (CPI-U).[32] For generic drugs, the base rebate is 13 percent of the AMP.[33] In addition to the base rebate, manufacturers must also pay an additional rebate if the prices of their drugs rise faster than general inflation.

As a result of this coverage requirement, state Medicaid programs are more limited than other payers in how they can lower drug costs. One of the most common approaches is through the use of a tiered formulary, typically referred to as a preferred drug list (PDL) for Medicaid programs. Tiered formularies are lists of drugs split into groups, primarily based on cost.[34] While private payers are able to exclude drugs from their formularies outright, states are limited to tiering drugs within their PDL and imposing additional utilization management restrictions on higher-tiered drugs. Prior authorization of non-preferred drugs – requiring approval from the state or MCO prior to prescribing and dispensing a drug – is a common tool used to encourage the prescription of preferred, lower-priced drugs by Medicaid providers.[35] In addition, states commonly use step therapy – requiring the use of a less costly drug or showing that such a drug is medically inappropriate before "stepping up" to a more expensive drug.[36]

In addition to federal rebates, nearly every state has negotiated additional rebates that go to the state, referred to as Supplemental Rebate Agreements (SRAs), which can further inform state decisions about PDL placement and step-therapy requirements.[37] New Mexico, however, does not have any such agreement in place.[38] This lack of rebate agreement has a serious fiscal impact – in 2017, SRAs and federal rebates reduced prescription drug spending by more than 55 percent.[39] While New Mexico's reduction in spending was in line with this, many neighboring states with SRAs in place saw higher reductions – Texas, Utah, and Oklahoma each saw their spending reduced by between 60 and 65 percent.[40] Based on New Mexico's 2017 spending and Federal Medical Assistance Percentage (the

percentage of Medicaid expenditures that the federal government pays), this could have resulted in an additional $6 to 12 million in savings on prescription drugs.[41]

If New Mexico decides to pursue supplemental rebates, the state should first require drug manufacturers to submit additional, more detailed pricing information. By requiring detailed information about discounts and rebates, states will have a better understanding of the prices charged for specific products.[42] Leveraging favorable PDL placement can be used to ensure that drug manufacturers provide this information and enter into supplemental rebate agreements with the state. One important feature to include in an SRA is an inflation adjustor similar to that included in the federal rebate agreement. This will help ensure that the rebates borne through an SRA continue to benefit the state as drug companies increase their prices.

Although it is more common for states to enter into SRAs for fee-for-service (FFS) Medicaid drug coverage, 18 states have negotiated supplemental rebates for managed care organizations (MCOs), and Minnesota has negotiated additional rebates for Hepatitis C drugs.[43] As the vast majority of New Mexico's Medicaid drug spending is through its Medicaid managed care organizations, this represents a large opportunity for saving on prescription drugs.[44] There are two primary methods for states to reduce retail drug spending through MCOs: establishing a single PDL for Medicaid MCOs or carving out the pharmacy benefit entirely into FFS. This memorandum discusses the benefits of establishing common formularies in more detail later, but the key concept is that by establishing a single PDL across Medicaid, it creates uniformity throughout the Medicaid system, allowing for a stronger negotiating position both for the remainder of the FFS program and MCOs. An alternative to this could be carving out prescription drug coverage from the MCOs entirely and contracting with a single pharmacy benefits manager (PBM) to administer this benefit. Both of these would effect the same outcome of uniformity and increased negotiating power, though carving out could be more efficient as it would reduce administrative costs associated with splitting the benefit across multiple PBMs.

Supplemental rebates can also include some measure of value as the metric for a supplemental rebate amount. For example, New York requires drug manufacturers to enter into negotiations based on the value, efficacy, or outcome of a drug.[45] This process has been used to help achieve prescription drug savings goals of $55 million for fiscal year 2017-2018.[46] Similarly, Massachusetts is considering imposing this same requirement as part of its annual state budget, though the Massachusetts law would go further by allowing the Attorney General to pursue civil penalties on drug companies that refuse to participate.[47] Washington state has implemented value measures since 2004, as well, focusing solely on a drug's efficacy as a determinant of PDL placement.[48] Oklahoma has entered into two narrowly tailored contracts promoting value-based purchasing of costly drugs – one for antipsychotic medications and one for bacterial skin infection medications.[49]

Enhancing Drug Utilization Review

In addition to negotiating supplemental rebates, states can use utilization management tools to help ensure its Medicaid prescription drug spending is appropriate. Generally speaking, states must have both prospective and retrospective Medicaid drug utilization review (DUR) programs.[50] In prospective review, a state's Medicaid agency evaluates a proposed prescription prior to dispensing to ensure that the drugs used are both most appropriate for a patient as well as cost-effective. Often, the responsibility for this review is passed onto a pharmacist – for example, Arizona requires a pharmacist to review "a patient's allergies and incompatibilities with a patient's currently-taken medications."[51] Retrospective review operates similarly – state Medicaid agencies review drug dispensing after the fact to ensure that prescriptions are medically appropriate and not indicative of fraud or abuse.[52] While states are required to perform DUR for their FFS drug benefit, this same requirement does not exist for physician-

administered drugs or managed care drug benefits.[53] DUR data represents an important opportunity to ensure that Medicaid is operating efficiently in terms of both health and financial outcomes.

By expanding and aligning DUR across the Medicaid program, New Mexico can help ensure that these programs are operating as efficiently as possible. For example, while New Mexico contracts its DUR program to Qualis Health, this program is limited to FFS drug prescribing, which makes up a minority of the state's drug spending.[54] Under the Medicaid managed care program, each plan has their own DUR program. Expanding the state's FFS DUR program to managed care and physician-administered drugs has significant potential for savings – in 2017, the Centers for Medicare and Medicaid Services (CMS) surveyed state Medicaid agencies on their DUR practices and found that New Mexico saved an estimated 5 percent through DUR, despite a nationwide average of 20 percent.[55] According to a CMS survey of states in 2017, most states, including New Mexico, do not currently include physician-administered drugs in their DUR programs.[56] Expanding DUR programs to these drugs can save significant money by ensuring that medically appropriate, cost-effective drugs are being used in physician-administered care settings as well as outpatient drug settings.

Additionally, New Mexico is one of many states that does not require MCOs to submit detailed information on their DUR processes beyond what federal law requires, resulting in an inability to examine these processes for efficiency and compliance with other laws.[57] States have implemented this policy in a variety of ways: California requires DUR information to be submitted on a monthly basis from MCOs and includes financial information related to pharmacy claims, while Texas explicitly does not require reporting of financial outcomes.[58] This information can also be used to help inform rebate agreements and dispensing patterns through PDL placement.

Combined Purchasing and Negotiations

A number of the specific policies listed in SB131 are designed to increase the purchasing power of state agencies with policies such as combined prescription drug purchasing and formulary decision making. Today, the state of New Mexico pays for health care for over 1 million individuals, the majority of which are enrolled in the state's Medicaid program.[59] Consolidating purchasing across the various agencies and programs, as well as with other states, would allow for a stronger negotiating position in order to extract more favorable prices from manufacturers and other entities in the prescription drug supply chain.

Consolidated Purchasing and Risk Pooling

Consolidating drug purchasing across state programs or across multiple states similarly increases the states' ability to negotiate greater discounts with drug manufacturers and to potentially reduce administrative costs.[60] New Mexico currently participates in the Minnesota Multistate Contracting Alliance for Pharmacy, discussed below, so any additional consolidation would be an extension of this current practice.

California is currently implementing a combined purchasing policy across state agencies. In his first official action as governor, Gavin Newsom (D) ordered the consolidation of drug purchasing across all state-run programs—including CalPERS, Medicaid, and the criminal justice system—through the development of a single formulary. [61] Currently, California's Medicaid program (Medi-Cal) contracts with 25 managed care organizations, which contract with 10 PBMs for pharmacy benefit management.[62] The nonpartisan Legislative Analyst's Office has estimated that consolidating drug purchasing would likely save California "hundreds of millions of dollars annually." [63] The Newsom administration estimates that Medi-Cal alone will save $150 million per year.[64] Los Angeles County recently announced it will also join

the purchasing program.[65] Because the state is in the early stages of evaluation and implementation, it is not ready to share any best practices or lessons learned.

In addition to programs combining purchasing across agencies, many states also coordinate purchasing for their programs. In 2003, the nation's first multi-state bulk buying pool – the National Medicaid Pooling Initiative – was established to purchase drugs for four states. Since then, the program has expanded to include Alaska, Kentucky, Michigan, Minnesota, Montana, New Hampshire, New York, North Carolina, Rhode Island, and South Carolina as well as the District of Columbia.[66] In 2005, two other pools – the Top Dollar Program (TOP$) and the Sovereign States Drug Consortium (SSDC) – were established. Between the three pools, over half of the country participates in drug purchasing pooling for Medicaid.[67] These programs largely operate through additional rebates negotiated as a result of participation in the programs. For example, Vermont reported an additional 4.7 percent in savings in its first year participating in the SSDC program, and New York reported an additional $80.5 million in savings.[68] By building on their collective leverage, states are able to improve upon the supplemental rebates negotiated individually to effect even greater savings. New Mexico could benefit from these savings by participating in a multi-state buying pool.

Beyond programs solely focused on bulk purchasing drugs for Medicaid, some states have implemented bulk purchasing programs for private payers. Oregon and Washington each operate consolidated drug purchasing programs, both initially designed to serve near-elderly, low-income populations. In 2006, the two states combined forces to form the Northwest Prescription Drug Consortium.[69] The program is estimated to have saved over $130 million in drug costs in 2017.[70] The consortium's drug plan, which is administered by Moda Health in both states, is open not just to state and local government entities but also to employer groups, labor organizations and the uninsured.[71]

Another example of non-Medicaid bulk purchasing is the Minnesota Multistate Contracting Alliance for Pharmacy. The organization was founded in 1985 to purchase prescription drugs for government facilities that provide health care services.[72] Nearly every state, including New Mexico, participates in the program – Massachusetts is the only state that does not.[73] The program accrues significant savings for its members, even compared to other group purchasing collectives. An evaluation of the program found that its prices were between 2.8 percent and 4.4 percent lower than prices for the same drugs purchased by other group purchasing organizations, and its average prices paid were comparable to Medicaid's best price.[74]

Establishing a Common Formulary

Establishing a single formulary is an important step to ensuring that consolidated purchasing is as effective as possible. By doing so, the state bolsters the increased leverage of the consolidated purchasing by streamlining its pharmaceutical pipeline. For example, Washington state maintains a combined preferred drug list (PDL) for its Medicaid, public employee, and worker compensation programs—a useful example of how a state can utilize multiple approaches across programs to lower drug costs. In addition to the state's participation in the Northwest Prescription Drug Consortium, Washington state employs an evidence-based drug review process to determine the quality and effectiveness of drugs before their placement on the PDL. Under the program, the Pharmacy & Therapeutics (P&T) Committee reviews evidence of each drug's clinical effectiveness and safety, including evidence-based reports compiled by Oregon Health and Science University's Drug Effectiveness and Review Project.[75]

Based on the P&T Committee's recommendations, as well as rebate offers from pharmaceutical manufacturers, Washington then conducts an actuarial cost analysis to determine which drugs should

be included on the PDL. In addition to ensuring the drugs on the PDL are therapeutically equivalent or superior to other drugs in the same class, the process ensures that the drugs are purchased at the lowest possible cost to the state. The program has produced a savings of approximately $20 million per year for the state.[76]

Michigan is also among the states that have established a common PDL for its Medicaid services. In 2015, the state implemented a law requiring the development and use of a common formulary for Medicaid beneficiaries, which all MCOs must use as the baseline for their own formulary.[77] While MCOs are permitted to offer a more generous PDL, they cannot use a more restrictive one. Establishing a single formulary as part of a consolidation of drug purchasing across the state can help ensure that people are choosing the least expensive drug when multiple medically appropriate options are available.[78]

Considerations for consolidating purchasing and common formulary design

The following are key issues to consider when designing and implementing consolidated purchasing and a common formulary.

1. Identifying areas for savings
   - Which drugs or conditions are the main drivers for spending?
   - What information is available about negotiated rates with other payers?
2. Defining the scope
   - Will the common purchasing and formulary be for retail pharmacy drugs, medical spending, or both?
   - Which drugs or classes of drugs should be included?
   - Will the changes impact vulnerable populations' access to medications?

Common Procurement of PBM and Other Plan Management Services

Pharmacy benefit managers (PBMs) are a form of third-party administrator (TPA) used by payers – including both commercial payers as well as public payers such as Medicaid and public employee benefit programs – to manage their pharmacy benefit. PBMs develop formularies, manage drug utilization review, and contract with pharmacies.[79]

By consolidating the procurement of PBMs and other plan management services across state programs, New Mexico can increase its bargaining power and reduce administrative costs. New Mexico's Medicaid PBM services are currently split across three different PBMs, as each MCO that administers part of the program uses a different PBM.[80] Additionally, the New Mexico Group Benefits Plan, the state's public employees' insurance benefit, has its own PBM contract.[81] This split of services reduces New Mexico's ability to negotiate effectively with PBMs and can result in inconsistent care throughout the state. Other services that could be consolidated include medical direction, actuarial services, and utilization management services. As with PBMs, consolidating these other TPAs can help reduce administrative costs and ensure that New Mexico is receiving the lowest cost for these services.

Other states have pursued the consolidation of PBM services. Most notable is New Jersey's use of "reverse auctioning" for its state employee and retiree plans. In 2017, state legislators passed a bill to reform drug purchasing for the state's public employee programs aimed at addressing rising drug spending and "rooting out PBM profiteering" in public programs.[82] Beginning in 2018, the state used a

"reverse auctioning" system to select a PBM, under which PBMs bid against each other to charge less than competitors for the same level of services.[83] The new bidding method is expected to save at least $1.6 billion over the course of the three-year contract period. The reverse auction process includes price comparisons and real-time auditing, establishing "apples to apples" comparisons of what each PBM should be spending on drugs.[84**] A New Jersey task force on improving the quality and value of state health care benefits also recommended including value measures in TPA contracts, a reform that would be most feasible from a consolidated perspective.[85]

By consolidating PBM purchasing, New Mexico could then implement a similar system for contracting with a single PBM. This increased bargaining power would enable greater negotiations for PBM service pricing and make auditing the selected PBM for compliance with state laws easier, especially 2019 SB 415 which prohibits PBMs from reimbursing out-of-network pharmacies at a rate lower than an in-network pharmacy.[86] A similar approach would be feasible for other TPA services, allowing for greater oversight of utilization reviews and denials.

Considerations for modifying procurement processes for PBMs and plan management services

The following are key issues to consider when designing and implementing a new procurement policy for PBMs and plan management services.

1. Contracting issues
   - When do the current contracts expire?
   - How do union agreements treat changes to employee benefits?
2. Identifying services to consolidate
   - Which plan management services are the drivers of spending?
   - To what extent are plan management services operated by overlapping entities?
3. Legal issues
   - How does the state's existing procurement law interact with a potential reform?
   - What provisions need to be included in the request for proposals to avoid issues of potential invalidation?

Negotiating Rebates with Other Pharmaceutical Supply Chain Entities

Beyond rebates negotiated with pharmaceutical manufacturers, New Mexico can also effect savings by negotiating rebates with other entities in the pharmaceutical supply chain. These entities range the gamut of the supply chain, from wholesale distributors to pharmacies to PBMs. Pharmaceutical wholesale distributors purchase large amounts of drugs from manufacturers and distribute them throughout the United States to local pharmacies, hospitals, and providers.[87] Each of these entities negotiates discounts and rebates throughout the process in addition to receiving payments for services.[88] Despite the range of the pharmaceutical supply chain, only PBMs lend themselves towards rebate negotiation.

** In May 2018, a state court invalidated the plans' initial contract with OptumRx. The procurement process for the replacement contract is underway.

While regulation of PBMs is not uncommon, only three states – Arkansas, Louisiana, and New York – have required more from PBMs regarding rebates beyond reporting requirements.[89] As enacted, each of these state's bills prohibits "spread pricing" – reimbursing a pharmacy for less than it charged the health plan whose pharmacy benefit the PBM administers and retaining the difference.[90] In other words, these states prohibit PBMs from marking up the price of drugs charged to plans. Montana also passed a similar bill in its state legislature, but Governor Steve Bullock (D) vetoed the bill in May, citing concerns that it would burden regional and non-profit health insurers.[91] The legislature failed to override this veto in June.[92] This practice can have significant fiscal impacts on state Medicaid budgets – an analysis by the Massachusetts Health Policy Commission on its state Medicaid program found that nearly 25 percent of prescriptions had spread pricing of more than $10 and nearly 10 percent of prescriptions had spread pricing of $50 or more.[93] This approach can be combined with other PBM regulations, such as New Jersey's "reverse auctioning" method. Consolidating the state's PBM contracts from four PBMs to one could increase negotiating power of the state, allowing New Mexico to leverage greater rebates and discounts. By negotiating with PBMs to ensure that spread pricing is minimized or including such limitations in contract renewals, New Mexico can lead in the adoption of this policy.

Other State Reforms

In addition to the reforms discussed above that focus on increasing the state's negotiating power, SB 131 lists a number of reforms designed to directly lower the unit price of prescription drugs: establishing a drug affordability board, reference pricing drugs, and maximizing state facilities' 340B participation. Below we discuss these policies, as well as options for promoting the use of generics, lowering the cost of physician-administered drugs, and importing lower priced drugs from Canada.

Establishing a Drug Affordability Board

The National Academy for State Health Policy (NASHP) has written model legislation establishing a drug affordability board, calling it similar to "states' regulation of consumer payment rates for essential services, such as clean drinking water, safe and consistent electricity, and public transportation" and describing the board's duties as "[looking] at valuable drugs and [determining] at what cost they are affordable – at what cost will everyone who needs the drug be able to afford the drug."[94]

Maryland will be the first state to put in place this type of entity. In April 2019, the Maryland General Assembly passed a bill based on this model legislation, and on May 25th, it became law without the signature of Governor Larry Hogan (R).[95] The bill will be implemented over the next several years, starting with the establishment of the board and its first report. In its study of the state's pharmaceutical distribution and payment system, the board is required to examine several approaches to reducing drug prices, including the possibility of setting upper limits.[96]

The board is limited to regulating only drugs that the public sector pays for – whether through Medicaid fee for service, Medicaid MCOs, or through state employee programs. For this reason, it is unable to truly establish payment rates for these drugs as the NASHP legislation proposes. Because of this limitation, Maryland's board is more comparable to the "maximum allowable cost" (MAC) approach that several payers and PBMs utilize, rather than actual rate setting. Under this approach, payers or their PBMs determine the upper limit of what a plan will pay for a given drug.[97] Maryland's approach essentially delegates the determination of such a list to this board, and notably does not impose these limits on other payers in the state, such as commercial health plans. Additionally, the board is required to submit a plan to impose an upper limit to the state legislature for approval before such a plan can be implemented and is required to study the impact that such a limit has on prescription drug availability.

The impact of such a board will not be as large if it is restricted to regulating only state-purchased drugs. States, including New Mexico, could accomplish similar savings through other methods – such as negotiating SRAs and consolidating purchasing – without establishing a new state body. If New Mexico were to expand its board's jurisdiction beyond Maryland's approach to include privately purchased drugs, the board would have a significantly greater impact.

Considerations for establishing a drug affordability board

The following are key issues to consider when designing and implementing a drug affordability board

1. Designing the scope
   - Which drugs will be subject to review by the board?
   - Which payers will have access to the prices?
   - What information and data will the board consider when setting prices or limits?
2. Determining the timeline
   - Will there be a review process for board recommendations?
   - Over what time period would any recommendations be implemented?

Reference Pricing for Prescription Drugs

Reference pricing can be a viable approach for lowering spending for certain prescription drugs. Reference pricing for prescription drugs establishes a price across a class of drugs, which are groups of drugs with similar characteristics. Therapeutic classes sort drugs based on the condition or disease they are meant to treat.[98] Drugs can also be assigned to classes based on their mechanism of action (the biochemical reaction that happens after a person takes a drug), their mode of action (the body's reaction to a drug), or the drug's chemical structure.[99] Drug reference pricing sets the price at some point within a class of drugs—potentially the minimum, median, or other percentile—and requires enrollees to pay the difference between the reference price and the charged price for a drug within that class.[100] It is usually applied to drug classes that have price variation within the same formulary tier and low generic utilization.[101]

Reference pricing for prescription drugs is meant to encourage patients to choose lower cost drugs and encourage drug manufacturers to charge less. [102] Prescription drugs that are best suited for reference pricing are those that are interchangeable within a class that has no therapeutically superior drug. It is also critical to consider patient safety.[103]

Due to these challenges, drug reference pricing in the United States has been relatively limited. In California, CalPERS plans to implement a reference pricing pilot program starting in 2020 that will apply to limited classes of prescription drugs: inhaled corticosteroids, thyroid agents, and oral estrogen. When determining which drugs would be good candidates, CalPERS and its pharmacy vendor, UMass Medical School of Clinical Pharmacy Services, focused considerable attention on patient safety and the needs of the population taking the drug. These factors led to CalPERS choosing a small number of drug classes due to concerns about interchangeability and patient outcomes, foregoing higher savings potential.[104]

While precise estimates of future saving are not yet available, CalPERS expects the program to help lower or stabilize drug spending in these classes.[105]

More expansive examples of reference pricing illustrate the importance of careful design and the need to ensure reference pricing does not simply shift costs to patients. Arkansas's state employee plan has had reference priced prescription drugs since 2005.[106] The plan currently reference prices twelve classes of drugs: antihyperlipidemic-HMG, angiotensin II rec antagonists/direct renin inhibitors, long-acting amphetamines, fibromyalgia-related anticonvulsants, serotonin norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors, migraine medications, sedatives, proton pump inhibitors, overactive bladder agents, nasal steroids, and osteoporosis-calcium regulators.[107] Evaluations of the Arkansas program as a whole have not yet been conducted, but an evaluation published in the *Journal of Managed Care Pharmacy* found that after about four years of reference pricing for proton pump inhibitors, spending decreased by nearly half despite "essentially unchanged" utilization.[108]

The most dramatic example of prescription drug reference pricing is the Reta Trust, which purchases health insurance for the employees of 55 Catholic organizations. Since 2013, Reta has used reference pricing for outpatient drugs.[109] Prior to implementing the program, a Reta analysis found dramatic price variation within therapeutic classes, with a monthly price variation of "$222 between the least and most costly drug within the 30 therapeutic classes that had the highest prescription rates."[110]

Reta now has reference prices for 1,302 outpatient drugs from 78 therapeutic classes.[111] Under the program, the employer's contribution for a drug is limited to the least expensive drug in the class. In cases where a patient has medical need for a more expensive drug, physicians can request a clinical exemption. This sweeping program saved Reta's employers $1.3 million over 18 months of implementation, and the use of low-priced drugs increased. However, much of this savings appears to be from shifting costs to employees; there was also a 5.2 percent increase in cost-sharing.[112]

Considerations for reference pricing for pharmaceuticals

The following are key issues to consider when designing and implementing a reference pricing policy.

1. Identifying areas for savings
   - What are the main drivers of cost among retail drug spending?
   - What information is available about utilization and prices for drugs included in medical benefit spending?
2. Defining the scope
   - Will it be for retail pharmacy drugs, medical spending, or both?
   - What drugs or classes of drugs should be included?
   - Will the changes impact vulnerable populations' access to medications?
3. Educating enrollees and providers
   - How will enrollees be informed about the program, including participating providers, the pricing structure, included services, and the exception process?
   - How will providers be informed of the reference priced drugs?

Maximizing 340B Participation

The 340B Drug Pricing Program is a federal program meant to allow covered entities – organizations providing care to low-income and otherwise vulnerable populations such as children, HIV/AIDS patients, cancer patients, and Native Americans – to "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[113] The program, named after section 340B of the Public Health Service Act, requires pharmaceutical companies to provide these organizations with discounts similar to those provided under the Medicaid Drug Rebate Program.[114]

The program requires covered entities to register with the Office of Pharmacy Affairs (OPA) within the Health Resources and Services Administration (HRSA) to receive the statutory discounts but does not require that drugs purchased under this discount agreement be limited to the patients through which the entity is eligible to participate in the program – i.e. a hospital can purchase its drugs for all its patients, regardless of their payer status or administration method, at the reduced rate.[115] The law does, however, restrict the resale or transfer of these discounted drugs to anyone other than the patient of a covered entity and requires patients to have an established relationship with the entity for a service beyond receiving a drug for self-administration.[116] The 340B program can result in savings for New Mexico, both through maximizing participation and through ensuring that participating providers are maximizing those savings.

There are six distinct hospital types and 10 distinct clinic types that are eligible for participation in the 340B program as a covered entity.[117] 16 of New Mexico's 55 hospitals currently participate in the program through one of these eligibility categories.[118] Additionally, there are 176 clinics participating through one of the 10 non-hospital eligibility categories.[119] The state could offer assistance to the remaining 39 hospitals throughout the state to ensure that all eligible hospitals are aware of their eligibility under federal law as well as state regulations on how such hospitals may operate. Due to the resource-stretched nature of eligible entities, there is a possibility that such entities do not currently have the staff resources needed to confirm eligibility and apply with OPA. Similarly, non-hospital entities would likely be less able than hospitals to work through this process due to their smaller staff numbers.

Beyond ensuring that all eligible entities participate in the program, New Mexico can also ensure that its state policies promote the highest savings within those covered entities. The 340B program prohibits "duplicate discounts" – receiving both the Medicaid rebates *and* the 340B discount. As a result, all 340B drugs dispensed to Medicaid patients must be identified to ensure that drug manufacturers are not paying discounts on these drugs twice. While New Mexico has regulations in place to help avoid this, the regulations allow for two possible approaches to the issue, potentially creating confusion among providers and resulting in duplicate discounts as well as the loss of potential rebates as states neither purchase a drug under the 340B program nor claim the rebate to which they are entitled.[120] By changing these regulations to either exclude all Medicaid prescriptions from the 340B program or identify all 340B prescriptions when billed to Medicaid, New Mexico can reduce provider confusion and ensure that the highest savings are achieved, particularly if supplemental rebates are pursued. California is pursuing such a change as part of its consolidated purchasing strategy, and though detailed savings estimates are not yet available, Governor Newsom's administration anticipates savings.[121]

Promoting the Use of Generic Drugs

Another option that can be used to reduce prescription drug expenditures without sacrificing quality is through the increased use of generic drugs. Generic drugs, also called multi-source drugs, operate identically to the brand-name drug they are based on in terms of dosage form, safety, strength, route of administration, quality, and performance.[122] These drugs are often cheaper than their-brand name

alternatives because drug companies producing generic drugs are not required to conduct the same studies to show safety and efficacy.[123] A 2019 study of drug prices by brand status found that generic drugs were an average of 18 times less expensive than brand name drugs.[124] While generic prescription rates are already high, there are a variety of tools available to promote the further use of generic drugs, including generic substitution and incentive programs.

Generic substitution is the practice of substituting a brand-name drug with its generic equivalent at the point of dispensing – often in a pharmacy. While New Mexico has a law permitting generic substitution, this law does not require pharmacists to dispense a generic drug.[125] By amending this law to require, rather than permit, generic substitution, New Mexico would accrue additional savings. Around 15 percent of New Mexico's Medicaid prescriptions in 2018 were brand drugs.[126] While not all of these prescriptions can be shifted to a generic counterpart, small shifts would represent significant savings – brand prescriptions represented over 77 percent of New Mexico's Medicaid drug spending in 2018.[127]

In addition to legislative mandates, incentive programs can be used to promote the prescription and dispensation of generic drugs. The programs operate similar to shared savings programs – providers receive increased payments for switching patients from brand-name to generic prescriptions.[128] One example of this is BlueCross BlueShield of Michigan's "Blue Reward$" program. The program, operated in 2007, paid an additional $100 for each patient who switched from brand-name statins to a then-newly available generic statin.[129] The program was effective in influencing prescriber behavior – physicians received $2 million in incentive payments over the course of the program, while annual drug spending by BlueCross BlueShield of Michigan decreased by $5 million and its enrollees paid around $1 million less in copayments.[130]

It is important to ensure that the promotion of generic drugs does not come at the expense of patient quality outcomes, however. There are instances when a brand-name drug is medically appropriate – a patient may be allergic to an inactive ingredient used in a generic version or some aspect of the patient's drug regimen may mean that the generic drug is medically contraindicated. For generic substitution approaches, one important safeguard is ensuring providers retain ability to require the dispensing of a brand-name drug when medically appropriate. New Mexico law currently allows prescribers to do so by including the words "no substitution" or "no sub" on a prescription.[131] Additionally, establishing a robust appeals process and ensuring that patients are educated about it can help allay the risks of medically inappropriate generic prescriptions. This process can be based on the step therapy appeals process established by 2018 NM SB 11.[132]

Reducing the Cost of Physician-Administered Drugs

Health plans also pay for certain drugs as part of medical benefits in addition to the drugs covered under a pharmacy benefit. Drugs included in medical spending are primarily administered by doctors in hospitals or other health care facilities. Many of these are expensive specialty drugs, such as oncology drugs and treatments for autoimmune diseases. Non-retail drugs are about 28 percent of total prescription drug spending nationally, according to a report by the Altarum Institute.[133]

PBM contracts typically cover administration of the retail prescription drug benefit. In contrast, drugs that are administered in medical settings by injection or infusion are separately purchased by the provider. The plan then reimburses the provider for the drug as well as for the provider's services. [134] In addition, the medical claims submission process is very different from that of the retail pharmacy benefit.[135]

Claims for drugs covered under the plan's pharmacy benefit include national drug codes (NDCs).[136] Each approved drug receives an NDC, which identifies not only the drug, but also the dosage and the number of units in the package.[137] But when providers submit claims to plans for payment of physician administered drugs, NDCs are rarely included. Instead, these drugs are coded on medical claims using J-codes, which only list the chemical name of the drug.[138] Moreover, more than one drug may be assigned to the same J-code, and there can be a significant lag in the time between the drug's approval and its assignment to a J-code. [139] In these situations, the provider bills the plan using an unclassified J-code that lacks even the most basic information about the drug.[140]

This lack of data is a major hurdle to addressing the costs of physician-administered drugs. Despite these challenges, some states and other employers have taken initial steps to better understand this category of spending with the goal of informing future reforms to ensure proper utilization and lower prices of these drugs.

In 2018, Colorado contracted with the consulting firm Myers and Stauffer to survey Medicaid-participating physicians about their drug acquisition costs. It discovered that these costs for physician-administered drugs were 12 percent lower than the state had estimated.[141]

Nevada's state employee health plan also analyzed the costs of specialty drugs administered in medical facilities and found that there were large differences in the costs charged for these drugs depending on the site of care.[142] To address this variation, the state required specialty drugs administered in medical settings to be purchased through the plan's specialty pharmacy under its PBM contract. Providers could only purchase a drug through other channels if they found it available at a lower price. This switch lowered costs for the plan by $800,000 in 2017.[143]

The Minnesota Health Action Group—a coalition of over 50 in-state employers, including state departments and county and local governments—has undertaken a large-scale project to better understand specialty drug spending and to improve data collection on costs and utilization of physician-administered drugs.[144] The Action Group's key recommendations include requiring the submission of NDCs in addition to J-codes on medical claims, as well as additional information on the quantity prescribed, such as a unit definition and days of supply.

In conversations with CAP, the Action Group explained that their member employers will then use this information to inform future decisions about prior authorization, utilization management, and provider contracts.[145] They hope this additional information will improve employers' ability to manage outcomes, especially by tracking complications and ensuring that drugs are appropriate for patients, consistent with their diagnoses and administered in the appropriate settings and amounts. Employers also plan to use this data to provide feedback to providers on their practices compared to other providers, costs, and use of specialty drugs.

Importation

While many of the reforms discussed in this memorandum pertain to purchasing drugs within the United States, the ability to import prescription drugs from Canada is also an option for states looking to reduce prescription drug costs. The practice is permitted under limited circumstances under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: to establish an importation program, states must apply to the United States Secretary of Health and Human Services (HHS) for a waiver from the general prohibition of importation of drugs.[146] While no Secretary has yet to approve a waiver, Colorado, Florida, and Vermont are in the process of pursuing one.

Vermont enacted a law in 2018 that allowed the importation of drugs from Canada and required the Vermont Agency of Human Services (VAHS) to study and report on the drugs that would create the most savings for the state, as well as establish a state mechanism to regulate the importation.[147] In its initial report, VAHS found that for 17 prescription drugs, including insulin, contraceptives, and treatments for HIV and multiple sclerosis, importation could result in annual savings between $1-5 million for commercial payers.[148] The report concluded that importation would not generate significant savings for the Medicaid program, largely due to the state's rebate agreements.[149] In addition to this evaluation, the state established two new state-level licenses – Rx Drug Importer-Wholesaler and Canadian Rx Drug Supplier – that would report to the Vermont Office of Professional Regulation.[150] The state has yet to apply for a federal waiver to implement this program.

Colorado and Florida's approaches are much more recent. Colorado Governor Jared Polis (D) and Florida Governor Ron DeSantis (R) signed bills in May and June, respectively, requiring the state to apply for an importation waiver with the federal government.[151] Similar to Vermont, both states' laws require the state to import those drugs that are likely to have the "highest potential for cost savings."[152] Due to the recency of the laws, projections on cost savings as a result of the potential for importation are not yet available. During the bill signing ceremony, Governor DeSantis announced that he is currently working with HHS regarding the program but that he does not anticipate the program being operational until sometime in 2020.[153] Similarly, Colorado's program is not expected to go into effect until 2021.[154]

While drug importation has the potential for savings, it is also important to guard against negative outcomes, such as failing to ensure drug safety, as well as overcome barriers to implementation, such as contracting and drug supply chain issues. One of the largest concerns by both opponents and proponents of importation programs is the feasibility of ensuring that the drugs imported are both the proper drugs and are not intentionally or inadvertently contaminated during the importation process, though many drugs are approved under similar standards and made in the same facilities.[155] Vermont, Florida, and Colorado have all taken steps to address this concern, including requiring entities involved in the importation process submit to regular audits as well as reporting requirements. In addition to ensuring drug safety, policymakers must work to smooth any implementation issues. For example, there are concerns that Canadian companies would decline to contract with Vermont. According to NASHP, however, this is not the case; the organization's executive director has stated that some wholesalers have already expressed interest in contracting with the state.[156]

Conclusion

Prescription drug spending is increasing across the country, including in New Mexico. Patient outcomes must be a central component of any reforms to reduce prescription drug spending – if not implemented carefully, some reforms have the potential to reduce patient access to necessary drugs or to promote the prescription of medically inappropriate drugs in the name of reducing costs. There are a variety of tools that New Mexico can use to reduce its spending on prescription drugs. While some of these can be done via executive action, others will require legislative participation, and will therefore not be available to implement until the 2020 legislative session. Some, such as reference pricing and negotiating supplemental rebate agreements, have the potential to generate significant savings to the state, while others, such as promoting generic drug use and importation, are less likely. The Interagency Pharmaceuticals Purchasing Council should carefully consider which of the reforms contained in this memorandum it will recommend to ensure that New Mexicans receive the greatest benefit from their work.

Appendix A: Discussion of Policies Listed in SB 131

SB 131 Reform Section and Title	CAP Heading	Page Number
1. The benchmarking of pricing for pharmaceuticals and pharmacy benefits to the pricing that the state's medical assistance plans achieve for pharmaceuticals and pharmacy benefits	Reference Pricing for Prescription Drugs	16-17
2. Active medical management to optimize health outcomes and reduce costs	Reducing the Cost of Physician-Administered Drugs	19-20
3. The establishment of a common formulary for all pharmaceuticals and pharmacy benefits plans offered by constituent agencies	Establishing a Common Formulary	12-13
4. A single purchase agreement for all constituent agencies' pharmaceuticals and pharmacy benefits	Consolidated Purchasing and Risk Pooling	11-12
5. Common procurement of expert services, including, at minimum, pharmacy benefits management, pharmacy benefits management oversight services, medical direction and actuarial services	Common Procurement of PBM and Other Plan Management Services	13-14
6. Identifying any opportunities to consolidate purchasing among two or more constituent agencies	Consolidated Purchasing and Risk Pooling	11-12
7. Identifying any opportunities for pooling risk among two or more constituent agencies or populations the constituent agencies serve	Consolidated Purchasing and Risk Pooling	11-12
8. Identifying any opportunities for consolidating purchasing with other entities and states of the United States	Consolidated Purchasing and Risk Pooling	11-12
9. Ensuring that all agencies, programs, clinics, hospitals and other health-related centers and entities… that are eligible for pharmaceutical discounts pursuant to Section 340B of the federal Public Health Service Act participate in that Section 340B federal pharmaceutical price discount program	Maximizing 340B Participation	18
10. Identifying any opportunities for maximizing the use of generic pharmaceuticals where safe and cost-effective to do so	Promoting the Use of Generic Drugs	18-19
11. Negotiating advantageous pricing and incentives with insurers, pharmacy benefits managers, pharmacies, manufacturers, distributors and vendors of pharmaceuticals and other third-party entities involved in supplying pharmaceuticals, pharmacy benefits and management services to the council's constituent entities	Negotiating Rebates with Other Pharmaceutical Supply Chain Entities	14-15

SB 131 Reform Section and Title	CAP Heading	Page Number
12. Identifying ways to leverage constituent agencies' pharmaceutical and pharmacy benefits procurement to maximize the purchasing power of New Mexico residents purchasing pharmaceuticals and pharmacy benefits in the private sector	Establishing a Drug Affordability Board	15-16
13. Identifying other cost-saving opportunities for New Mexico residents purchasing pharmaceuticals or pharmacy benefits in the private sector	Importation	20-21
14. Identifying any other opportunities for maximizing efficiency and a high standard of health care quality	Supplemental Rebates; Enhancing Drug Utilization Review	9-11

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