SENATE BILL 14

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

Elizabeth "Liz" Stefanics and Elizabeth "Liz" Thomson

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE PHARMACY BENEFITS MANAGER REGULATION ACT; ADDING NEW REQUIREMENTS FOR RENEWAL OF PHARMACY BENEFITS MANAGER LICENSES; REQUIRING DISCLOSURE OF DOCUMENTS DURING AN INVESTIGATION; REQUIRING TRANSPARENCY IN PHARMACY BENEFITS REIMBURSEMENT; PROVIDING FOR CONFIDENTIALITY; PROVIDING FOR CHANGES IN THE REIMBURSEMENT PROCESS; ADDRESSING THE APPEALS PROCESS; REQUIRING THE PROVISION OF CERTAIN INFORMATION UPON REQUEST; REQUIRING THE INCLUSION OF CERTAIN CONTRACT PROVISIONS; LIMITING CHARGES TO THOSE ITEMIZED IN A CONTRACT; ADDRESSING COST SHARING; MAKING AN APPROPRIATION.

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

SECTION 1. Section 59A-61-2 NMSA 1978 (being Laws 2014, Chapter 14, Section 2, as amended) is amended to read:

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1 "59A-61-2. DEFINITIONS.--As used in the Pharmacy Benefits
2 Manager Regulation Act:
3 A. "health benefits plan" means a policy or
4 agreement entered into or offered or issued by an insurer to
5 provide, deliver, arrange for, pay for or reimburse any of the
6 costs of health care services; provided that "health benefits
7 plan" does not include any of the following:
8 (1) an accident-only policy;
9 (2) a credit-only policy;
10 (3) a long- or short-term care or disability
11 income policy;
12 (4) a specified disease policy;
13 (5) coverage provided pursuant to Title 18 of
14 the federal Social Security Act, as amended;
15 (6) coverage provided pursuant to Title 19 of
16 the federal Social Security Act and the Public Assistance Act;
17 (7) a federal TRICARE policy, including a
18 federal civilian health and medical program of the uniformed
19 services supplement;
20 (8) a fixed or hospital indemnity policy;
21 (9) a dental-only policy;
22 (10) a vision-only policy;
23 (11) a workers' compensation policy;
24 (12) an automobile medical payment policy; or
25 (13) any other policy specified in rules of

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the superintendent;

B. "insured" means an individual who is entitled to receive health care benefits provided by a health benefits plan;

C. "insurer" means a health insurance plan or multiple welfare arrangement subject to the Health Care Purchasing Act, Chapter 59A, Article 22 or 23 NMSA 1978, the Health Maintenance Organization Law or the Nonprofit Health Care Plan Law;

[A.] D. "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug;

[B.] E. "maximum allowable cost list" means a searchable, electronic and internet-based listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist is made;

[C.] F. "obsolete" means a product that is listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured;

[D.] G. "pharmacist" means an individual licensed as a pharmacist by the board of pharmacy;

[E.] H. "pharmacy" means a licensed place of business where drugs are compounded or dispensed and pharmacist

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services are provided;

[~~F.~~] I. "pharmacy benefits management" means a service provided to or conducted by [~~a health plan as defined in Section 59A-16-21.1 NMSA 1978~~] an insurer or [~~health insurer~~] plan sponsor that involves:

(1) prescription drug claim administration;

(2) pharmacy network management;

(3) negotiation and administration of prescription drug discounts, rebates and other benefits;

(4) design, administration or management of prescription drug benefits;

(5) formulary management;

(6) payment of claims to pharmacies for dispensing prescription drugs;

(7) negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or

(8) any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity;

[~~G.~~] J. "pharmacy benefits manager" means an entity that provides pharmacy benefits management services;

[~~H.~~] K. "pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by or is under common ownership or control with a

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pharmacy benefits manager;

[~~I.~~] L. "pharmacy services administrative organization" means an entity that contracts with a pharmacy or pharmacist to act as the pharmacy or pharmacist's agent with respect to matters involving a pharmacy benefits manager or third-party payor, including negotiating, executing or administering contracts with the pharmacy benefits manager or third-party payor; [~~and~~

~~J. "superintendent" means the superintendent of insurance.~~]

M. "plan sponsor" means an employer organization that offers group health plans to its employees or members;

N. "rebate" means all price concessions paid by a manufacturer to a pharmacy benefits manager or insurer that are based on the:

(1) actual or estimated use of a prescription drug; or

(2) effectiveness of a prescription drug pursuant to the terms of a value-based or performance-based contract; and

O. "spread pricing" means the model of prescription drug pricing in which a pharmacy benefits manager charges a health benefits plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or

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indirectly pays a pharmacist or pharmacy for pharmacist services."

SECTION 2. Section 59A-61-3 NMSA 1978 (being Laws 2014, Chapter 14, Section 3, as amended) is amended to read:

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

A. A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act and applicable federal and state laws. A licensee shall renew the licensee's pharmacy benefits manager license annually.

B. An initial application and a renewal application for licensure as a pharmacy benefits manager shall be made on a form and in a manner provided for by the superintendent, but at a minimum shall require:

(1) the identity of the pharmacy benefits manager;

(2) the name and business address of the contact person for the pharmacy benefits manager;

(3) where applicable, the federal employer identification number for the pharmacy benefits manager; and

(4) any other information specified in rules promulgated by the superintendent.

C. The superintendent shall enforce and promulgate rules to implement the provisions of the Pharmacy Benefits

Manager Regulation Act and may suspend or revoke a license issued to a pharmacy benefits manager or deny an application for a license or renewal of a license if:

(1) the pharmacy benefits manager is operating in contravention of its application;

(2) the pharmacy benefits manager has failed to continuously meet or comply with the requirements for issuance or maintenance of a license; or

(3) the pharmacy benefits manager has failed to comply with applicable state or federal laws or rules.

D. If the license of a pharmacy benefits manager is revoked, the manager shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs, notify each pharmacy in its network and conduct no further pharmacy benefits management services in the state, except as may be essential to the orderly conclusion of its affairs. The superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it to be in the best interest of patients.

E. [~~A person~~] An entity whose pharmacy benefits manager license has been denied, suspended or revoked may seek review of the denial, suspension or revocation pursuant to the provisions of Chapter 59A, Article 4 NMSA 1978.

F. Nothing in the Pharmacy Benefits Manager Regulation Act shall be construed to authorize a pharmacy

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benefits manager to transact the business of insurance.

G. A pharmacy benefits manager that subcontracts with another pharmacy benefits manager to perform pharmacy benefits management services shall be independently licensed and comply with the provisions of the Pharmacy Benefits Manager Regulation Act.

H. The superintendent shall not require a licensed pharmacy benefits manager to also be licensed as an insurance administrator pursuant to Chapter 59A, Article 12A NMSA 1978, unless the pharmacy benefits manager provides insurance administration services beyond the scope of the Pharmacy Benefits Manager Regulation Act.

I. An entity licensed as a pharmacy benefits manager shall comply with the applicable provisions of Chapter 59A, Articles 12 and 12A NMSA 1978, unless the entity provides insurance administration.

J. As a condition of licensure, the superintendent may require a pharmacy benefits manager to report compliance with any portion of the Pharmacy Benefits Manager Regulation Act in a time and manner required by rule."

SECTION 3. Section 59A-61-4 NMSA 1978 (being Laws 2014, Chapter 14, Section 4, as amended) is amended to read:

"59A-61-4. PHARMACY REIMBURSEMENT PRACTICES FOR [~~GENERIC~~] DRUGS--APPEALS PROCESS REQUIRED.--

A. A pharmacy benefits manager shall determine a

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reimbursement amount for a [~~generic~~] drug based on objective and verifiable sources.

B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses itself or a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service. The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number.

C. A pharmacy benefits manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the drug:

(1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;

(2) is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and

(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence

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evaluations, also known as the "orange book".

D. A pharmacy benefits manager using maximum allowable cost pricing shall:

(1) upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(2) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;

(3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in at least seven business days to remain consistent with pricing changes and product availability in the marketplace;

(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:

(a) directly to the pharmacy benefits manager; or

(b) through a pharmacy services administrative organization;

(5) provide an appeals process that, at a minimum, includes the following:

(a) a dedicated telephone number and

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electronic mail address or website for the purpose of submitting appeals;

(b) the ability to submit an appeal directly to the pharmacy benefits manager; and

(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;

(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;

(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, in writing, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;

(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;

(9) within one business day of granting or

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denying a network pharmacy's appeal, notify all network pharmacies and the pharmacy services administration organization of the decision;

(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; [~~and~~]

(11) provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the maximum allowable cost list specific to that provider; and

(12) allow a pharmacy to file an exemption request to a maximum allowable cost denial or when the national average drug wholesale acquisition cost and the average sales price maximum allowable cost are unavailable to the pharmacy.

E. The superintendent may hear and resolve any dispute between a pharmacy benefits manager and a pharmacy after all internal appeals processes provided by the pharmacy benefits manager have been exhausted.

F. A pharmacy benefits manager shall not:

(1) reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the:

(a) national average drug acquisition cost; or

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(b) if the drug is unavailable at the cost pursuant to Subparagraph (a) of this paragraph, at the time the drug is administered or dispensed, the wholesale acquisition cost of the drug, as defined in 42 U.S.C. Section 1395w-3a(c)(6)(B);

(2) provide a professional dispensing fee of less than ten dollars forty-nine cents ($10.49) per drug; or

(3) calculate a reimbursement amount as of any date other than the date that the pharmacist dispensed or administered the drug.

[~~E.~~] G. A maximum allowable cost list specific to a provider and maintained by a [~~managed care organization~~] health benefits plan or pharmacy benefits manager is confidential.

[~~F.~~] H. Pursuant to Section 59A-4-3 NMSA 1978, a pharmacy benefits manager shall provide information contained in a maximum allowable cost list or the purchase prices negotiated and the prices paid to pharmacies in and out of network to the superintendent upon request by the superintendent.

I. A pharmacy benefits manager or representative of a pharmacy benefits manager shall not make or permit any reduction of payment for pharmacist services by a pharmacy benefits manager or a health care payer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand

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effective rates, direct and indirect remuneration fees or any other reduction or aggregate reduction of payment."

SECTION 4. Section 59A-61-5 NMSA 1978 (being Laws 2014, Chapter 14, Section 5, as amended) is amended to read:

"59A-61-5. PHARMACY BENEFITS MANAGER CONTRACTS--CERTAIN PRACTICES PROHIBITED--CERTAIN DISCLOSURES REQUIRED UPON REQUEST.--

A. A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.

B. A pharmacy benefits manager shall provide to a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.

C. A contract between a pharmacy benefits manager and a pharmacy shall identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice.

D. The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract.

E. A pharmacy benefits manager shall not:

(1) cause or knowingly permit the use of any

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1 advertisement, promotion, solicitation, representation,
2 proposal or offer that is untrue, deceptive or misleading;
3 (2) require pharmacy validation and
4 revalidation standards inconsistent with, more stringent than
5 or in addition to federal and state requirements for licensure
6 and operation as a pharmacy in this state;
7 (3) prohibit a pharmacy or pharmacist from:
8 (a) mailing or delivering drugs to a
9 patient as an ancillary service;
10 (b) providing a patient information
11 regarding the patient's total cost for pharmacist services for
12 a prescription drug; or
13 (c) discussing information regarding the
14 total cost for pharmacist services for a prescription drug or
15 from selling a more affordable alternative to the insured if a
16 more affordable alternative is available;
17 (4) require or prefer a generic drug over its
18 generic therapeutic equivalent;
19 (5) prohibit, restrict or limit disclosure of
20 information by a pharmacist or pharmacy to the superintendent;
21 [~~or~~]
22 (6) prohibit, restrict or limit pharmacies or
23 pharmacists from providing to state or federal government
24 officials general information for public policy purposes;
25 <u>(7) require an insured to use a specific</u>

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pharmacy or entity to fill a prescription drug if the pharmacy benefits manager or corporate affiliate has an ownership interest in the pharmacy or entity or if the pharmacy or entity has an ownership interest in the pharmacy benefits manager or a corporate affiliate;

(8) charge a different cost-sharing amount for prescription drugs or pharmacy services obtained at a non-affiliated pharmacy;

(9) require or incentivize the purchase of a medication in a quantity greater than prescribed;

(10) require a physician's office, hospital or infusion center to accept drugs for administration purchased by the pharmacy benefits manager or an affiliated pharmacy, whether delivered to the patient or the infusion center;

(11) require that infusion drugs be administered at home, unless the ordering physician determines that the insured's home is a safe infusion site;

(12) charge different cost-sharing for different infusion sites; however a pharmacy benefits manager may communicate with an insured regarding lower-cost sites of service; or

(13) after adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless one or more of the following applies:

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(a) the original claim was intentionally submitted fraudulently;

(b) the original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services; or

(c) the pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.

F. A pharmacy benefits manager or health [~~benefit~~] benefits plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health [~~benefit~~] benefits plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

G. Within seven business days of a request by the superintendent or a contracted pharmacy or pharmacist, a pharmacy benefits manager or pharmacy services administrative organization shall provide as appropriate:

(1) a contract;

(2) an agreement;

(3) a claim appeal document;

(4) a disputed claim transaction document or price list; or

(5) any other information specified by law.

H. In a time and manner required by rules

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promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide.

I. Pursuant to the provisions of Section 59A-4-3 NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the information confidential."

SECTION 5. Section 59A-61-7 NMSA 1978 (being Laws 2017, Chapter 16, Section 2, as amended) is amended to read:

"59A-61-7. PHARMACY BENEFITS MANAGERS--PROHIBITED PHARMACY FEES.--

A. A pharmacy benefits manager shall not charge a pharmacy a fee related to the adjudication of a claim, including:

(1) the receipt and processing of a pharmacy claim;

(2) the development or management of a claim processing or adjudication network; or

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(3) participation in a claim processing or claim adjudication network.

B. A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract.

C. A pharmacy benefits manager or health benefits plan shall not impose a fee on a pharmacy for scores or metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefits plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

D. A pharmacy benefits manager shall not conduct spread pricing in New Mexico."

SECTION 6. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] REGISTRATION OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS REQUIRED.--A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent."

SECTION 7. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] PHARMACY BENEFITS REIMBURSEMENT TRANSPARENCY.--

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A. The superintendent may review and approve the compensation program of a pharmacy benefits manager with a health benefits plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefits plan under the standards issued by rule. All information and data acquired during the review under this section:

(1) shall be confidential and are not subject to disclosure pursuant to the Inspection of Public Records Act; and

(2) may be shared with the office of the attorney general, the human services department, the federal trade commission and the federal centers for medicare and medicaid services.

B. A pharmacy benefits manager shall report to the superintendent on an annual basis the following information for each insurer:

(1) the itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees or any other fees;

(2) the individual amount of rebates per drug distributed to the appropriate insurer or payor;

(3) the individual amount of rebates per drug

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1 passed on to insureds of each insurer or payor at the point of
2 sale that reduced the insureds' applicable deductible,
3 copayment, coinsurance or other cost-sharing amount;
4 (4) the individual and aggregate amount the
5 insurer paid to the pharmacy benefits manager for pharmacy
6 goods or services itemized for pharmacy goods and services; and
7 (5) the impact on premiums, insureds' cost
8 sharing or other plan costs of the Pharmacy Benefits Manager
9 Regulation Act.
10 C. A pharmacy benefits manager shall allow a plan
11 sponsor contracting with a pharmacy benefits manager an
12 opportunity to:
13 (1) audit, annually, compliance with the terms
14 of the contract by the pharmacy benefits manager, including
15 full disclosure of any and all rebate amounts secured, whether
16 product-specific or generalized rebates, that were provided to
17 the pharmacy benefits manager by a pharmaceutical manufacturer;
18 (2) request that the pharmacy benefits manager
19 disclose the actual amounts paid by the pharmacy benefits
20 manager to the pharmacy; and
21 (3) request information about any
22 consideration that the pharmacy benefits manager receives from
23 the manufacturer for dispense-as-written prescriptions once a
24 generic or biologically similar product becomes available.
25 D. Failure of a pharmacy benefits manager to allow

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a plan sponsor to audit contract terms pursuant to Subsection C of this section may be enforced through a private right of action.

E. A pharmacy benefits manager shall not be paid a percentage of the cost of the drug but shall be paid a fixed fee determined in advance."

SECTION 8. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] FIDUCIARY DUTY.--An insurer that contracts with a pharmacy benefits manager to perform any activities related to the insurer's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the insurer's agent and owes a fiduciary duty to the insurer in the pharmacy benefits manager's management of activities related to the insurer's prescription drug benefits."

SECTION 9. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] PATIENT COST SHARING.--

A. An insurer or its pharmacy benefits manager shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

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(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or insurer, including the cost-sharing amount paid by an insured; or

(4) value of the rebate from the manufacturer provided to the pharmacy benefits manager for the prescribed drug.

B. If a prescription drug rebate is more than the amount needed to reduce the patient copayment to zero on a particular drug, the remainder shall be credited to the insurer or plan sponsor.

C. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to individual or group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit the insured for the out-of-pocket cost for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

D. Any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

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E. If an insured or the insured's health care provider identifies a clinically appropriate, non-formulary, specialty prescription drug available at a lower cost than a drug covered on the pharmacy benefits manager's formulary, the pharmacy benefits manager shall reimburse the insured, minus applicable cost sharing, for the non-formulary drug.

F. For purposes of this section:

(1) "cost sharing" means any:

(a) copayment;

(b) coinsurance;

(c) deductible;

(d) out-of-pocket maximum amount;

(e) other financial obligation, other than a premium or share of a premium; or

(f) combination thereof; and

(2) "individual or group health coverage" means any coverage issued under the following provisions of the Insurance Code:

(a) group health coverage governed by the provisions of the Health Care Purchasing Act;

(b) individual health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

(c) multiple-employer welfare

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arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;

(d) group and blanket health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

(e) individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; or

(f) individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law."

SECTION 10. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] DEVELOPING DRUG FORMULARY--COVERAGE REQUIREMENTS.--A pharmacy benefits manager that administers a pharmacy benefits program or develops a drug formulary on behalf of an insurer shall cover all medically necessary drugs."

SECTION 11. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] NETWORK PARTICIPATION--RESTRICTIONS.--An insurer or plan sponsor, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall not restrict participation of a

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pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacy meets such accreditation standards or certification requirements."

SECTION 12. TEMPORARY PROVISION--DEADLINE FOR ADOPTION OF PREFERRED DRUG LIST.--The medical assistance division of the human services department shall adopt a preferred drug list and promulgate necessary rules pursuant to this 2023 act by January 1, 2025."

SECTION 13. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to the office of superintendent of insurance for expenditure in fiscal year 2024 and subsequent fiscal years to hire staff to regulate, monitor compliance and enforce the provisions of the Pharmacy Benefits Manager Regulation Act. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall not revert to the general fund.

SECTION 14. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2023.

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