LEGISLATIVE COMMITTEE MINUTES

SB686

Bill as Introduced

SB 686-FN - AS INTRODUCED

2020 SESSION

20-2726
01/10

SENATE BILL ***686-FN***

AN ACT relative to rebates paid to pharmacy benefits managers.

SPONSORS: Sen. Rosenwald, Dist 13; Sen. Fuller Clark, Dist 21; Sen. Morgan, Dist 23; Sen. Watters, Dist 4; Sen. Levesque, Dist 12; Sen. Chandley, Dist 11; Sen. Hennessey, Dist 5; Sen. Feltes, Dist 15; Sen. Kahn, Dist 10; Sen. Cavanaugh, Dist 16; Sen. Bradley, Dist 3; Sen. Carson, Dist 14; Rep. Williams, Hills. 4; Rep. Muscatel, Graf. 12; Rep. Marsh, Carr. 8; Rep. McMahon, Rock. 7

COMMITTEE: Commerce

ANALYSIS

This bill requires pharmacy benefit managers to pass rebates paid by manufacturers on to the consumer or health benefit plan.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

20-2726
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to rebates paid to pharmacy benefits managers.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Health Plans That Provide Prescription Drug Benefits. Amend RSA by inserting after chapter 402-N the following new chapter:

CHAPTER 402-O

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

402-O:1 Definitions. In this chapter:

I. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Commissioner" means the insurance commissioner.

IV. Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

V. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

VI. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health plan. "Covered person" includes the authorized representative of a covered person.

VII. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

VIII. "Formulary" means a list of prescription drugs covered by a health benefit plan and any tier levels applicable to a prescription drug.

IX. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

X. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

XI. "Health benefit plan" means "health benefit plan" as defined in RSA 420-J:3, XIX.

XII. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

XIII. "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, by fax or through electronic submissions and to dispense medication to covered persons through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.

XIV. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

XV. "Network pharmacy" means a licensed retail pharmacy or other pharmacy provider that contracts with a pharmacy benefits manager.

XVI. "Pharmacy" means an established location, either physical or electronic, that is licensed under RSA 318 and that has entered into a network pharmacy contract with a pharmacy benefits manager or health carrier.

XVII. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a health carrier to develop and maintain formularies.

XVIII. "Pharmacy benefits manager" means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity. "Pharmacy benefits manager" shall include a health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds. "Pharmacy benefits manager" shall not include a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries. "Pharmacy benefits management" means the administration of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefits manager and the covered entity and the provision of mail order pharmacy services.

XIX. "Pharmacy provider" means a retail pharmacy, mail order pharmacy, or licensed pharmacist.

XX. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

402-O:2 Oversight and Contracting Responsibilities.

I. A health carrier is responsible for monitoring all activities carried out by the health carrier, or all activities carried out on behalf of the health carrier by a pharmacy benefits manager if the health carrier contracts with a pharmacy benefits manager, related to a health carrier's prescription drug benefits and for ensuring that all requirements of this chapter are met.

II. A health carrier that contracts with a pharmacy benefits manager to perform any activities related to the health carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the health carrier's agent and owes a fiduciary duty to the health carrier in the pharmacy benefits manager's management of activities related to the health carrier's prescription drug benefits.

III. A health carrier shall not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the health carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

(a) Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's health carrier if the cash price is less than the covered person's cost-sharing amount: or

(b) Providing information to a state or federal agency, law enforcement agency or the commissioner when such information is required by law.

IV.(a) A health carrier or pharmacy benefits manager shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

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

(2) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts.

(3) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.

(4) The amount a health carrier or pharmacy benefits manager would pay for the prescription drug if the carrier or pharmacy benefits manager paid the pharmacy the full amount for the drug, with no cost sharing due.

(b) When calculating the cost-sharing for any prescription subject to a co-insurance, a health carrier or pharmacy benefits manager shall use the amount the pharmacy will be reimbursed for the prescription drug from the health carrier or pharmacy benefits manager minus any cost-sharing to be paid by a covered person.

V. A health carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy shall not be included in determining the adequacy of a retail pharmacy network.

402-O:3 Prescription Drug Pricing; Maximum Allowable Cost.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one

generic alternative available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same maximum allowable cost list for each pharmacy provider.

II. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

(a) Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

(b) Is not obsolete and is generally available for purchase in New Hampshire from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the health carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

IV. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall respond to, investigate and resolve an appeal under paragraph III within 14 days after the receipt of the appeal. The health carrier or pharmacy benefits manger shall respond to an appeal as follows:

(a) If the appeal is upheld, the health carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

(b) If the appeal is denied, the health carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

V. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use only one national drug pricing source during a calendar year, except that a health carrier, or a pharmacy benefits manager under contract with a health carrier, may use a different national drug pricing source if the original pricing source is no longer available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same national drug pricing source for each pharmacy provider and identify on

its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

VI. This paragraph governs payments between a health carrier or a health carrier's pharmacy benefits manager and a pharmacy provider.

(a) The amount paid by a health carrier or a health carrier's pharmacy benefits manager to a pharmacy provider under contract with the health carrier or the health carrier's pharmacy benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

(b) The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and shall be disclosed by the health carrier's pharmacy benefits manager to the carrier.

(c) Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this paragraph.

(d) A pharmacy provider shall not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

402-O:4 Responsibility to Use Compensation for Benefit of Covered Persons.

I. All compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a health carrier, or to a pharmacy benefits manager under contract with a health carrier, related to its prescription drug benefits shall be:

(a) Remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular prescription drug; or

(b) Remitted to, and retained by, the health carrier. Compensation remitted to the health carrier shall be applied by the health carrier in its plan design and in future plan years to offset the premium for covered persons.

II. Beginning March 1, 2021 and annually thereafter, a health carrier shall file with the commissioner a report in the manner and form determined by the commissioner demonstrating how the health carrier has complied with this section.

402-O:5 Prescription Drug Formularies; Pharmacy and Therapeutics Committee.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall establish a pharmacy and therapeutics committee. A health carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the health carrier's pharmacy benefits manager to use one or more formularies.

II. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall not allow a person with a conflict of interest, as described in subparagraphs (a) and (b), to be a member of its pharmacy and therapeutics committee. A person shall not serve as a member of a pharmacy and therapeutics committee if the person:

(a) Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor; or

(b) Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

402-O:6 Access to Records; Audits.

I. A health carrier shall maintain and have the ability to access all data related to the administration and provision of prescription drug benefits under a health plan of a health carrier, including, but not limited to:

(a) The names, addresses, member identification numbers, protected health information, and other personal information of covered persons; and

(b) All contracts, documentation, and records, including transaction and pricing data, related to the dispensing of prescription drugs to covered persons under the health plan.

II. A sale or transaction involving the transfer of any records, information, or data described in paragraph I shall comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the federal Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 and any regulations adopted pursuant to those laws.

III. A health carrier may audit all transaction records related to the dispensing of prescription drugs to covered persons under a health plan of the health carrier. A health carrier may conduct audits at a location of its choosing and with an auditor of its choosing.

IV. A health carrier shall maintain all records, information, and data described in paragraph I and all audit records described in paragraph III for a period of no less than 5 years.

V. Upon request, a health carrier shall provide to the commissioner any records, contracts, documents, or data held by the health carrier or the health carrier's pharmacy benefits manager for inspection, examination, or audit purposes.

402-O:7 Treatment of Pharmacy Benefits Manager Compensation.

I. In this section:

(a) "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

(b) "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a health carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health benefit plan.

II.(a) If a health carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

(1) Constitutes an administrative cost incurred by the carrier in connection with a health benefit plan; and

(2) May not constitute a benefit provided under a health benefit plan.

(b) A health carrier shall claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

III. Each rate filing submitted by a health carrier with respect to a health benefit plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager shall include:

(a) A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

(b) Such records and supporting information as the commissioner reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

IV. Upon request, a health carrier shall provide any records to the commissioner that relate to the calculation of the pharmacy benefits manager compensation.

V. A pharmacy benefits manager shall provide any necessary documentation requested by a health carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

2 Managed Care Law. Amend RSA 420-J:8, XV(b)(3) to read as follows:

(3) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every [~~14~~] *7* days.

3 Effective Date. This act shall take effect January 1, 2021.

LBAO
20-2726
12/18/19

SB 686-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to rebates paid to pharmacy benefits managers.

FISCAL IMPACT: **[X] State** **[X] County** **[X] Local** **[ ] None**

	Estimated Increase / (Decrease)			
STATE:	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Appropriation	$0	$0	$0	$0
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	$0	$0	$0	$0
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill requires pharmacy benefit managers to pass rebates paid by manufacturers on to the consumer or health benefit plan.

The Insurance Department assumes the additional requirements imposed on the Department could be handled within its current administrative budget and resources. It is unclear to the Department what impact, if any, the changes in the bill would have on claim costs and plan pricing. To the extent there is an impact there may also be an impact on premium tax revenue. However, due to insurance purchasing decisions, any impact on premium tax revenue would not necessarily be proportionate to changes in premiums.

The Department of Administrative Services indicates there would be no fiscal impact on the State Health Benefit Plans for Employees and Retirees (Plan). Because the Plan is a governmental sail-insured plan, it is not subject to managed care law and the bill would have no impact on the Plan.

The Department of Health and Human Services assumes the bill would apply to commercial carriers and not the Medicaid Plan and the bill would have no fiscal impact to the Department.

AGENCIES CONTACTED:

Departments of Insurance, Administrative Services and Health and Human Services

SB 686-FN - AS AMENDED BY THE SENATE

03/11/2020 1063s

2020 SESSION

20-2726
01/10

SENATE BILL ***686-FN***

AN ACT relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

SPONSORS: Sen. Rosenwald, Dist 13; Sen. Fuller Clark, Dist 21; Sen. Morgan, Dist 23; Sen. Watters, Dist 4; Sen. Levesque, Dist 12; Sen. Chandley, Dist 11; Sen. Hennessey, Dist 5; Sen. Feltes, Dist 15; Sen. Kahn, Dist 10; Sen. Cavanaugh, Dist 16; Sen. Bradley, Dist 3; Sen. Carson, Dist 14; Rep. Williams, Hills. 4; Rep. Muscatel, Graf. 12; Rep. Marsh, Carr. 8; Rep. McMahon, Rock. 7

COMMITTEE: Commerce

AMENDED ANALYSIS

This bill regulates the maximum allowable cost for prescription drug benefits paid by health insurers or pharmacy benefit managers.

This bill also establishes the New Hampshire prescription drug competitive marketplace.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Health Plans That Provide Prescription Drug Benefits. Amend RSA by inserting after chapter 402-N the following new chapter:

CHAPTER 402-O

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

402-O:1 Definitions. In this chapter:

I. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Commissioner" means the insurance commissioner.

IV. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

V. "Contracted pharmacy" means "contracted pharmacy" as defined in RSA 420-J:3, X-a.

VI. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

VII. "Covered person" means "covered person" as defined in RSA 420-J:3, XII.

VIII. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

IX. "Formulary" means a list of prescription drugs covered by a health benefit plan and any tier levels applicable to a prescription drug.

X. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

XI. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

XII. "Health benefit plan" means "health benefit plan" as defined in RSA 420-J:3, XIX.

XIII. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or

the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

XIV. "Mail order pharmacy" means "mail order pharmacy" as defined in RSA 318:1, VII-b.

XV. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

XVI. "Pharmacy" means "pharmacy" as defined in RSA 318:1, XI.

XVII. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a health carrier to develop and maintain formularies.

XVIII. "Pharmacy benefits manager" means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity. "Pharmacy benefits manager" shall include a health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds. "Pharmacy benefits manager" shall not include a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries. "Pharmacy benefits management" means the administration of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefits manager and the covered entity and the provision of mail order pharmacy services.

XIX. "Pharmacy provider" means a retail pharmacy, mail order pharmacy, or licensed pharmacist.

XX. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

402-O:2 Oversight and Contracting Responsibilities.

I. A health insurer shall ensure that oversight and management of its prescription drug benefits, whether managed and administered directly by the insurer, or by a pharmacy benefits manager under contract with the insurer, meets the requirements of this chapter.

II. A health carrier that contracts with a pharmacy benefits manager to perform any activities related to the health carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the health carrier's agent and owes a fiduciary duty to the health carrier in the pharmacy benefits manager's management of activities related to the health carrier's prescription drug benefits.

III. A health carrier shall not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the health carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

(a) Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's health

carrier if the cash price is less than the covered person's cost-sharing amount; or

(b) Providing information to a state or federal agency, law enforcement agency, or the commissioner when such information is required by law.

IV.(a) A health carrier or pharmacy benefits manager shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

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

(2) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts.

(3) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.

(4) The amount a health carrier or pharmacy benefits manager would pay for the prescription drug if the carrier or pharmacy benefits manager paid the pharmacy the full amount for the drug, with no cost sharing due.

(b) When calculating the cost-sharing for any prescription subject to a co-insurance, a health carrier or pharmacy benefits manager shall use the amount the pharmacy will be reimbursed for the prescription drug from the health carrier or pharmacy benefits manager minus any cost-sharing to be paid by a covered person.

V. A health carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy shall not be included in determining the adequacy of a retail pharmacy network.

402-O:3 Prescription Drug Pricing; Maximum Allowable Cost.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same maximum allowable cost list for each pharmacy provider.

II. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

(a) Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

(b) Is not obsolete and is generally available for purchase in New Hampshire from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy

benefits manager.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the health carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

IV. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall respond to, investigate, and resolve an appeal under paragraph III within 14 days after the receipt of the appeal. The health carrier or pharmacy benefits manager shall respond to an appeal as follows:

(a) If the appeal is upheld, the health carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

(b) If the appeal is denied, the health carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

V. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use only one national drug pricing source during a calendar year, except that a health carrier, or a pharmacy benefits manager under contract with a health carrier, may use a different national drug pricing source if the original pricing source is no longer available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

VI. This paragraph governs payments between a health carrier or a health carrier's pharmacy benefits manager and a pharmacy provider.

(a) The amount paid by a health carrier or a health carrier's pharmacy benefits manager to a pharmacy provider under contract with the health carrier or the health carrier's pharmacy benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

(b) The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and shall be disclosed by the health carrier's pharmacy benefits

manager to the carrier.

(c) Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this paragraph.

(d) A pharmacy provider shall not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

402-O:4 Prescription Drug Formularies; Pharmacy and Therapeutics Committee.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall establish a pharmacy and therapeutics committee. A health carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the health carrier's pharmacy benefits manager to use one or more formularies.

II. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall not allow a person with a conflict of interest, as described in subparagraphs (a) and (b), to be a member of its pharmacy and therapeutics committee. A person shall not serve as a member of a pharmacy and therapeutics committee if the person:

(a) Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor; or

(b) Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

402-O:5 Treatment of Pharmacy Benefits Manager Compensation.

I. In this section:

(a) "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

(b) "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a health carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health benefit plan.

II.(a) If a health carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

(1) Constitutes an administrative cost incurred by the carrier in connection with a

health benefit plan; and

(2) May not constitute a benefit provided under a health benefit plan.

(b) A health carrier shall claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

III. Each rate filing submitted by a health carrier with respect to a health benefit plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager shall include:

(a) A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

(b) Such records and supporting information as the commissioner reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

IV. Upon request, a health carrier shall provide any records to the commissioner that relate to the calculation of the pharmacy benefits manager compensation.

V. A pharmacy benefits manager shall provide any necessary documentation requested by a health carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

2 Managed Care Law. Amend RSA 420-J:8, XV(b)(3) to read as follows:

(3) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every [~~14~~] *7* days.

3 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

21-I:96 Purpose and Intent. The purpose and intent of this subdivision is to authorize the commissioner of the department of administrative services, with the approval of the governor and the executive council, to establish the New Hampshire prescription drug competitive marketplace in accordance with this subdivision. The objective of this subdivision is to optimize prescription drug savings by the state of New Hampshire through the following:

I. Adoption of a dynamically competitive reverse auction process for the state health plan selection of pharmacy benefit managers (PBM).

II. Ongoing, real-time electronic review and validation of PBM claims invoices as the foundation for reconciling pharmacy bills.

III. Conduct of market checks using technology driven evaluation of the incumbent PBM's prescription drug pricing based on benchmark comparators.

21-I:97 Definitions. In this subdivision:

I. "Department" means the department of administrative services.

II. "Pharmacy benefits manager" means a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to

a contract with the health carrier or self-funded health benefit plan, manages the prescription drug coverage provided by the health carrier or self-funded health benefit plan, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

III. "PBM reverse auction" means an automated, transparent, and dynamically competitive bidding process conducted online that starts with an opening round of bids and allows qualified PBM bidders to counter-offer a lower price for as many rounds of bidding as determined by the department of administrative services or its authorized representative conducting the reverse auction for a multiple health plan prescription drug purchasing group.

IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing PBM proposals over the duration of the PBM services contract.

V. "Real-time" means within no more than 12 hours.

VI. "PBA" means a participant bidding agreement entered into by all participants in the PBM reverse auction prior to participation therein.

21-I:98 New Hampshire Prescription Drug Competitive Marketplace.

I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM for the administration of benefits under this subdivision may be procured by the department, at its sole discretion, in a transparent, online competitive process, or "PBM reverse auction" as set forth in this subdivision. If the department, acting in its discretion, opts to conduct such a process, it shall procure, through the solicitation of proposals from qualified professional services vendors, the following products and services based upon price, capabilities, and other factors as determined by the department:

(a) Technical assistance from a technology operator with respect to all of the following:

(1) Evaluating the qualifications of PBM bidders.

(2) Conducting online-automated reverse auction services to support the department or its authorized representatives in comparing the pricing for the PBM procurement.

(3) Providing related professional services.

(b) Technology platform with the required capabilities for conducting a PBM reverse auction, along with the related services of a technology operator, as described in subparagraph (a). The technology platform shall, at a minimum, possess the capacity to do the following:

(1) Conduct an automated, online, reverse auction of PBM services.

(2) Automate repricing of diverse and complex PBM prescription drug pricing proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of annual prescription drug claims data available for state-funded health plans or a multiple health

plan prescription drug purchasing group and using code-based classification of drugs from nationally accepted drug sources.

(3) Produce an automated report and analysis of PBM bids, including the ranking of PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time period following the close of each round of reverse auction bidding.

(4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the PBM services contract resulting from the reverse auction process.

(c) The contract for procurement of the technology platform and technology operator services shall not be awarded to any of the following:

(1) A vendor that is a PBM.

(2) A vendor that is a subsidiary or affiliate of a PBM.

(3) A vendor that is managed by a PBM or receives remuneration from a PBM for aggregating clients into a contractual relationship with a PBM.

(d) The vendor shall not outsource any part of the PBM reverse auction or the automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription drug claims.

(e) With technical assistance and support provided by the technology operator, the department or its authorized representative shall specify the terms of the PBA. The terms of the PBA shall not be modified except by specific consent of the department of administrative services or its authorized representatives.

II. When and if procured, the technology platform used to conduct the reverse auction shall be repurposed over the duration of the PBM services contract as an automated pharmacy claims adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of PBM services contracts.

III. An entity may request in writing and subject to the approval of the commissioner to participate in a joint purchasing group with the state employee and retiree group insurance program for procuring for PBM services through a PBM reverse auction or otherwise. All entities participating in a joint purchasing group shall share proportionally in the cost of procurement including all support services.

IV. If the department opts, at its discretion, to conduct a transparent, online competitive PBM selection process, as set forth in this subdivision, the processes and procedures set forth in this section shall apply to prescription drug coverage in connection with the state employee health plan for benefits under this part including for state employees, retirees, spouses, and eligible dependents in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining agreements. Any other state-funded health plan or self-funded municipal employee or other local

government employee health plan, public school employee health plans, operating individually or collectively, and the health plans of the university system of New Hampshire and the community college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of a first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. Any PBM providing services to the department or a self-funded health plan as described in paragraphs IV and V, shall provide the department and the plan the complete pharmacy claims data necessary to conduct the reverse auction and carry out their administrative and management duties.

VIII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

4 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

5 Effective Date.

I. Sections 1 and 2 of this act shall take effect January 1, 2021.

II. The remainder of this act shall take effect upon passage.

LBAO
20-2726
Amended 5/28/20

SB 686-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2020-1063s)

AN ACT relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

FISCAL IMPACT: [X] State [X] County [X] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Appropriation	$0	$0	$0	$0
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill regulates the maximum allowable cost for prescription drug benefits paid by health insurers or pharmacy benefit managers. This bill also establishes the New Hampshire prescription drug competitive marketplace.

The Insurance Department indicates it is unclear what impact, if any, these changes may have on claim costs and plan pricing. To the extent there is an impact, there also may be an impact premium tax revenue. However, due to purchasing decisions, such as buy downs, the impact on premium tax revenue isn't necessarily proportional to the impact on premiums.

The Department of Administrative Services indicates the fiscal impact to the State of proposed RSA Chapter 402-O regarding health plans that provide prescription drug benefits and the proposed amendment to RSA 420-J would be zero since the State Health Benefit Plan for Employees and Retirees is a governmental self-insured plan and not governed by the New Hampshire Department of Insurance or managed care law. The impact to the Department of the proposed amendment to RSA 21-1 concerning the New Hampshire Prescription Drug

Competitive Marketplace is indeterminable because the Department is not able to predict the costs that would be incurred to contract with vendors necessary to: provide the technology platform, technical operator services, and other professional services required to conduct the reverse auction and claims audit and reconciliation services. The Department is also not able to predict the savings from a reverse bidding process versus the traditional procurement processor or the extent to which the cost and savings might offset one another.

The Department of Health and Human Services assumes the bill would apply to commercial carriers and not the Medicaid Plan and the bill would have no fiscal impact to the Department.

AGENCIES CONTACTED:

Departments of Insurance, Administrative Services and Health and Human Services

Amendments

Sen. Rosenwald, Dist 13
Sen. Giuda, Dist 2
January 16, 2020
2020-0112s
01/10

Amendment to SB 686-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to regulation of pharmacy benefits managers and establishing the New Hampshire prescription drug competitive marketplace.

Amend the bill by replacing all after section 2 with the following:

3 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

21-I:96 Definitions. In this subdivision:

I. "Department" means the department of administrative services.

II. "Pharmacy benefits manager" or PBM means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity.

III. "PBM reverse auction" means an automated, transparent, and dynamically competitive bidding process conducted online that starts with an opening round of bids and allows qualified PBM bidders to counter-offer a lower price for as many rounds of bidding as determined by the department of administrative services or its authorized representative conducting the reverse auction for a multiple health plan prescription drug purchasing group.

IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing PBM proposals over the duration of the PBM services contract.

V. "Real-time" means within no more than 12 hours.

VI. PBA" means a participant bidding agreement entered into by all participants in the PBM reverse auction prior to participation therein.

21-I:97 New Hampshire Prescription Drug Competitive Marketplace.

I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM for the administration of benefits under this subdivision may be procured by the department in a transparent, online competitive process. On and after January 1, 2021, the department may procure through the solicitation of proposals from qualified professional services vendors, the following

products and services based upon price, capabilities, and other factors as determined by it:

(a) Technical assistance from a technology operator with respect to all of the following:

(1) Evaluating the qualifications of PBM bidders.

(2) Conducting online-automated reverse auction services to support the department or its authorized representatives in comparing the pricing for the PBM procurement.

(3) Providing related professional services.

(b) Technology platform with the required capabilities for conducting a PBM reverse auction, along with the related services of a technology operator, as described in subparagraph (a). The technology platform shall, at a minimum, possess the capacity to do the following:

(1) Conduct an automated, online, reverse auction of PBM services.

(2) Automate repricing of diverse and complex PBM prescription drug pricing proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of annual prescription drug claims data available for state-funded health plans or a multiple health plan prescription drug purchasing group and using code-based classification of drugs from nationally accepted drug sources.

(3) Produce an automated report and analysis of PBM bids, including the ranking of PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time period following the close of each round of reverse auction bidding.

(4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the PBM services contract resulting from the reverse auction process.

(c) The contract for procurement of the technology platform and technology operator services shall not be awarded to any of the following:

(1) A vendor that is a PBM.

(2) A vendor that is a subsidiary or affiliate of a PBM.

(3) A vendor that is managed by a PBM or receives remuneration from a PBM for aggregating clients into a contractual relationship with a PBM.

(d) The vendor shall not outsource any part of the PBM reverse auction or the automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription drug claims.

(e) With technical assistance and support provided by the technology operator, the department or its authorized representative shall specify the terms of the PBA. The terms of the PBA shall not be modified except by specific consent of the department of administrative services or its authorized representatives.

II. When and if procured, the technology platform used to conduct the reverse auction shall be repurposed over the duration of the PBM services contract as an automated pharmacy claims adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100

percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of PBM services contracts.

III. The department may opt to forgo payment of all costs for use of the technology platform and related technology operator services to conduct PBM reverse auctions, ongoing, automated PBM invoice reviews, and periodic market checks. In such a case, the department may instead elect a "no-pay" option that obligates the winning PBM to pay the technology operator for the use of its technology platform and technology operator services by assessing the PBM a per-prescription fee in an amount agreed to by the parties and requiring the PBM to pay these fees to the technology operator over the duration of the PBM services contract. If the department of administrative services elects this option, the obligation of the winning PBM to pay the technology operator the per-prescription fees shall be incorporated as a term of the PBA and the PBM services contract awarded to the PBM reverse auction winner.

IV. The processes and procedures set forth in this section shall apply to prescription drug coverage in connection with the state employee health plan for benefits under this part including for state employees, retirees, spouses, and eligible dependents in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining agreements. Any other state-funded health plan or self-funded municipal employee or other local government employee health plan, public school employee health plans, operating individually or collectively, and the health plans of the university system of New Hampshire and the community college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of the first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

4 Effective Date.

I. Sections 1 and 2 of this act shall take effect January 1, 2021.

II. The remainder of this act shall take effect upon passage.

2020-0112s

AMENDED ANALYSIS

This bill requires pharmacy benefit managers to pass rebates paid by manufacturers on to the consumer or health benefit plan.

This bill also establishes the New Hampshire prescription drug competitive marketplace.

Sen. Rosenwald, Dist 13
January 16, 2020
2020-0113s
01/10

Amendment to SB 686-FN

Amend RSA 402-O as inserted by section 1 of the bill by inserting after RSA 402-O:7 the following new RSA section:

402-O:8 Severability. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

Sen. Rosenwald, Dist 13
Sen. Cavanaugh, Dist 16
March 2, 2020
2020-0968s
01/10

Amendment to SB 686-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; Health Plans That Provide Prescription Drug Benefits. Amend RSA by inserting after chapter 402-N the following new chapter:

CHAPTER 402-O

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

402-O:1 Definitions. In this chapter:

I. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Commissioner" means the insurance commissioner.

IV. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

V. "Contracted pharmacy" means "contracted pharmacy" as defined in RSA 420-J:3, X-a.

VI. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

VII. "Covered person" means "covered person" as defined in RSA 420-J:3, XII.

VIII. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

IX. "Formulary" means a list of prescription drugs covered by a health benefit plan and any tier levels applicable to a prescription drug.

X. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-

name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

XI. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

XII. "Health benefit plan" means "health benefit plan" as defined in RSA 420-J:3, XIX.

XIII. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

XIV. "Mail order pharmacy" means "mail order pharmacy" as defined in RSA 318:1, VII-b.

XV. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

XVI. "Pharmacy" means "pharmacy" as defined in RSA 318:1, XI.

XVII. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a health carrier to develop and maintain formularies.

XVIII. "Pharmacy benefits manager" means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity. "Pharmacy benefits manager" shall include a health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds. "Pharmacy benefits manager" shall not include a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries. "Pharmacy benefits management" means the administration of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefits manager and the covered entity and the provision of mail order pharmacy services.

XIX. "Pharmacy provider" means a retail pharmacy, mail order pharmacy, or licensed pharmacist.

XX. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

402-O:2 Oversight and Contracting Responsibilities.

I. A health insurer shall ensure that oversight and management of its prescription drug benefits, whether managed and administered directly by the insurer, or by a pharmacy benefits manager under contract with the insurer, meets the requirements of this chapter.

II. A health carrier that contracts with a pharmacy benefits manager to perform any activities related to the health carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the health carrier's agent and owes a fiduciary duty to the health carrier in the pharmacy benefits manager's management of activities related to the health carrier's prescription drug benefits.

III. A health carrier shall not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the health carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

(a) Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's health carrier if the cash price is less than the covered person's cost-sharing amount; or

(b) Providing information to a state or federal agency, law enforcement agency, or the commissioner when such information is required by law.

IV.(a) A health carrier or pharmacy benefits manager shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

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

(2) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts.

(3) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.

(4) The amount a health carrier or pharmacy benefits manager would pay for the prescription drug if the carrier or pharmacy benefits manager paid the pharmacy the full amount for the drug, with no cost sharing due.

(b) When calculating the cost-sharing for any prescription subject to a co-insurance, a health carrier or pharmacy benefits manager shall use the amount the pharmacy will be reimbursed for the prescription drug from the health carrier or pharmacy benefits manager minus any cost-sharing to be paid by a covered person.

V. A health carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy shall not be included in determining the adequacy of a retail pharmacy network.

402-O:3 Prescription Drug Pricing; Maximum Allowable Cost.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same maximum allowable cost list for each pharmacy provider.

II. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

(a) Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

(b) Is not obsolete and is generally available for purchase in New Hampshire from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the health carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

IV. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall respond to, investigate, and resolve an appeal under paragraph III within 14 days after the receipt of the appeal. The health carrier or pharmacy benefits manager shall respond to an appeal as follows:

(a) If the appeal is upheld, the health carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

(b) If the appeal is denied, the health carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

V. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use only one national drug pricing source during a calendar year, except that a health carrier, or a pharmacy benefits manager under contract with a health carrier, may use a different national drug pricing source if the original pricing source is no longer available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

VI. This paragraph governs payments between a health carrier or a health carrier's pharmacy benefits manager and a pharmacy provider.

(a) The amount paid by a health carrier or a health carrier's pharmacy benefits manager to a pharmacy provider under contract with the health carrier or the health carrier's pharmacy benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

(b) The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and shall be disclosed by the health carrier's pharmacy benefits manager to the carrier.

(c) Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this paragraph.

(d) A pharmacy provider shall not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

402-O:4 Prescription Drug Formularies; Pharmacy and Therapeutics Committee.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall establish a pharmacy and therapeutics committee. A health carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the health carrier's pharmacy benefits manager to use one or more formularies.

II. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall not allow a person with a conflict of interest, as described in subparagraphs (a) and (b), to be a member of its pharmacy and therapeutics committee. A person shall not serve as a member of a pharmacy and therapeutics committee if the person:

(a) Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor; or

(b) Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

402-O:5 Treatment of Pharmacy Benefits Manager Compensation.

I. In this section:

(a) "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

(b) "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a health carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health benefit plan.

II.(a) If a health carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

(1) Constitutes an administrative cost incurred by the carrier in connection with a health benefit plan; and

(2) May not constitute a benefit provided under a health benefit plan.

(b) A health carrier shall claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

III. Each rate filing submitted by a health carrier with respect to a health benefit plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager shall include:

(a) A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

(b) Such records and supporting information as the commissioner reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

IV. Upon request, a health carrier shall provide any records to the commissioner that relate to the calculation of the pharmacy benefits manager compensation.

V. A pharmacy benefits manager shall provide any necessary documentation requested by a health carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

2 Managed Care Law. Amend RSA 420-J:8, XV(b)(3) to read as follows:

(3) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every [~~14~~] 7 days.

3 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

21-I:96 Purpose and Intent. The purpose and intent of this subdivision is to authorize the commissioner of the department of administrative services, with the approval of the governor and the executive council, to establish the New Hampshire prescription drug competitive marketplace in accordance with this subdivision. The objective of this subdivision is to optimize prescription drug savings by the state of New Hampshire through the following:

I. Adoption of a dynamically competitive reverse auction process for the state health plan selection of pharmacy benefit managers (PBM).

II. Ongoing, real-time electronic review and validation of PBM claims invoices as the foundation for reconciling pharmacy bills.

III. Conduct of market checks using technology driven evaluation of the incumbent PBM's prescription drug pricing based on benchmark comparators.

21-I:97 Definitions. In this subdivision:

I. "Department" means the department of administrative services.

II. "Pharmacy benefits manager" means a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to a contract with the health carrier or self-funded health benefit plan, manages the prescription drug coverage provided by the health carrier or self-funded health benefit plan, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

III. "PBM reverse auction" means an automated, transparent, and dynamically competitive bidding process conducted online that starts with an opening round of bids and allows qualified PBM bidders to counter-offer a lower price for as many rounds of bidding as determined by the department of administrative services or its authorized representative conducting the reverse auction for a multiple health plan prescription drug purchasing group.

IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing PBM proposals over the duration of the PBM services contract.

V. "Real-time" means within no more than 12 hours.

VI. "PBA" means a participant bidding agreement entered into by all participants in the PBM reverse auction prior to participation therein.

21-I:98 New Hampshire Prescription Drug Competitive Marketplace.

I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM for the administration of benefits under this subdivision may be procured by the department, at its sole discretion, in a transparent, online competitive process, or "PBM reverse auction" as set forth in this subdivision. If the department, acting in its discretion, opts to conduct such a process, it shall procure, through the solicitation of proposals from qualified professional services vendors, the following products and services based upon price, capabilities, and other factors as determined by the department:

(a) Technical assistance from a technology operator with respect to all of the following:

(1) Evaluating the qualifications of PBM bidders.

(2) Conducting online-automated reverse auction services to support the department or its authorized representatives in comparing the pricing for the PBM procurement.

(3) Providing related professional services.

(b) Technology platform with the required capabilities for conducting a PBM reverse auction, along with the related services of a technology operator, as described in subparagraph (a). The technology platform shall, at a minimum, possess the capacity to do the following:

(1) Conduct an automated, online, reverse auction of PBM services.

(2) Automate repricing of diverse and complex PBM prescription drug pricing proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of annual prescription drug claims data available for state-funded health plans or a multiple health plan prescription drug purchasing group and using code-based classification of drugs from nationally accepted drug sources.

(3) Produce an automated report and analysis of PBM bids, including the ranking of PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time period following the close of each round of reverse auction bidding.

(4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the PBM services contract resulting from the reverse auction process.

(c) The contract for procurement of the technology platform and technology operator services shall not be awarded to any of the following:

(1) A vendor that is a PBM.

(2) A vendor that is a subsidiary or affiliate of a PBM.

(3) A vendor that is managed by a PBM or receives remuneration from a PBM for aggregating clients into a contractual relationship with a PBM.

(d) The vendor shall not outsource any part of the PBM reverse auction or the automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription drug claims.

(e) With technical assistance and support provided by the technology operator, the department or its authorized representative shall specify the terms of the PBA. The terms of the PBA shall not be modified except by specific consent of the department of administrative services or its authorized representatives.

II. When and if procured, the technology platform used to conduct the reverse auction shall be repurposed over the duration of the PBM services contract as an automated pharmacy claims adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of PBM services contracts.

III. An entity may request in writing and subject to the approval of the commissioner to participate in a joint purchasing group with the state employee and retiree group insurance program for procuring for PBM services through a PBM reverse auction or otherwise. All entities

participating in a joint purchasing group shall share proportionally in the cost of procurement including all support services.

IV. If the department opts, at its discretion, to conduct a transparent, online competitive PBM selection process, as set forth in this subdivision, the processes and procedures set forth in this section shall apply to prescription drug coverage in connection with the state employee health plan for benefits under this part including for state employees, retirees, spouses, and eligible dependents in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining agreements. Any other state-funded health plan or self-funded municipal employee or other local government employee health plan, public school employee health plans, operating individually or collectively, and the health plans of the university system of New Hampshire and the community college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of a first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. Any PBM providing services to the department or a self-funded health plan as described in paragraphs IV and V, shall provide the department and the plan the complete pharmacy claims data necessary to conduct the reverse auction and carry out their administrative and management duties.

VIII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

4 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

5 Effective Date.

I. Sections 1 and 2 of this act shall take effect January 1, 2021.

II. The remainder of this act shall take effect upon passage.

2020-0968s

AMENDED ANALYSIS

This bill regulates the maximum allowable cost for prescription drug benefits paid by health insurers or pharmacy benefit managers.

This bill also establishes the New Hampshire prescription drug competitive marketplace.

Commerce
March 4, 2020
2020-1063s
01/04

Amendment to SB 686-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; Health Plans That Provide Prescription Drug Benefits. Amend RSA by inserting after chapter 402-N the following new chapter:

CHAPTER 402-O

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

402-O:1 Definitions. In this chapter:

I. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

II. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

III. "Commissioner" means the insurance commissioner.

IV. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

V. "Contracted pharmacy" means "contracted pharmacy" as defined in RSA 420-J:3, X-a.

VI. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

VII. "Covered person" means "covered person" as defined in RSA 420-J:3, XII.

VIII. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

IX. "Formulary" means a list of prescription drugs covered by a health benefit plan and any tier levels applicable to a prescription drug.

X. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-

name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

XI. "Health carrier" means "health carrier" as defined in RSA 420-J:3, XXIII.

XII. "Health benefit plan" means "health benefit plan" as defined in RSA 420-J:3, XIX.

XIII. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

XIV. "Mail order pharmacy" means "mail order pharmacy" as defined in RSA 318:1, VII-b.

XV. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

XVI. "Pharmacy" means "pharmacy" as defined in RSA 318:1, XI.

XVII. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a health carrier to develop and maintain formularies.

XVIII. "Pharmacy benefits manager" means a person who performs pharmacy benefits management services, including a person acting on behalf of a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity. "Pharmacy benefits manager" shall include a health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds. "Pharmacy benefits manager" shall not include a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries. "Pharmacy benefits management" means the administration of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefits manager and the covered entity and the provision of mail order pharmacy services.

XIX. "Pharmacy provider" means a retail pharmacy, mail order pharmacy, or licensed pharmacist.

XX. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

402-O:2 Oversight and Contracting Responsibilities.

I. A health insurer shall ensure that oversight and management of its prescription drug benefits, whether managed and administered directly by the insurer, or by a pharmacy benefits manager under contract with the insurer, meets the requirements of this chapter.

II. A health carrier that contracts with a pharmacy benefits manager to perform any activities related to the health carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the health carrier's agent and owes a fiduciary duty to the health carrier in the pharmacy benefits manager's management of activities related to the health carrier's prescription drug benefits.

III. A health carrier shall not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the health carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

(a) Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's health carrier if the cash price is less than the covered person's cost-sharing amount; or

(b) Providing information to a state or federal agency, law enforcement agency, or the commissioner when such information is required by law.

IV.(a) A health carrier or pharmacy benefits manager shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

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

(2) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts.

(3) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.

(4) The amount a health carrier or pharmacy benefits manager would pay for the prescription drug if the carrier or pharmacy benefits manager paid the pharmacy the full amount for the drug, with no cost sharing due.

(b) When calculating the cost-sharing for any prescription subject to a co-insurance, a health carrier or pharmacy benefits manager shall use the amount the pharmacy will be reimbursed for the prescription drug from the health carrier or pharmacy benefits manager minus any cost-sharing to be paid by a covered person.

V. A health carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy shall not be included in determining the adequacy of a retail pharmacy network.

402-O:3 Prescription Drug Pricing; Maximum Allowable Cost.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same maximum allowable cost list for each pharmacy provider.

II. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

(a) Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

(b) Is not obsolete and is generally available for purchase in New Hampshire from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the health carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

IV. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall respond to, investigate, and resolve an appeal under paragraph III within 14 days after the receipt of the appeal. The health carrier or pharmacy benefits manager shall respond to an appeal as follows:

(a) If the appeal is upheld, the health carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

(b) If the appeal is denied, the health carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

V. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use only one national drug pricing source during a calendar year, except that a health carrier, or a pharmacy benefits manager under contract with a health carrier, may use a different national drug pricing source if the original pricing source is no longer available. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

VI. This paragraph governs payments between a health carrier or a health carrier's pharmacy benefits manager and a pharmacy provider.

(a) The amount paid by a health carrier or a health carrier's pharmacy benefits manager to a pharmacy provider under contract with the health carrier or the health carrier's pharmacy benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

(b) The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and shall be disclosed by the health carrier's pharmacy benefits manager to the carrier.

(c) Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this paragraph.

(d) A pharmacy provider shall not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

402-O:4 Prescription Drug Formularies; Pharmacy and Therapeutics Committee.

I. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall establish a pharmacy and therapeutics committee. A health carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the health carrier's pharmacy benefits manager to use one or more formularies.

II. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall not allow a person with a conflict of interest, as described in subparagraphs (a) and (b), to be a member of its pharmacy and therapeutics committee. A person shall not serve as a member of a pharmacy and therapeutics committee if the person:

(a) Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor; or

(b) Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

III. A health carrier, or a pharmacy benefits manager under contract with a health carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

402-O:5 Treatment of Pharmacy Benefits Manager Compensation.

I. In this section:

(a) "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

(b) "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a health carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health benefit plan.

II.(a) If a health carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

(1) Constitutes an administrative cost incurred by the carrier in connection with a health benefit plan; and

(2) May not constitute a benefit provided under a health benefit plan.

(b) A health carrier shall claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

III. Each rate filing submitted by a health carrier with respect to a health benefit plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager shall include:

(a) A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

(b) Such records and supporting information as the commissioner reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

IV. Upon request, a health carrier shall provide any records to the commissioner that relate to the calculation of the pharmacy benefits manager compensation.

V. A pharmacy benefits manager shall provide any necessary documentation requested by a health carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

2 Managed Care Law. Amend RSA 420-J:8, XV(b)(3) to read as follows:

(3) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every [~~14~~] *7* days.

3 New Subdivision; New Hampshire Prescription Drug Competitive Marketplace. Amend RSA 21-I by inserting after section 95 the following new subdivision:

New Hampshire Prescription Drug Competitive Marketplace

21-I:96 Purpose and Intent. The purpose and intent of this subdivision is to authorize the commissioner of the department of administrative services, with the approval of the governor and the executive council, to establish the New Hampshire prescription drug competitive marketplace in accordance with this subdivision. The objective of this subdivision is to optimize prescription drug savings by the state of New Hampshire through the following:

I. Adoption of a dynamically competitive reverse auction process for the state health plan selection of pharmacy benefit managers (PBM).

II. Ongoing, real-time electronic review and validation of PBM claims invoices as the foundation for reconciling pharmacy bills.

III. Conduct of market checks using technology driven evaluation of the incumbent PBM's prescription drug pricing based on benchmark comparators.

21-I:97 Definitions. In this subdivision:

I. "Department" means the department of administrative services.

II. "Pharmacy benefits manager" means a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to a contract with the health carrier or self-funded health benefit plan, manages the prescription drug coverage provided by the health carrier or self-funded health benefit plan, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

III. "PBM reverse auction" means an automated, transparent, and dynamically competitive bidding process conducted online that starts with an opening round of bids and allows qualified PBM bidders to counter-offer a lower price for as many rounds of bidding as determined by the department of administrative services or its authorized representative conducting the reverse auction for a multiple health plan prescription drug purchasing group.

IV. "Price" means the projected cost of a PBM proposal or "bid" for providing prescription drug benefits pursuant to this part, to enable "apples-to-apples" comparison of the costs of competing PBM proposals over the duration of the PBM services contract.

V. "Real-time" means within no more than 12 hours.

VI. "PBA" means a participant bidding agreement entered into by all participants in the PBM reverse auction prior to participation therein.

21-I:98 New Hampshire Prescription Drug Competitive Marketplace.

I. Notwithstanding any provision of law to the contrary, a contract for the services of a PBM for the administration of benefits under this subdivision may be procured by the department, at its sole discretion, in a transparent, online competitive process, or "PBM reverse auction" as set forth in this subdivision. If the department, acting in its discretion, opts to conduct such a process, it shall procure, through the solicitation of proposals from qualified professional services vendors, the following products and services based upon price, capabilities, and other factors as determined by the department:

(a) Technical assistance from a technology operator with respect to all of the following:

(1) Evaluating the qualifications of PBM bidders.

(2) Conducting online-automated reverse auction services to support the department or its authorized representatives in comparing the pricing for the PBM procurement.

(3) Providing related professional services.

(b) Technology platform with the required capabilities for conducting a PBM reverse auction, along with the related services of a technology operator, as described in subparagraph (a). The technology platform shall, at a minimum, possess the capacity to do the following:

(1) Conduct an automated, online, reverse auction of PBM services.

(2) Automate repricing of diverse and complex PBM prescription drug pricing proposals to enable "apples-to-apples" comparisons of the price of PBM bids utilizing 100 percent of annual prescription drug claims data available for state-funded health plans or a multiple health plan prescription drug purchasing group and using code-based classification of drugs from nationally accepted drug sources.

(3) Produce an automated report and analysis of PBM bids, including the ranking of PBM bids based on the comparative costs and qualitative aspects thereof within a 48-hour time period following the close of each round of reverse auction bidding.

(4) Perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of the PBM services contract resulting from the reverse auction process.

(c) The contract for procurement of the technology platform and technology operator services shall not be awarded to any of the following:

(1) A vendor that is a PBM.

(2) A vendor that is a subsidiary or affiliate of a PBM.

(3) A vendor that is managed by a PBM or receives remuneration from a PBM for aggregating clients into a contractual relationship with a PBM.

(d) The vendor shall not outsource any part of the PBM reverse auction or the automated, real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM prescription drug claims.

(e) With technical assistance and support provided by the technology operator, the department or its authorized representative shall specify the terms of the PBA. The terms of the PBA shall not be modified except by specific consent of the department of administrative services or its authorized representatives.

II. When and if procured, the technology platform used to conduct the reverse auction shall be repurposed over the duration of the PBM services contract as an automated pharmacy claims adjudication engine to perform real-time, electronic, line-by-line, claim-by-claim review of 100 percent of invoiced PBM prescription drug claims, and identify all deviations from the specific terms of PBM services contracts.

III. An entity may request in writing and subject to the approval of the commissioner to participate in a joint purchasing group with the state employee and retiree group insurance program for procuring for PBM services through a PBM reverse auction or otherwise. All entities

participating in a joint purchasing group shall share proportionally in the cost of procurement including all support services.

IV. If the department opts, at its discretion, to conduct a transparent, online competitive PBM selection process, as set forth in this subdivision, the processes and procedures set forth in this section shall apply to prescription drug coverage in connection with the state employee health plan for benefits under this part including for state employees, retirees, spouses, and eligible dependents in accordance with the provisions of RSA 21-I:30 and any applicable collective bargaining agreements. Any other state-funded health plan or self-funded municipal employee or other local government employee health plan, public school employee health plans, operating individually or collectively, and the health plans of the university system of New Hampshire and the community college system of New Hampshire may utilize the processes and procedures set forth in this section individually or collectively or as a joint purchasing group with the state employee health plan.

V. After completion of a first PBM reverse auction by the department for the administration of benefits under the state employee health plan, and at the discretion of the department, self-funded private sector employer or multi-employer health plans with substantial participation by New Hampshire employees and their dependents may be permitted to participate in a joint purchasing pool with state employees for conduct of subsequent PBM reverse auctions provided that such participation shall comply with and shall be consistent with all applicable state and federal law and requirements of ERISA.

VI. The state employee health plan and any self-funded public or private sector health plans that may be permitted to participate with the state in a joint PBM reverse auction purchasing pool shall retain full autonomy over determination of their respective prescription drug formularies and pharmacy benefit designs and shall not be required to adopt a common drug formulary or common prescription pharmacy benefit design. Any such entity or purchasing group shall agree, before participating in the PBM reverse auction, to accept the prescription drug pricing plan that is selected through the PBM reverse auction process.

VII. Any PBM providing services to the department or a self-funded health plan as described in paragraphs IV and V, shall provide the department and the plan the complete pharmacy claims data necessary to conduct the reverse auction and carry out their administrative and management duties.

VIII. The department may adopt rules, pursuant to RSA 541-A, to implement the provisions of this subdivision.

4 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

5 Effective Date.

I. Sections 1 and 2 of this act shall take effect January 1, 2021.

II. The remainder of this act shall take effect upon passage.

2020-1063s

AMENDED ANALYSIS

This bill regulates the maximum allowable cost for prescription drug benefits paid by health insurers or pharmacy benefit managers.

This bill also establishes the New Hampshire prescription drug competitive marketplace.

Committee Minutes

SENATE CALENDAR NOTICE
Commerce

Sen Kevin Cavanaugh, Chair
Sen Jon Morgan, Vice Chair
Sen Donna Soucy, Member
Sen Chuck Morse, Member
Sen Harold French, Member

Date: January 16, 2020

HEARINGS

Tuesday	01/21/2020
(Day)	(Date)

Commerce	State House 100	1:00 p.m.
(Name of Committee)	(Place)	(Time)

1:00 p.m.	**SB 685-FN**	establishing a wholesale prescription drug importation program.
1:15 p.m.	**SB 688-FN**	prohibiting price gouging in the sale of prescription drugs.
1:30 p.m.	**SB 690**	relative to prescription drug formulary changes.
1:45 p.m.	**SB 687-FN**	relative to transparency in prescription drug pricing and establishing a New Hampshire prescription drug affordability board.
2:00 p.m.	**SB 689-FN**	relative to the pharmacy anti-steering law.
2:15 p.m.	**SB 686-FN**	relative to rebates paid to pharmacy benefits managers.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 685-FN

Sen. Feltes	Sen. Levesque	Sen. Rosenwald	Sen. Bradley
Sen. Chandley	Sen. Morgan	Sen. Watters	Sen. Cavanaugh
Sen. Fuller Clark	Sen. Sherman	Sen. Hennessey	Rep. Bartlett
Rep. McMahon	Rep. Marsh	Rep. Campion	Rep. Wall

SB 688-FN

Sen. Fuller Clark	Sen. Rosenwald	Sen. Hennessey	Sen. Sherman
Rep. McMahon	Rep. Bartlett		

SB 687-FN

Sen. Sherman	Sen. Morgan	Sen. Dietsch	Sen. Rosenwald
Sen. Fuller Clark	Sen. Hennessey	Rep. Marsh	Rep. McMahon
Rep. Bartlett			

SB 690

Sen. Fuller Clark	Sen. Rosenwald	Sen. Bradley	Sen. Sherman
Rep. MacKay	Rep. Marsh	Rep. Bartlett	Rep. McMahon

SB 689-FN

Sen. Sherman	Sen. Morgan	Sen. Kahn	Sen. Fuller Clark
Rep. Muscatel			

SB 686-FN

Sen. Rosenwald	Sen. Fuller Clark	Sen. Morgan	Sen. Watters
Sen. Levesque	Sen. Chandley	Sen. Hennessey	Sen. Feltes
Sen. Kahn	Sen. Cavanaugh	Sen. Bradley	Sen. Carson
Rep. Williams	Rep. Muscatel	Rep. Marsh	Rep. McMahon

Aaron Jones 271-1403

Kevin Cavanaugh
Chairman

SENATE CALENDAR NOTICE
Commerce

Sen Kevin Cavanaugh, Chair
Sen Jon Morgan, Vice Chair
Sen Donna Soucy, Member
Sen Chuck Morse, Member
Sen Harold French, Member

Date: January 23, 2020

HEARINGS

Tuesday	01/28/2020
(Day)	(Date)

Commerce	State House 100	1:00 p.m.
(Name of Committee)	(Place)	(Time)

1:00 p.m.	**SB 686-FN**	relative to rebates paid to pharmacy benefits managers.
		(THE PREVIOUS HEARING FOR SB 686-FN WAS RECESSED ON JANUARY 21ST)
1:15 p.m.	**SB 708-FN**	relative to treatment alternatives to opioids.
1:30 p.m.	**SB 513-FN**	relative to vehicle repair standards.
1:45 p.m.	**SB 710-FN**	establishing a homeowners' association act.
2:00 p.m.	**SB 709-FN**	relative to the definition of controlled drug analog.
2:15 p.m.	**SB 739-FN**	relative to mental health and substance use disorder insurance coverage.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 686-FN

Sen. Rosenwald	Sen. Fuller Clark	Sen. Morgan	Sen. Watters
Sen. Levesque	Sen. Chandley	Sen. Hennessey	Sen. Feltes
Sen. Kahn	Sen. Cavanaugh	Sen. Bradley	Sen. Carson
Rep. Williams	Rep. Muscatel	Rep. Marsh	Rep. McMahon

SB 708-FN

Sen. Carson	Sen. French	Sen. Bradley	Rep. Lundgren
Rep. McMahon	Rep. Klein-Knight		

SB 513-FN

Sen. Birdsell	Sen. Watters	Sen. Bradley	Rep. Packard
Rep. Weyler	Rep. Williams	Rep. Steven Smith	

SB 710-FN

Sen. Fuller Clark

SB 709-FN

Sen. D'Allesandro	Sen. Rosenwald	Sen. Hennessey	Sen. Giuda
Sen. Cavanaugh			

SB 739-FN

Sen. Sherman	Sen. Watters	Sen. Morgan	Sen. Hennessey
Sen. Bradley	Rep. Indruk	Rep. Marsh	Rep. Fothergill

Aaron Jones 271-1403

Kevin Cavanaugh
Chairman

Senate Commerce Committee

Aaron Jones 271-1403

SB 686-FN, relative to rebates paid to pharmacy benefits managers.

Hearing Date: January 28, 2020

Time Opened: 1:01 p.m. **Time Closed:** 1:24 p.m.

Members of the Committee Present: Senators Cavanaugh, Morgan, Soucy, Morse and French

Members of the Committee Absent : None

Bill Analysis: This bill requires pharmacy benefit managers to pass rebates paid by manufacturers on to the consumer or health benefit plan.

Sponsors:

Sen. Rosenwald	Sen. Fuller Clark	Sen. Morgan
Sen. Watters	Sen. Levesque	Sen. Chandley
Sen. Hennessey	Sen. Feltes	Sen. Kahn
Sen. Cavanaugh	Sen. Bradley	Sen. Carson
Rep. Williams	Rep. Muscatel	Rep. Marsh
Rep. McMahon		

Who supports the bill: Senator Cindy Rosenwald, Senator Kevin Cavanaugh, Senator Sharon Carson, Senator Jay Kahn, Senator Martha Hennessey, Senator Martha Fuller Clark, Senator Jon Morgan, Senator Dan Feltes, Senator David Watters, Senator Melanie Levesque, Senator Shannon Chandley, Representative Wendy Chase, Representative William Marsh, Representative Cam Kenney, Holly Stevens (New Futures), Glenn Brackett (NH AFL-CIO), Louise Spencer, Susan Covent, Cheri Falk, Melissa Bernardiu (SEA/SEIU 1984), Randy Hoyer, Angela Shepard (NH Rare Disorders Association), Kathy Cahill, Fran Wendelbee (NHIPA), Sara Lutat (Dismas Home), Epilepsy Association of New England, Beverly Goodell (LFNE), Michael Padmore (NH Medical Society), Jay Ward (SEA), Renia Woods, Michael Smith, Brian Hawkins (NEA-NH), Dudley Burdge (Commissioner of the NJ Health Benefits Commission)

Who opposes the bill: Sam Hallemeier, Lindsay Nadeau (Cigna), Katie Cole (Tufts Freedom Health Plan), Heidi Kroll (AHIP), Jodi Grimbilas (on behalf of CVS Health)

Who is neutral on the bill: Tyler Brannen (NHID), Paula Rogers (Anthem)

Summary of testimony presented in support:

Senator Cindy Rosenwald

- Roughly 20% of New Hampshire residents are unable to afford their prescription drugs.
- This bill will eliminate excessive prescription drug markups, while also increasing accountability and transparency.
- Senator Rosenwald offered two amendments:
    - The first amendment was suggested by the Insurance Department. Senator Rosenwald stated that the language reflects what already exists in other statutes.
    - The second amendment would permit a reverse auction for the state prescription drug PBM contract to occur. This would only happen if the Commissioner of Administrative Services agrees it. Senator Rosenwald noted that this would provide relief to taxpayers through the elimination of excessive drug costs incurred by state health plans.
        - Through New Jersey's PBM reverse auction, the state saved more than $1 billion in 2 years. Based on savings from NH's current 3-year PBM rate, it's projected NH could save over $55 million.
- PBMs may provide savings to consumers; however, there would be greater cost savings for patients and taxpayers through greater accountability, transparency, and fairness.
- Senator Rosenwald stated it's important to acknowledge that the bill analysis doesn't accurately reflect what the bill would do. In fact, rebates are only one aspect of this bill.
- There are six significant elements to this bill.
    - First, PBMs would have a fiduciary duty to act in the best interest of the insurance carriers that they're contracted with. Similar legislation exists in Maine and it has survived legal challenges.
    - Second, it clarifies that patients are charged the lowest price possible for a drug, including not just the co-pay, but cost sharing.
    - Third, it simplifies and makes the process fairer and more predictable for pharmacies by establishing maximum allowable costs.
    - Fourth, it prohibits spread pricing. This is when a PBM charges more than what it reimburses to pharmacies.
    - Fifth, any drug rebates are required to be returned directly to the patient at the pharmacy counter or used to lower premiums. This provision has been adopted in Maine as well.

- Finally, it requires insurance carriers to exclude the cost of PBM contracts from their medical loss ratio calculations. Those contracts must be considered an administrative cost.

Holly Stevens, New Futures

- Requiring PBMs to act in the best interest of the insurer protects consumers. That's because insurance carriers are already required to act in the best interest of plan beneficiaries.
- This bill would ensure that insurance beneficiaries are charged the least amount on their co-insurance. Currently, if you have a co-insurance of 45%, then you're being charged 45% of the cash price, but not the amount the PBM negotiated.
- Finally, this bill would require that any rebates filter back down to the consumer.

Fran Wendelbee, NHIPA

- She stated that she supported the bill, but she believed there was a drafting error.
  - On page 4, line 5, she thought it should state "(a) Is rated AB..." instead of "(a) Is rated 'A' or 'B'...".

Dudley Burdge, Commissioner of the NJ Health Benefits Commission (provided written testimony)

- In 2016, under bipartisan support, New Jersey adopted a PBM reverse online auction process.
- Between 2017 and 2019, NJ saw prescription drug prices decline dramatically for public employees, retirees, and dependents. Public employee prescription drug savings were $822 million in 2018 and $578 million in 2019.
  - In 2019, there was a decrease in pharmacy plan premiums of 25% for public employees and 18% for early and Medicare retirees.
  - In terms of prescription drug spending, there was a decrease of 4.5% for employees and 13.7% for Medicare retirees. For early retirees, however, there was a 0.2% increase.
- Based on results from the first two years, it's projected that the reverse auction will save NJ approximately $2.5 billion dollars over the 5-year contract.
- Mr. Burdge stated this process creates a competitive market, which helps to drive down costs.
- During the auction process, the state had access to technology that could price incoming bids and show what the ultimate cost would be to the state.

- Through this technology, the state can conduct an ongoing bill review throughout the year.
- Mr. Burdge concluded that the savings to the state are a result of holding PBMs accountable.

Summary of testimony presented in opposition:

Sam Hallemeier, PCMA

- As Senator Rosenwald mentioned, similar legislation has been passed in Maine. However, Maine is still assessing its impact.
- New Hampshire has passed several pieces of legislation that already address components of this bill. For example, SB 226 required PBMs to collect and report how rebates are being used in NH, which is still ongoing.

Heidi Kroll, on behalf of AHIP

- She believed the committee should proceed with caution.
- As Mr. Hallemeier commented, there are provisions that are being addressed under current bills, rulemaking procedures, and study committees.
- In Maine, for instance, there have been problems operationalizing the fiduciary duty language.
- **Senator Morgan** asked if Ms. Kroll could elaborate on the problems Maine has faced trying to operationalize the fiduciary requirements.
    - **Ms. Kroll** stated that she would get back to the committee with more information on these problems.

Jodi Grimbilas, on behalf of CVS Health (provided written testimony)

- This bill would represent a significant departure by not including input from the regulatory community. Further, it fails to reconcile the laws that have already been passed addressing PBMs.
- She stated there were some concerns raised, which the committee should look at further.
    - Some of the definitions contained in section 402-O:1 are incorrect or diverge from existing statutory language. For example, generics and biosimilars are not the same thing.
    - Fiduciary standards established under section 402-O:2 were tried in Maine (2006, then in 2019) and D.C. (2007). These standards led to market disruptions and extensive litigation.
    - Section 402-O:2 also creates a "gag clause", which was addressed in HB 1791 (2018). The "gag clause" permits pharmacists to tell consumers that

the cash price for a prescription might be cheaper. Since this issue has already been covered, she asked how this bill goes further.

- Section 402-O:3 addresses MAC (maximum allowable cost), which once again has already been addressed.
- Section 402-O:4 contains language already in SB 63, which will be returning to the Senate for concurrence. Further, CVS Health already offers clients the choice of whether to apply their rebate to the point of sale or use it to lower premiums.
- Section 402-O:7 would make PBMs file contracts and other records, which may contain private or proprietary information.
- Typically, severability is included in legislation that may cause potential litigation. She stated that instead of adopting the severability amendment, the committee should allow the commission established under SB 226 to vet any potential problems.
- Finally, she stated that she had no position on the reverse auction amendment if the process is the same for all bidders.

- She suggested that committee interim study this bill because it would cause compliance chaos within the industry and create significant disruptions to the commercial market.

Neutral Information Presented:

Paula Rogers, Government Relations Director, Anthem

- Ms. Rogers reiterated that SB 226 established regulatory authority over PBMs and created a study commission on greater transparency for prescription drug costs and rebates. The final report for that commission is due in November 2020.
- She stated that definitions contained within this bill are contrary to what's in SB 63. For example, rebates are treated much more narrowly in this bill.
- Additionally, she didn't see any definitional information on spread pricing, which Senator Rosenwald mentioned.
- She concluded that this bill may be the right thing to do; however, it needs further discussion.

Tyler Brannen, NHID

- In recent years, the legislature has passed several insurance requirements that PBMs must meet. For example, last year, PBMs were required to register if they were contracted with more than one carrier. In theory, however, if a PBM services only one carrier they're exempt from that statute.

AJ
Date Hearing Report completed: February 3, 2020

Speakers

Senate Commerce Committee
SIGN-IN SHEET

Date: 01/21/2020 **Time:** 2:15 p.m.

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing *(please print neatly)*	Support	Oppose	Speaking?	Yes	No
Angela Stepard NH Rare Disorders Association	☒	☐		☐	☐
Sen Watters SD #4	☒	☐		☐	☒
Sen. Melanie Levesque SD12	☑	☐		☐	☑
Sen. Shannon Chandley SD11	☑	☐		☐	☑
B Gordell LFNE	☐	☐		☐	☐
Kathy Cahill Concord	☑	☐		☐	☑
Fran Wendelboe NHIPA	☒	☐		☒	☐
Heidi Kroll / AHIP	☐	☒		☒	☐
PAULA ROGERS / Anthem	☐	☒ in part		☒	☐
Sara Thatcher, BoSmartHome	☑	☐		☑	☐
Epilepsy Association of New England	☑	☐		☐	☐
B Gordell LFNE	☑	☐		☑	☐
Mel Blatt AFL-CIO	☒	☐		☐	☒
Tyler Brannen NH Insurance Dept	☐	☒		☒	☐
Michael Padmore NH Medical Society	☑	☐		☐	☑
JAY WARD SEA	☑	☐		☐	☑
Rep. Cam Kenney Strafford 6	☑	☐		☐	☑
Senator Feltes SD15	☒	☐		☐	☒
Rena Woods Self	☑	☐		☐	☒

Senate Commerce Committee
SIGN-IN SHEET

Date: 01/21/2020 **Time:** 2:15 p.m.

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing *(please print neatly)*

	Support	Oppose	Speaking?	Yes	No
Sen. Cindy Rosenwald District #13	☑	☐		☑	☐
Sen. Sharon Carson SD #11	☑	☐		☐	☑
Sen. Jay Kahn, District #10	☑	☐		☐	☑
Morgan Manoney	☒	☐		☐	☒
Holly Stevens New Futures	☒	☐		☒	☐
[illegible]	☒	☐		☐	☐
[illegible]	☐	☐		☐	☐
Senator Hennessey SD #5	☒	☐		☐	☒
Senator Fuller Clark SD #21	☒	☐		☐	☒
Glenn Brackett NH AFL-CIO	☑	☐		☐	☐
Louise Spencer Concord NH	☑	☐		☐	☑
Rep Chase Strafford Dist 18	☒	☐		☐	☐
Susan Covert Contoocook	☒	☐		☐	☒
Karen Tufts Health Freedom Plan	☐	☒		☐	☒
Dennis Jalbert SEIU Local 1984	☑	☐		☐	☐
Cheri Falk Self	☐	☐		☐	☐
Sam Hallenmeier	☐	☑		☑	☐
Lindsay Nadeau - Cigna	☐	☐		☐	☒
Melissa Bernardin SEA/SEIU 1984	☑	☐		☐	☑
Rep. Margo Carroll 8	X				X
Randy Hayes	Y				

Senate Commerce Committee
SIGN-IN SHEET

Date: 01/21/2020 **Time:** 2:15 p.m.

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking? Yes	Speaking? No
Sen Jen Morgan Dist 23	☑	☐	☐	☑
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Senate Commerce Committee
SIGN-IN SHEET

Date: 01/28/2020 **Time:** 1:00 p.m. (PREVIOUS HEARING WAS RECESSED)

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking?	Yes	No
Michael Padmore NH Medical Society	☑	☐	Speaking?	☐	☑
Michael Smith	☑	☐	Speaking?	☐	☑
Brian Hawkins NEA-NH	☑	☐	Speaking?	☐	☑
Senator Fuller Clark SD#21	☑	☐	Speaking?	☐	☑
Senator Hennessey SD#5	☑	☐	Speaking?	☐	☑
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Senate Commerce Committee
SIGN-IN SHEET

Date: 01/28/2020 **Time:** 1:00 p.m. (PREVIOUS HEARING WAS RECESSED)

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking? Yes	Speaking? No
Sen. Sharon Carson, District 14	X			X
Sen. Jay Kahn, District 10	X			X
Rep. Marsh Carroll 8	X			X
Jodi Grimbilas CVS Health		X	X	
Sen David Watters SD#4	X			X
Dudley Brudge	X		X	

Senate Commerce Committee
SIGN-IN SHEET

Date: 01/28/2020 **Time:** 1:00 p.m. (PREVIOUS HEARING WAS RECESSED)

SB 686-FN An ACT relative to rebates paid to pharmacy benefits managers.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking?	Yes	No
Sen. Melanie Levesque SD12	☑	☐	Speaking?	☐	☑
Sen. Shannon Chandley SD11	☑	☐	Speaking?	☐	☑
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Testimony

Testimony of Jodi Grimbilas, on behalf of CVS Health
SB 686 – relative to rebates paid to pharmacy benefit managers
January 28, 2020

For the record, my name is Jodi Grimbilas and I am here on behalf of CVS Health in opposition to SB 686. CVS Health is a health care company that offers a suite of health care services designed to help consumers stay on a path to better health. I have included a State report for New Hampshire which demonstrates the footprint of CVS Health in our state for your review.

SB 686 represents a significant change in the regulatory scheme for PBMs, without any input from the regulated community. Just last year, SB 226 was passed into law which enacted a new statute for the registration and regulation of PBM's (RSA 402-N). Over the past decade, NH has monitored the practices within the pharmacy industry, including those of PBM's, and has acted in ways to protect consumers with the input of all stakeholders. The bill before you, appears to take the State of Maine's recently passed law that went into effect on January 1st and place it as a new law in NH – without any reconciliation with the laws we currently have and the issues we have addressed. Going though the bill briefly, I'd like to point out just a few of the issues and inconsistencies:

- RSA 402-O:1
  - Definitions section.
    - Many new definitions are broad and unclear. In speaking with some of the pharmacy and regulatory experts at CVS, some of the definitions appear to be incorrect. (ex. "biosimilars are not generics") We need detailed discussions about these new definitions.
    - Several of the definitions are different than the definitions we have in other NH statutes. For example, the definition of "pharmacy benefit manager" is different than the one we passed last year. Other definitions seem to conflict with definitions in the pharmacy statute and managed care statute. (" mail order pharmacy" and "covered person") From a compliance standpoint, this is a significant problem.

- RSA 402-O:2
  - Oversight & Contract Responsibility.
    - Section I states a health carrier is responsible for its subcontractor PBM. This seems to be government micromanaging private contracts.
    - Section II requires a fiduciary standard. The issue of fiduciary has been before this legislature several times before in 2006 & 2007. Both bills eventually died in the House. The concept of fiduciary was passed in Maine and Washington DC in 2003 and 2004 respectively. After extended litigation and market disruption, Maine repealed their fiduciary requirement – which as of last year, they enacted once again. Washington DC also faced litigation. Ultimately, several of the provisions of the DC law were deemed to be preempted by federal ERISA laws and thus unconstitutional.
    - Section III of this section appears to be aimed at what has been deemed the "gag clause" issue that was addressed by the passage of HB 1791 in 2018. The issue pertains to making sure the pharmacist can provide a consumer options that may lower their costs at the counter. The language is a little different, but

without knowing more about the intent of the section, the issue may already be covered.

- Section IV of this section pertains to allowing consumers always get the lowest price. This again has been the subject of legislation and rulemaking (Ins 2704) in NH. The question that belies this section is what problems are there with NH's current laws & practices? This particular issue led to protracted disagreements between pharmacists and the DOI. I would note that pharmacies have the ability to file complaints under Insurance Regulation 2704 – I have included the Ins. Dept. quarterly reports which are available on-line. There have been no complaints.
- Section V appears to redefine network adequacy specifically for pharmacies. Is there a current issue with the network adequacy requirements in NH? As NH has been an "any willing pharmacy" state where any pharmacy can join a network so long as it agrees to the same terms and conditions, it is not clear where the need is for this new section.

- RSA 402-O:3
  - Maximum Allowable Cost. In 2016, effective 2017, Rep. Luneau worked with stakeholders specifically on MAC pricing and the process of how it can be used in New Hampshire. This new section appears to make changes, but we have no idea, or testimony as to why a change is needed. The section (particularly section VI) specifically appears to govern payments between a health carrier and a pharmacy. Are we really seeking to set prices and payments in statute? We believe this will have the effect of eliminating any type of competition in the marketplace and increasing prices for consumers. Overall it seems in one section you are trying to achieve the lowest cost for consumers, but in a separate section, you are seeking to achieve a higher payment for pharmacies. Its not clear how these policies will interact and what the unintended consequences will be.

- RSA 402-O:4
  - This section specifically deals with rebates and the choice of whether the rebates goes directly to the consumer or whether it is used to help lower premiums. This is essentially the same language as is in SB 63, which has passed the House and will be coming back to this Committee for a decision on concurrence. CVS Health already offers its clients the choice of offering Point of Sale rebates or using rebate dollars to lower premiums. As it is a practice that appears to be adopted in the marketplace, its not clear this provision is necessary – but you already have a vehicle for it if it is.

- RSA 402-O:5
  - Pharmacy & Therapeutics Committee. This is an issue that has never been raised to my knowledge. It is not clear if there is an issue that needs to be addressed. If so, we would like to understand the problem. We would note that there are currently CMS standards in this area and that from a compliance standpoint, it would make sense that those federal standards not be in conflict with what is being considered here.

- RSA 402-O:6
  - Audits. In 2013, Sen. Cataldo brought forth SB 38 relative to pharmacy audits. Stakeholders spent months negotiating a process that was fair to all parties and it

passed into law. It is not clear from the testimony what the problems have been, if any, under current NH law.

- RSA 402-O:7 Compensation
    - This section appears to govern compensation to pharmacy benefit managers and requires filing of contracts and records to the Department that would include sensitive confidential and proprietary information. Again, this seems to be a major step from the law that we passed last year to register and regulate PBMs that is currently in the process of rulemaking.

There were two amendments proposed at the hearing:

- DOI suggested an amendment on "Severability." While I have not seen the amendment, typically a severability clause is included when there is an expectation of litigation. Rather than enact a law that has the potential of litigation, it seems it would be a better path to include these issues in the ongoing SB 226 Transparency Study Commission that has a final report due at the end of the year. With the level of compliance issues for the regulated PBM's, there needs to be significant stakeholder engagement.

- The second amendment relative to permitting the state to undertake a "reverse auction" procurement for PBM services – we have no position on that amendment. It is up to the State on how it wishes to procure its services. As long as a process is the same for all bidders – we would have no position.

Finally, I would note that the legislation only impacts the commercial market. The State Employees pharmacy benefits plan, plans under ERISA and the Managed Medicaid plans are not covered under this bill. We believe that SB 686 will create significant market disruption and compliance chaos for the industry and its clients. We ask that the Committee consider sending the bill to Interim Study and allowing the SB 226 Commission to continue its work.

Thank you for the opportunity to testify.

PUBLIC Law, Chapter 469

SP0466
LD 1504

on - Session - 129th Maine Legislature

An Act To Protect Consumers from Unfair Practices Related to Pharmacy Benefits Management

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1711-E, sub-§1, ¶G, as amended by PL 2011, c. 443, §1, is further amended to read:

G. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section ~~1913~~ 4347, subsection ~~1, paragraph A~~ 17.

Sec. 2. 22 MRSA §8702, sub-§8-B, as amended by PL 2011, c. 443, §3, is further amended to read:

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section ~~1913~~ 4347, subsection ~~1, paragraph A~~ 17.

Sec. 3. 24-A MRSA §601, sub-§28, as enacted by PL 2009, c. 581, §3, is repealed.

Sec. 4. 24-A MRSA §601, sub-§28-A is enacted to read:

28-A. Pharmacy benefits manager. Pharmacy benefits manager licensing fees may not exceed:

A. Original issuance fee, $100; and

B. Renewal fee, $100.

Sec. 5. 24-A MRSA §1913, as repealed and replaced by PL 2011, c. 443, §4, is repealed.

Sec. 6. 24-A MRSA §4317, sub-§12, as enacted by PL 2015, c. 450, §1, is repealed.

Sec. 7. 24-A MRSA §4317, sub-§13, as enacted by PL 2017, c. 44, §1, is repealed.

Sec. 8. 24-A MRSA c. 56-C is enacted to read:

CHAPTER 56-C

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

§ 4347. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Average wholesale price. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

2. Brand-name drug. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

3. Carrier. "Carrier" has the same meaning as in section 4301-A, subsection 3, except that "carrier" does not include a multiple-employer welfare arrangement, as defined in section 6601, subsection 5, if the multiple-employer welfare arrangement contracts with a 3rd-party administrator to manage and administer health benefits, including benefits for prescription drugs. "Carrier" also includes the MaineCare program pursuant to Title 22, chapter 855 and the group health plan provided to state employees and other eligible persons pursuant to Title 5, section 285.

4. Compensation. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

5. Cost-sharing amount. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

6. Covered person. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health plan. "Covered person" includes the authorized representative of a covered person.

7. Dispensing fee. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

8. Formulary. "Formulary" means a list of prescription drugs covered by a health plan and any tier levels applicable to a prescription drug.

9. Generic drug. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

10. Health plan. "Health plan" has the same meaning as in section 4301-A, subsection 7.

11. Ingredient cost. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

12. Mail order pharmacy. "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, by fax or through electronic submissions and to dispense medication to covered persons through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.

13. Maximum allowable cost. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

14. Network pharmacy. "Network pharmacy" means a licensed retail pharmacy or other pharmacy provider that contracts with a pharmacy benefits manager.

15. Pharmacy. "Pharmacy" means an established location, either physical or electronic, that is licensed by the State and that has entered into a network pharmacy contract with a pharmacy benefits manager or carrier.

16. Pharmacy and therapeutics committee. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a carrier to develop and maintain formularies.

17. Pharmacy benefits manager. "Pharmacy benefits manager" means a person, business or other entity that, pursuant to a contract or under an employment relationship with a carrier, a self-insurance plan or other 3rd-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, self-insurance plan or other 3rd-party payer, including, but not limited to, processing and paying claims for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudicating appeals or grievances related to prescription drug coverage, contracting with network pharmacies and controlling the cost of covered prescription drugs.

18. Pharmacy provider. "Pharmacy provider" means a retail pharmacy, mail order pharmacy or licensed pharmacist.

19. Retail pharmacy. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this State and that dispenses medications to the public.

§ 4348. Licensure of pharmacy benefits managers

Beginning January 1, 2020, a person may not act as a pharmacy benefits manager in this State without first obtaining a license from the superintendent in accordance with this section and paying the licensing fee required under section 601, subsection 28-A.

1. Applicant information. An applicant for licensure as a pharmacy benefits manager must file with the superintendent at least the following information:

A. The name of the applicant;

B. The address and telephone number of the applicant;

C. The name and address of the applicant's agent for service of process in the State;

D. The name and address of each person beneficially interested in the applicant; and

E. The name and address of each person with management or control over the applicant.

2. Qualification. The superintendent may issue a pharmacy benefits manager license to an applicant only if the superintendent is satisfied that the applicant possesses the necessary organization, expertise and financial integrity to supply the services sought to be offered.

3. Restrictions permitted. The superintendent may issue a pharmacy benefits manager license subject to restrictions or limitations, including the type of services that may be supplied or the activities in which the pharmacy benefits manager may engage.

4. Valid for 3 years. A license issued pursuant to this section is valid for a period of 3 years and must be renewed.

5. Nontransferable. A license issued pursuant to this section is not transferable.

6. Suspension, revocation or probationary license. The superintendent may suspend, revoke or place on probation a pharmacy benefits manager license under any of the following circumstances:

A. The pharmacy benefits manager has engaged in fraudulent activity that constitutes a violation of state or federal law;

B. The superintendent has received consumer complaints that justify an action under this subsection to protect the safety and interests of consumers;

C. The pharmacy benefits manager fails to pay the original issuance or renewal fee for the license; or

D. The pharmacy benefits manager fails to comply with a requirement set forth in this chapter.

7. Penalty for failure to obtain license. If a pharmacy benefits manager acts without obtaining a license pursuant to this section, the pharmacy benefits manager is subject to a fine of $5,000 per day for the period the pharmacy benefits manager is found to be in violation.

8. Rules. The superintendent may adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to administer and enforce the requirements of this

section.

9. Enforcement. The superintendent may enforce this section under sections 220 and 223 and other provisions of this Title.

10. Registration remains effective until January 1, 2020 or registration date. The registration of a pharmacy benefits manager issued during 2019 in accordance with former section 1913 remains valid until January 1, 2020 or the next yearly anniversary of the registration date, whichever is later. Upon expiration of that registration, the pharmacy benefits manager shall obtain a license under this section in order to do business in this State.

§ 4349. Oversight and contracting responsibilities

1. Compliance. A carrier is responsible for monitoring all activities carried out by the carrier, or all activities carried out on behalf of the carrier by a pharmacy benefits manager if the carrier contracts with a pharmacy benefits manager, related to a carrier's prescription drug benefits and for ensuring that all requirements of this chapter are met.

2. Fiduciary duty. A carrier that contracts with a pharmacy benefits manager to perform any activities related to the carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty to the carrier in the pharmacy benefits manager's management of activities related to the carrier's prescription drug benefits.

3. Contract requirements. A carrier may not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

A. Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's carrier if the cash price is less than the covered person's cost-sharing amount; or

B. Providing information to a state or federal agency, law enforcement agency or the superintendent when such information is required by law.

4. Excess payments at point of sale prohibited. A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

A. The applicable cost-sharing amount for the prescription drug;

B. The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and

C. The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.

5. Adequate network. A carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network. The superintendent may adopt rules as necessary to carry out the purposes of this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

§ 4350. Prescription drug pricing; maximum allowable cost

1. Single maximum allowable cost list. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider.

2. Listing of prescription drug. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

A. Is rated as "A" or "B" 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 an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

B. Is not obsolete and is generally available for purchase in this State from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

3. Changes to maximum allowable cost list. A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a process for removing a prescription drug from a maximum allowable cost list or modifying a maximum allowable cost for a prescription drug in a timely manner to remain consistent with changes to such costs and the availability of the drug in the national marketplace.

4. Disclosure. With regard to a pharmacy with which the carrier, or the pharmacy benefits manager under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits manager under contract with a carrier, shall:

A. Upon request, disclose the sources used to establish the maximum allowable costs;

B. Provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a maximum allowable cost list; and

C. At least once every 7 business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable payment available to a pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits manager under contract with a carrier.

5. Appeal procedure. A carrier, or a pharmacy benefits manager under contract with a carrier, shall provide a reasonable administrative appeal procedure,

including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

6. Resolution of appeals. A carrier, or a pharmacy benefits manager under contract with a carrier, shall respond to, investigate and resolve an appeal under subsection 5 within 14 days after the receipt of the appeal. The carrier or pharmacy benefits manager shall respond to an appeal as follows:

A. If the appeal is upheld, the carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

B. If the appeal is denied, the carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

7. Average wholesale price; use of a prescription drug not on maximum allowable cost list. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a carrier, or a pharmacy benefits manager under contract with a carrier, must use only one national drug pricing source during a calendar year, except that a carrier, or a pharmacy benefits manager under contract with a carrier, may use a different national drug pricing source if the original pricing source is no longer available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

8. Payment. This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider.

A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier.

C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection.

D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

§ 4350-A. Responsibility to use compensation for benefit of covered persons

1. Compensation used to reduce point-of-sale costs, improve benefits or lower premiums. All compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier, or to a pharmacy benefits manager under contract with a carrier, related to its prescription drug benefits must be:

A. Remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular prescription drug; or

B. Remitted to, and retained by, the carrier. Compensation remitted to the carrier must be applied by the carrier in its plan design and in future plan years to offset the premium for covered persons.

2. Compliance. Beginning March 1, 2021 and annually thereafter, a carrier shall file with the superintendent a report in the manner and form determined by the superintendent demonstrating how the carrier has complied with this section.

§ 4350-B. Prescription drug formularies; pharmacy and therapeutics committee

1. Pharmacy and therapeutics committee; use of formulary. A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a pharmacy and therapeutics committee. A carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the carrier's pharmacy benefits manager to use one or more formularies.

2. Pharmacy and therapeutics committee; no conflict of interest for members. A carrier, or a pharmacy benefits manager under contract with a carrier, may not allow a person with a conflict of interest, as described in paragraph A or B, to be a member of its pharmacy and therapeutics committee. A person may not serve as a member of a pharmacy and therapeutics committee if the person:

A. Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor; or

B. Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

3. Compensation prohibited. A carrier, or a pharmacy benefits manager under contract with a carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

§ 4350-C. Access to records; audits

1. Requirements; record keeping. A carrier shall maintain and have the ability to access all data related to the administration and provision of prescription drug benefits under a health plan of a carrier, including, but not limited to:

A. The names, addresses, member identification numbers, protected health information and other personal information of covered persons; and

B. All contracts, documentation and records, including transaction and pricing data, related to the dispensing of prescription drugs to covered persons under the health plan.

2. Compliance with federal law. A sale or transaction involving the transfer of any records, information or data described in subsection 1 must comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the federal Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 and any regulations adopted pursuant to those laws.

3. Audit records. A carrier may audit all transaction records related to the dispensing of prescription drugs to covered persons under a health plan of the carrier. A carrier may conduct audits at a location of its choosing and with an auditor of its choosing.

4. Maintenance of records. A carrier shall maintain all records, information and data described in subsection 1 and all audit records described in subsection 3 for a period of no less than 5 years.

5. Authority of superintendent. Upon request, a carrier shall provide to the superintendent any records, contracts, documents or data held by the carrier or the carrier's pharmacy benefits manager for inspection, examination or audit purposes.

§ 4350-D. Treatment of pharmacy benefits manager compensation

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

B. "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health plan.

2. Pharmacy benefits manager compensation included as administrative cost. If a carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

A. Constitutes an administrative cost incurred by the carrier in connection with a health plan; and

B. May not constitute a benefit provided under a health plan.

A carrier may claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

3. Calculation of pharmacy benefits manager compensation. Each rate filing submitted by a carrier with respect to a health plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager must include:

A. A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

B. Such records and supporting information as the superintendent reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

4. Records. Upon request, a carrier shall provide any records to the superintendent that relate to the calculation of the pharmacy benefits manager compensation.

5. Documentation from pharmacy benefits manager. A pharmacy benefits manager shall provide any necessary documentation requested by a carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

§ 4350-E. Effective date

This chapter takes effect January 1, 2020.

Sec. 9. Effective date. This Act takes effect January 1, 2020.

Effective 90 days following adjournment of the 129th Legislature, First Regular Session, unless otherwise indicated.

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PART Ins 2704 PRESCRIPTION PRICES FOR PHARMACISTS AND PHARMACIES

Statutory Authority: RSA 400-A:15, I; RSA 415:26; RSA 420-J:7-b, X; and RSA 420-J:12

Ins 2704.01 Scope. This part shall apply to all health benefit plans providing prescription benefits through a network of participating pharmacies.

Source. #12121, eff 2-24-17

Ins 2704.02 Definitions.

(a) "Commissioner" means the insurance commissioner.

(b) "Covered benefits" means those health care services and other medical services to which a covered person is entitled under the terms of a health benefit plan, including pharmacy benefits.

(c) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(d) "Contracted copayment" means a fixed amount an individual is responsible to pay for covered prescriptions as set forth in the health benefit plan, or the price for filling the prescription as contracted between the health carrier or its pharmacy benefits manager and the pharmacy, whichever is less.

(e) "Health benefit plan" means a plan, policy, or certificate of insurance that constitutes health coverage as defined in RSA 420-G:2, IX.

(f) "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the covered costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(g) "New Hampshire pharmacy board" means the board established in RSA 318:2.

(h) "Participating pharmacy" means a pharmacy that, under a contract with the health carrier or its contractor or subcontractor, including any pharmacy benefits manager, has agreed to provide pharmacy services to covered persons with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly, from the health carrier.

(i) "Pharmacist" means a person defined in RSA 318:1, XI.

(j) "Pharmacy benefits manager"' means a "pharmacy benefits manager" as defined in RSA 420-J:3, XXVIII-a.

Source. #12121, eff 2-24-17

Ins 2704.03 Claims Processing.

(a) Every health carrier that provides prescription benefits as a covered benefit under a health benefit plan shall ensure that prescription benefit claims are adjusted and paid in accordance with the requirements of Ins 1001 and RSA 420-J:8-a.

(b) Any health carrier or pharmacy benefits manager shall require all participating pharmacies to charge any covered person the lesser of:

(1) The pharmacy's usual and customary price for filling the prescription; or

(2) The contracted copayment.

(c) The health carrier or pharmacy benefits manager shall not be in violation of this section when the conditions set forth in RSA 420-J:8-a, IV exist, or the claim has been submitted fraudulently or with inaccurate or misrepresented information.

Source. #12121, eff 2-24-17

Ins 2704.04 Complaint Process.

(a) Any pharmacy that fills prescriptions as a covered benefit under a health benefit plan and is adversely affected by the failure of a health carrier or a pharmacy benefits manager to comply with RSA 420-J:7-b, X or RSA 415:26 may file a complaint with the commissioner.

(b) Complaints alleging violations of RSA 420-J:b, X or RSA 415:26 and received directly from pharmacies or referred from the New Hampshire pharmacy board to the commissioner shall be investigated by the commissioner in accordance with the provisions of RSA 400-A:16.

(c) The commissioner shall only investigate substantiated complaints that relate to a fully insured plan within the commissioner's jurisdiction.

(d) A "substantiated complaint" means a complaint that includes all the following information:

(1) The name, address, and license number of the pharmacy filing the complaint;

(2) The name and license number of, and the contact information for, a pharmacist who supports the allegations in the complaint filed;

(3) Information concerning the prescription, including the name of the prescription dispensed and the quantity and dose of the prescription dispensed, with units expressed in terms of volume, number of tablets or capsules, weight, or in other measurement;

(4) The name of the health carrier and the name of the pharmacy benefits manager, if a pharmacy benefits manager is involved in the prescription claim made by the consumer;

(5) A legible copy of the front and back of the consumer's insurance card for prescription benefits;

(6) The name of the subscriber to the health benefit plan, if that information is not shown on the consumer's insurance card;

(7) The date the pharmacy dispensed the prescription to the consumer;

(8) The name of the consumer that requested coverage for the prescription at issue in the complaint; and

(9) Written evidence that supports the allegations of violation.

(e) The commissioner shall inform the pharmacy if the filed complaint is unsubstantiated and what missing information is needed.

(f) The commissioner shall hold any complaint that is not substantiated in pending status for 90 days from the date of the notice described in (e) to allow the pharmacy to submit required missing information. If

missing information is not provided within 90 days of the date of the notice described in (e), the complaint that is not substantiated shall be closed.

Source. #12121, eff 2-24-17

Ins 2704.05 Enforcement. A health carrier or pharmacy benefits manager, when acting in connection with a fully insured plan under the commissioner's jurisdiction, shall be subject to action under RSA 400-A:15, in accordance with the notice and hearing requirements of RSA 400-A:16-24 and Ins 200 for acts or practices in violation of this part.

Source. #12121, eff 2-24-17

Ins 2704.06 Reporting to the New Hampshire Board of Pharmacy.

(a) The commissioner shall prepare public reports in regard to the complaints received from pharmacies or the New Hampshire board of pharmacy under this part.

(b) The public report shall contain the following information:

(1) A unique numerical identifier for each complaint received;

(2) The name, address, and license number of the pharmacy filing the complaint;

(3) The name and license number of the pharmacist who supports the allegations in the complaint filed;

(4) The name of the health carrier and the name of the pharmacy benefits manager, if a pharmacy benefits manager is involved in the prescription claim made by the consumer;

(5) The date the complaint was received;

(6) The nature of the complaint received, to include the prescription at issue, the facts concerning the complaint, and the section of rule or law that is alleged to have been violated;

(7) The status of the investigation or an indication that the complaint is in pending status, awaiting information from the pharmacy;

(8) The date of the final resolution of the complaint, if the complaint has been resolved; and

(9) A description of the final resolution of the complaint, to include the legal and factual findings of the commissioner as to the alleged violation.

(c) The report shall be posted electronically on the department's website at http://www.nh.gov/insurance/ at least quarterly and shall also be transmitted to the New Hampshire board of pharmacy.

(d) The commissioner shall provide to any complaining pharmacy, upon request, a report of the status of complaints filed by that pharmacy, which shall contain the information set forth in (b) above.

Source. #12121, eff 2-24-17

Ins 2704.07 Confidentiality. In accordance with RSA 400-A:16, III, and except as otherwise provided in this part, all information collected, obtained, or otherwise in the control or possession of the commissioner from any source relating to any investigation pursuant to this part shall be confidential by

law and privileged, shall not be subject to RSA 91-A, shall not be subject to subpoena, and shall not be subject to discovery or admissible as evidence in any private civil action.

Source. #12121, eff 2-24-17

Ins. 2704 - Pharmacy Complaints

Jan. 01, 2019 - Mar. 31, 2019

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
No Reportable Data														

Ins. 2704 - Pharmacy Complaints

April 01, 2019 - June 30, 2019

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
No Reportable Data														

Ins. 2704 - Pharmacy Complaints

July 01, 2019 - September 30, 2019

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
No Reportable Data														

Ins. 2704 - Pharmacy Complaints

October 01, 2019 - December 31, 2019

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
No Reportable Data														

Ins. 2704 - Pharmacy Complaints

Jan. 01, 2018 - Mar. 31, 2018

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
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Ins. 2704 - Pharmacy Complaints

April 01, 2018 - June 30, 2018

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
No Reportable Data														

Ins. 2704 - Pharmacy Complaints

July 01, 2018 - Sept. 30, 2018

Case #	Name Pharmacy	Address Pharmacy	License # Pharmacy	Name Pharmacist	License # Pharmacist	Name Carrier	Name PBM	Opened Date	Complaint Description	Prescription	Statute / Rule Violated	Case Status	Closed Date	Resolution & Findings
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No Reportable Data														

LUPUS
FOUNDATION
NEW ENGLAND

January 21, 2020

Senate Commerce Committee
NH State Senate
107 N. Main Street
Concord, NH 03301

Dear Chairman Cavanaugh and Members of the Committee:

Thank you for allowing me the opportunity to address you in this hearing. My name is Beverly Goodell, I am the Executive Director of the Lupus Foundation of New England. The mission of the Lupus Foundation is to educate and support people with lupus, promote awareness and fund scientific research that will lead to better treatments and ultimately a cure.

I have the fortunate opportunity to help patients and families that have been affected by Lupus. I am hear in support of Senate Bill 686 because I feel strongly that you too have the opportunity to directly help patients afford their medications.

As people struggle every day to afford their out of pocket healthcare costs, this is a clear cut way to alleviate some of that burden by mandating that rebates, or simply cost savings, are passed on to patients instead of being pocketed somewhere along the prescription medicine pipeline.

By supporting Senate Bill 686, we have the ability to lower premiums for Granite Staters or even saving patients money at the point of sale. We all know someone that at one point in their lives have struggled to afford either their medications or treatment. This is a wonderful opportunity for the state to reduce that burden, and with the rising cost of healthcare it's refreshing to think we can actually put some money back in the patient's pocket.

With that in mind, I'll close by urging you to support Senate Bill 686.

Sincerely,

Beverly Goodell
Executive Director
Lupus Foundation New England
40 Speen Street, Suite 101
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DISMAS HOME
NEW HAMPSHIRE

Dear Chairman Cavanaugh, Vice-Chair Morgan and members of the Committee:

My name is Sara Lutat, and I am the Executive Director of Dismas Home New Hampshire. Senate Bill 686 focuses on saving patient's money by reducing out of pocket expenses on their prescription drugs which is why I want to encourage you to support it.

It's vital that we find ways to pass savings on to Granite Staters and rebates are a great start. Rebates help many insured patients who are struggling with increasing out-of-pocket health care costs. Serving as Executive Director of Dismas Home New Hampshire I understand how vital it is for our residents to have ongoing access to medications, many of which live paycheck to paycheck. Personally, I have witnessed the disastrous results when they have to choose between paying for groceries or rent over prescriptions which are necessary for optimal health and sustained recovery. Patients can often struggle with deductibles and copays. Too often it leads to rationing, skipping doses, or worse, forgoing the medication completely, which destabilizes their mental health and affects their sustained recovery.

Rebates help improve access to prescription medicines that are often the difference between living a sustainable life and creating an undue burden which can lead to higher medical costs overall. Thank you for your time and attention to this important issue, in closing, I want to encourage you to support Senate Bill 686

Thank you for your consideration,

Sara J. Lutat MSW/MLADC

Sara J. Lutat, MSW/MLADC
Executive Director
Dismas Home of NH
102 Fourth Street
Manchester, NH 03102
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NEW JERSEY SENATE

STEPHEN M. SWEENEY
SENATE PRESIDENT

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January 21, 2020

Chairman Cavanaugh and Members of the New Hampshire State Senate Commerce Committee:

I am Steve Sweeney, President of the New Jersey Sate Senate. Unfortunately, prior commitments keep me from being with you in person today to testify before your Committee. However, I am pleased to submit this statement about our experience in New Jersey with deployment of 21st century technology to modernize our process for selecting the highest value pharmacy benefits manager, or "PBM," to provide prescription drug benefits to 750,000 New Jersey public sector employees, including State and local government workers, first responders, public school employees, retirees, and dependents. The development of an innovative approach to purchasing prescription medicines that I led with bipartisan support of my colleagues in the New Jersey Senate and Assembly, and in partnership with officials in the previous Administration, our State's public employee unions, and America's Agenda, a non-profit health care coalition and think tank, has yielded enormous, sustained savings for New Jersey taxpayers after we began implementation in 2017.

The innovative prescription drug purchasing feature conducts an online auction, powered by a cutting-edge, "big data" analytics technology platform, to create a dynamic, truly competitive marketplace in which PBMs bid and counter-bid against one another to win the State's business. Think of it as an 'eBay' for PBMs. Rather than trying to choose between extremely complex and diverse PBM drug pricing proposals and then trying to negotiate a good state contract with the selected PBM, we created a competitive marketplace in which PBMs must compete in a transparent, online auction, in an effort to underbid one another over multiple bidding rounds to fulfill a best-in class contract written by the State, the terms of which PBMs are required to accept as a pre-condition for bidding for the State account.

Equally important, our state re-purposed the same technology platform we used to conduct the PBM reverse auction to hold the selected PBM accountable for complying with the terms of our contract by conducting ongoing, automated and very fast review -- within a few hours -- of PBM prescription drug claims invoices throughout the duration of the pharmacy benefits contract. This real-time PBM bill review process enabled quick State reconciliation of PBM overcharges that were flagged within hours of PBM submission of each invoice.

So what were the results?

Reliable projections at conclusion of our first reverse auction set prescription drug savings to the State at **$1.6 Billion** or **18.5%** over a 3-year contract period.

In fact, savings to the State from the automated, online reverse auction and ongoing bill review exceeded this projection. In September 2018, just 9 months into the first plan year under the new pharmacy benefits contract awarded through our PBM reverse auction, Governor Phil Murphy reported that the our technology-enabled PBM selection and accountability process had "reduced pharmacy costs for state and local governments by **over 25%.** Active school employee members will see a sizable difference in their premiums for Plan Year 2019 with rates *decreasing* by 1.1 percent - in stark contrast to the 13% increase they saw last year – even before introduction of the new changes."

These remarkable savings to our state resulted from the combination of both conduct of the technology-enabled PBM reverse auction and our deployment of the same technology platform to electronically audit each PBM invoice claim-by-claim and line-by-line to flag errors and overcharges above prescription drug pricing that should be charged under the new State contract.

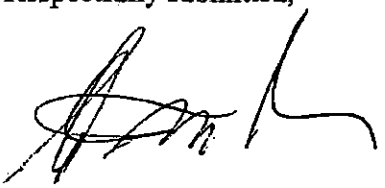
In October 2018, the New Jersey Senate and Assembly unanimously voted to conduct a second reverse auction for early award of a successor pharmacy benefits contract based on our projection that savings to the State could be deepened and extended for additional years beyond the initial agreement. We were correct. In the summer of 2019, the State conducted a second reverse auction for a successor to the PBM contract awarded through our first PBM reverse auction of 2017. The PBM that had won the first reverse auction in 2017 re-won award of the State contract in our 2019 reverse auction. Prescription drug savings were extended to State taxpayers and public employees to **$2.5 Billion** over two successor contracts covering a 5-year period from 2018 through 2022.

I'd like to note that the reverse auction is, in fact, an updated, faster, and improved successor to the traditional Request for Proposal process. As such, we found that no change to New Jersey statute was required to implement the dynamically competitive PBM reverse auction process in place of the less optimal, relatively static traditional RFP procedure that the State had previously used. However, we did enact legislation, Senate Bill 2479, that Governor Christie signed into law to enable an expedited RFP process for selection of a technology platform whose capabilities met minimum specifications defined in the bill. As a result, two successive State Administrations of Governor Christie and Governor Murphy both selected Truveris Technologies to operate the technology platform best equipped to conduct our PBM online reverse auction and the ongoing, automated PBM bill review. Whether or not enactment of new law is required in New Hampshire to adopt a process similar to ours in New Jersey, I would recommend strongly that you define the minimum requirements and specifications for technology capable of performing the complex analytics required to conduct a successful PBM reverse auction and ongoing bill review,

as we did in Senate Bill 2749. The procurement of a very capable, independent, technology platform operated, with deep understanding of pharmacy pricing, was crucial to our success in conducting a successful PBM auction and assuring accurate PBM invoicing to the State in "real-time" *before* funds leave the State treasury.

In New Jersey, we are on a mission to transform our state into a disciplined, 21st Century buyer of health care services and prescription medicines that provides public employees the level of benefits they deserve, while also delivering the value for the taxpayer dollars that are entrusted to state government for the benefit of our citizens. I am proud of the advances we've achieved for the people of New Jersey, particularly in the area of lowering, by substantial amounts, the cost of purchasing prescription medicines. Please do not hesitate to call upon me in the future if our experience in New Jersey can provide guidance to achieving your goals for the people of Granite State.

Respectfully submitted,



Stephen M. Sweeney
Senate President

January 21, 2020

The Honorable Kevin Cavanaugh, Chairman
Senate Commerce Committee
State House Room 100
Concord, NH 03301

Re: New Futures' support of SB 686-FN

Dear Chairman Cavanaugh and Members of the Committee:

New Futures appreciates the opportunity to testify in support of SB 686-FN, relative to rebates paid to pharmacy benefit managers. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all New Hampshire residents. In this role, we work extensively with policy makers, health care providers and families to increase access to quality, affordable health care throughout the Granite State.

SB 686-FN is quite complex and would make changes in New Hampshire law that would affect pharmacy benefit managers (PBM), insurers, pharmacies, pharmacists, and insurance beneficiaries. Given the mission of New Futures, this testimony will focus on how SB 686-FN would affect insurance beneficiaries.

First, SB 686-FN would create a fiduciary relationship between PBMs and each insurer that the PBM has a contract with to manage the pharmacy benefit. Currently, the pharmaceutical industry is very opaque with the PBMs acting as middlemen between the insurers and the manufactures, and they also work as middlemen between the insurers and pharmacies. It is unknown what kinds of rebates the PBMs are receiving from the manufactures and what contractual deals they are setting up with the pharmacies. Therefore, it is unknown if they are acting in the best interest of their contractual client, the insurer, or not. SB 686-FN would prohibit an insurer from entering into a contract with a PBM, unless that contract created a fiduciary duty from the PBM to the insurer.

Second, SB 686-FN would ensure that the insurance beneficiary would be charged the lowest cost at the pharmacy counter (cash price, negotiated rate between the PBM and the pharmacy, or the co-share amount). Currently under New Hampshire law, a beneficiary must be charged the lowest amount when the benefit is subject to a copay.[1] SB 686-FN would apply this same standard regardless if the cost sharing is a copay, a co-insurance, or if the pharmacy benefit is subject to a deductible. A beneficiary should not be paying more that the insurer is paying for a prescription medication. When a beneficiary pays more, the overpayment is sent back to the PBM who keeps the money.

The third part of this bill that has a direct impact on insurance beneficiaries, it the section on rebates. It requires that all rebates obtained by the PBMs from the drug manufactures must be passed on to the beneficiary either at the point of sale or through lower premiums. PBMs negotiate rebates with the manufactures in exchange for placement on the formulary. At times, manufactures raise the price of the medication so that they can provide a more substantial rebate. This results in

[1] N.H. RSA 402-N:4(I).

more money going to the manufacturers because of falsely inflated drug prices and money going to the PBMs in the form of large rebates. If the rebates had to be returned to the beneficiaries, then (1) it would make the beneficiary whole and (2) it might stop the game that the manufactures and PBMs play by inflating prices to give larger rebates for placement on the drug formulary.

For these reasons, New Futures urges the Committee to vote ought to pass on SB 686-FN.

Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

Holly A. Stevens, Esq.
Health Policy Coordinator

PCMA

January 28, 2020

Honorable Chair Kevin Cavanaugh
Senate Commerce Committee
New Hampshire State Capitol
Concord, NH 03301

RE: SB 686 - Pharmacy Benefit Managers
Fiduciary Duty

Dear Commerce Committee:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing you to on SB 686, relative to rebates paid to pharmacy benefit managers (PBMs). While PCMA has concerns with the bill as a whole and its various individual policy areas, the subject of "fiduciary duty" is one that has been around for many years and we wish to address that specifically in detail.

In just in the past three years, California, Minnesota and Nevada legislatures have rejected fiduciary requirements. Nevada SB 378 (2019), signed by Governor Sisolak's (D-NV), repealed the fiduciary requirement that the legislature enacted in SB 539 (2017). And as has been relayed to the Committee, Maine enacted a fiduciary duty in 2006 that was repealed a few years later. The issue is also not new to New Hampshire, having been proposed and rejected in legislation as early as 2006.

According to the U.S. Department of Labor (DOL) and federal courts,[1] PBMs are not fiduciaries. ERISA defines the term "fiduciary" as a person who (i) exercises any discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets or (ii) has any discretionary authority or discretionary responsibility in the administration of such plan."[2] The DOL has said that "Third Party Administrators (TPAs)," (which PBMs are) "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform [certain] administrative functions for an employee benefit plan...are not fiduciaries of the plan."[3]

The U.S. Supreme Court has ruled that a person is a fiduciary for an ERISA plan only "to the extent" a person has or exercises such discretionary authority or control on behalf of a plan.'[4] Following this decision, multiple federal courts have ruled that the PBM was not acting in a fiduciary capacity in managing its PBM-related services (e.g., negotiating with drug

[1] Pharm. Care Mgt Ass'n v. District of Columbia, 613 F.3d 179 (D.C. Cir. 2010).
[2] 29 U.S.C. § 1002(21)(A).
[3] 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.
[4] Pegram v. Herdrich, 530 U.S. at 223, 120 S. Ct. 2143.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

manufacturers or retail pharmacies or managing its formulary), but rather managing its own business which did not involve the discretionary control of plan assets.[5]

Imposing fiduciary duties on PBMs would raise drug benefit costs by increasing their legal liability because of the greater potential legal exposure that exists as an entity that exerts control over plan assets (as opposed to one that merely administers a plan, within the benefit parameters established by the plan sponsor). It could also undermine PBMs' ability to effectively implement cost management tools for their clients and increasing projected drug expenditures.

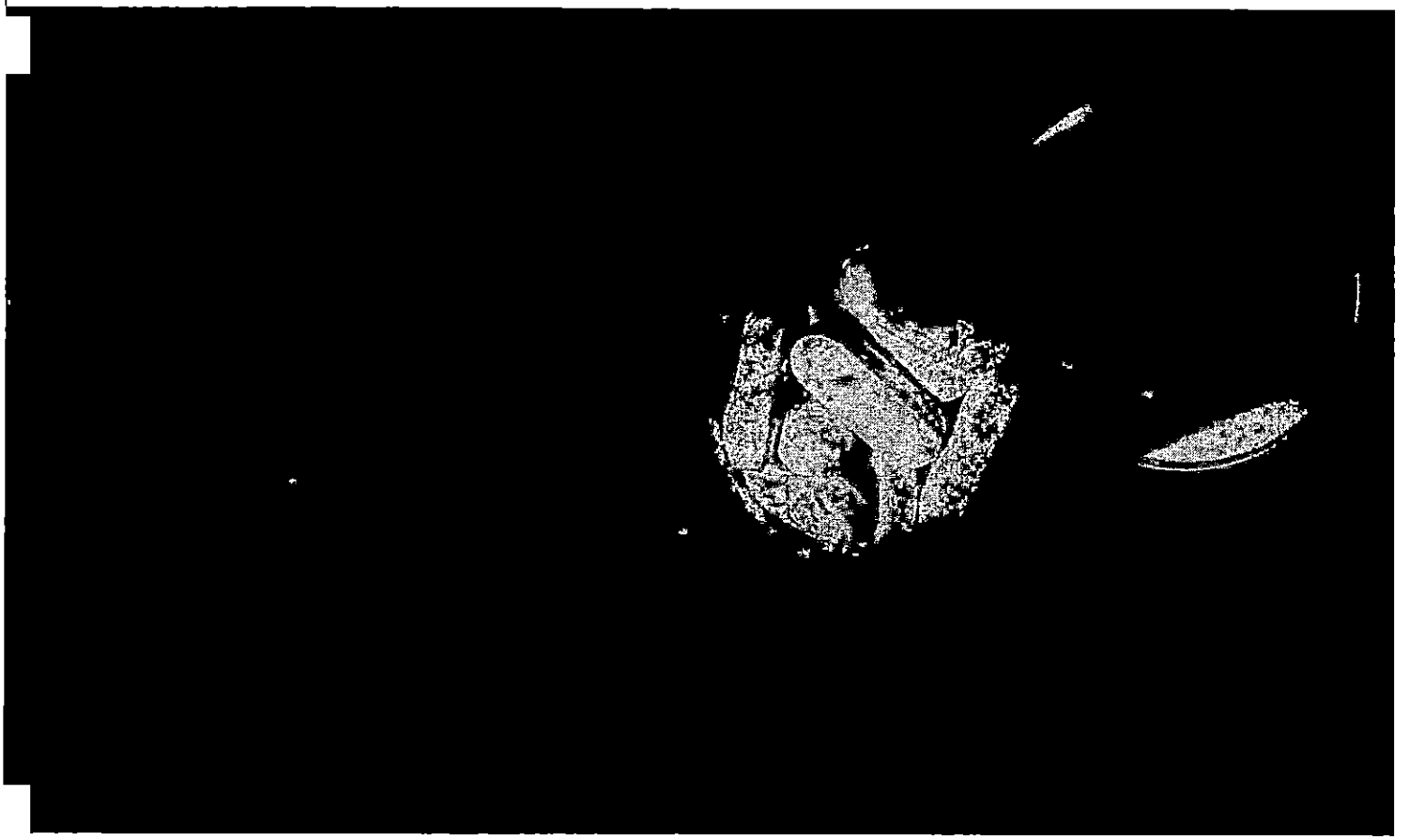
These legal liabilities are just some of the reasons that legislatures across the country have rejected fiduciary requirements that are not appropriate in carrier-PBM relationships. SB 686's fiduciary mandate is preempted by ERISA, and the bill would significantly increase costs in New Hampshire. For these reasons, we respectfully oppose SB 686. We are happy to discuss further. Please contact me at 202-756-5727 if you have any questions. Thank you.

Sincerely,

Sam Hallemeier
Director, State Affairs

PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

[5] See Chicago District Council of Carpenters Welfare Fund. v. Caremark, 474 F.3d 463, (7th Cir. 2007); *see also* Moeckel v. Caremark, Inc., 622 F. Supp. 2d 663 (M.D. Tenn. 2007), and In re Express Scripts/Anthem ERISA Litigation, 2018 WL 339346 (S.D.N.Y. Jan. 5, 2018).



'Cost-cutting' middlemen reap millions via drug pricing, data show

BY LUCAS SULLIVAN AND CATHERINE CANDISKY | THE COLUMBUS DISPATCH

A middleman company hired to keep the state's prescription-drug prices in check for Ohioans on Medicaid is receiving millions in taxpayer money meant to provide medications for the poor and disabled.

than it paid pharmacies to fill the prescriptions. The state-sanctioned practice, known as "spread pricing," allows the middlemen, called pharmacy benefit managers, to keep the difference on medications used to treat health concerns ranging from mental illness to osteoporosis.

CVS Caremark received more than $1.6 million for managing the payment for prescriptions filled by 40 pharmacies in 2017, according to a Dispatch analysis of drug transactions covered by taxpayer-funded Medicaid. The analysis shows that CVS Caremark received roughly 12 percent more from the state than it paid the pharmacies for the drugs.

The pharmacy pricing information provided to The Dispatch contained no patient information.

Although an exact projection of a statewide total flowing to CVS Caremark cannot be made based on this analysis, the figures indicate that it must be tens of millions of dollars. The pharmacies surveyed represent less than 1 percent of the total Medicaid prescriptions filled statewide in 2017 and about 2 percent of pharmacies in the state.

The state spent $3 billion last year for prescription drugs for Medicaid recipients.

The Dispatch analysis provides what might be the first detailed look nationwide behind the curtain of how pharmacy benefit managers such as CVS Caremark make billions of dollars annually. CVS Health Corp., which owns CVS Caremark and CVS Pharmacy, reported a net profit of $9.5 billion in 2017, according to its website.

The company reported $130.6 billion in net revenue from its pharmacy services division.

"The General Assembly has to put on their big-boy and big-girl pants and stop this nonsense," said state Sen. William P. Coley, R-West Chester. "It's easily tens of

Coley said the Department of Medicaid is not providing sufficient administrative oversight of its managed-care plans and the pharmacy benefit managers they hire to oversee drug benefits.

"We have to get ahold of this. It's hurting people," Coley said. "Every dollar we spend in a wasteful manner is a dollar we don't have to help people."

State Medicaid officials declined to comment on The Dispatch's findings, saying they are preparing their own analysis.

"The state's priority is to ensure that Medicaid enrollees have access to pharmaceutical benefits and taxpayers get a fair price. To ensure this, the state is conducting an analysis that includes every pharmacy transaction, not samples, with actual prices and actual spreads. Ohio consumers have every right to fair pricing of their pharmaceuticals. We are diligently working to make sure that happens," Medicaid spokesman Tom Betti said in a written statement.

The report commissioned by Medicaid is expected to be released this month.

Miranda C. Motter, president and CEO of the Ohio Association of Health Plans, would not comment on The Dispatch's findings, but said the analysis is incomplete because it isn't statewide and includes only a fraction of Medicaid spending.

"Spread," she said, "doesn't equal profit." The spread also covers administrative costs such as claims processing, pharmacy help desk, drug-utilization review, clinical programs and audit management, she said.

Others have a different view.

"PBMs have been fighting transparency, accountability and fiduciary obligations for years, and now I think we know why," said Antonio Ciaccia, a lobbyist for the Ohio Pharmacists Association. "PBMs criticize drug companies for inflating their prices. Here it seems they are the ones inflating prices."

drug-claim payment, which might have actually decreased. It is the primal role of managed-care plans to maximize value in all care networks. ... I remain deeply concerned the incentives to all parties are not aligned with the vision of the taxpaying citizen."

CVS Caremark is the pharmacy benefit manager, also known as a PBM, for four of the state's five managed-care contracts; Optum Rx is the other. The Dispatch analyzed data from CVS Caremark because the company, under the same umbrella as the national CVS pharmacy chain, represents the overwhelming majority of Medicaid patients in Ohio.

Mike DeAngelis, senior director of corporate communication for CVS Health, said the company would not comment on either The Dispatch analysis or the company's pricing information until a state analysis is finished. Both the Ohio Department of Medicaid and state Auditor Dave Yost are studying the pricing setup; the auditor recently asked for additional information.

The CVS spokesman said the Medicaid managed-care companies that hired them in Ohio actually requested that their compensation come via spread pricing, as many clients do, "because it provides them with stability and certainty around their drug costs."

"Spread pricing is regularly misrepresented, but it is simply the difference in pricing from what we are paid to what we reimburse — no different than what any business pays its suppliers vs. what it is paid by its end users. ... Under this model, we make money on some drugs, but lose money on others."

DeAngelis also said, "Reimbursement terms and other financial components of any PBM relationship with a client, including CVS Caremark's relationships with the Ohio managed Medicaid plans, are frequently monitored, audited and subjected to both market checks and competitive bidding. These processes are managed by independent third-party industry consultants retained by the clients. This helps

The Dispatch analysis included every Medicaid/Caremark transaction (125,000-plus) at 40 pharmacies in 2017 on a quarterly basis, because that's how often the state reports Medicaid pricing data. And of those 160 quarters examined (40 pharmacies times 4 quarters), 159 showed a price spread. The only exception was one pharmacy that came out $380 ahead in the second quarter. At the other end of the spectrum was an individual pharmacy that wound up short $78,000 in the last quarter of 2017.

Little state scrutiny

The pharmacy data analyzed by The Dispatch confirm suspicions among some Ohio legislators and pharmacists that the PBM middlemen are retaining what some would say is a significant portion of the cost of drugs, affecting prices and how much public money goes to the corporation.

For example, the PBM was given $8.64 per pill by the state for Vyvanse, a drug to treat attention-deficit/hyperactivity disorder and binge-eating disorder, while paying a pharmacy 67 cents per pill to provide it to patients, according to the records.

The state paid CVS Caremark $5.80 per pill for the antipsychotic drug aripiprazole, and $5.50 of that, or almost 95 percent of the taxpayer subsidy, went to CVS Caremark.

Although the data analysis shows that on occasion pharmacies are paid more than the PBM receives from the state, instances of the PBM keeping at least half of the taxpayer money intended to buy drugs are far more prevalent.

The system has a built-in incentive for CVS Caremark and other PBMs to maximize the price spreads: They get to keep the money. Although the PBMs must cover their costs with those dollars, the rest is profit. The debate in Ohio and

Until late last year, Ohio Medicaid officials gave PBMs little scrutiny. Because overall cost increases in the Medicaid program were running 2 percent a year or less, there was not great concern that within that sprawling empire, drug prices were sometimes going up by double-digit percentages annually.

The PBMs point to examples in which they keep the cost of drugs down for Ohio Medicaid recipients. But that appears to be only half of the story.

The cost increases that CVS Caremark mitigates are for brand-name drugs, DeAngelis said in an email to The Dispatch in May. The data obtained by The Dispatch from the pharmacies show that the largest spreads occurred among generic drugs, which are far more common.

Once a brand-name drug goes generic, more manufacturers flood the market with their version of the drug, and the price drops. What is unclear is how much of that decrease in generic-drug costs CVS Caremark is being passed along to the state.

"Growth in generic utilization played a major role in helping keep overall and member-specific costs low," DeAngelis said.

He said that 86 percent of the drugs dispensed for clients are generic drugs.

Managing benefits

How pharmacy benefit managers such as CVS Caremark do their work is complicated and somewhat shielded by confidentiality language in contracts.

The players in getting drugs to the marketplace include manufacturers, PBMs, pharmacists and insurers in the public and private sectors.

All of them receive a portion of the total cost of drugs, and all of that factors into how much consumers' prescriptions cost.

But in the middle of the negotiations with all of those layers are the PBMs.

Insurers rely on the PBM to decide which drugs should be covered.

The PBM also sets both the price that pharmacies charge and the amount the PBM will provide to pharmacies to cover the costs of those same drugs based on volume.

PBMs have not made public their pricing lists. They regard the information as "proprietary."

Sen. Coley said PBMs are profiting by keeping drug prices and pharmacy reimbursements secret. Legislators, he said, are working on bills to "take the wind out of the PBMs' sails."

The first bill would prohibit health insurers and PBMs from charging consumers co-payments that exceed what they would pay if they bought the drugs without using insurance, or what the pharmacy is being reimbursed to fill the prescriptions.

It also would ban "gag rules" that prevent pharmacists from telling their customers about cheaper options for acquiring medications, such as paying out of pocket. PBMs often include such provisions in contracts with pharmacies, although CVS Caremark has said that under its agreements, pharmacists are free to share pricing information.

Another bill would ban PBMs from requiring consumers to fill certain prescriptions — often of the more expensive medications — at designated specialty pharmacies. It's not unusual for PBMs to use such requirements to direct business to an affiliated mail-order pharmacy.

Rep Scott Lipps, R-Franklin, is sponsoring two of the bills targeting PBMs. He said more competition and more transparency will lower drug prices.

"No one knows what PBMs pay pharmacies. No one knows where (drug manufacturers') rebates go," he said. "Medicaid spending in Ohio accounts for 50 percent of the state budget. We need to get our arms around this problem and stop lining PBMs' pockets."

More than 100 independent pharmacies have closed in Ohio in recent years.

"This hurts patients," Peoples said of the closings, "and we are talking about the handicapped and children who now have a harder time getting their medications from someone locally who is counseling them on their health-care decisions, just so a middleman can make millions."

Dispatch Public Affairs Editor Darrel Rowland performed data analysis for this story.

How The Dispatch analyzed Medicaid drug prices

BY DARREL ROWLAND | THE COLUMBUS DISPATCH

Here is how The Dispatch analysis of Medicaid drug prices was performed:

The Dispatch downloaded a Medicaid drug-utilization database for 2017 (the most recent available) provided by Ohio but maintained by the federal government at Medicaid.gov. It shows how much taxpayer-funded Medicaid money was spent for more than 88,000 types of drugs, including the dosage and manufacturer. The total was more than 41 million prescriptions with nearly 2.4 billion units (typically some form of pill).

The Dispatch also obtained lists from 40 pharmacies of every drug transaction in 2017 involving Medicaid and the pharmacy benefit manager for four of the five managed-care organizations handling the program for the state: CVS Caremark. Those lists did not include patient information.

Despite CVS assertions that there is no "gag clause" prohibiting pharmacies from sharing information, no pharmacy would provide the data without a promise of confidentiality because of fear of reprisal from CVS. In fact, the pharmacies would

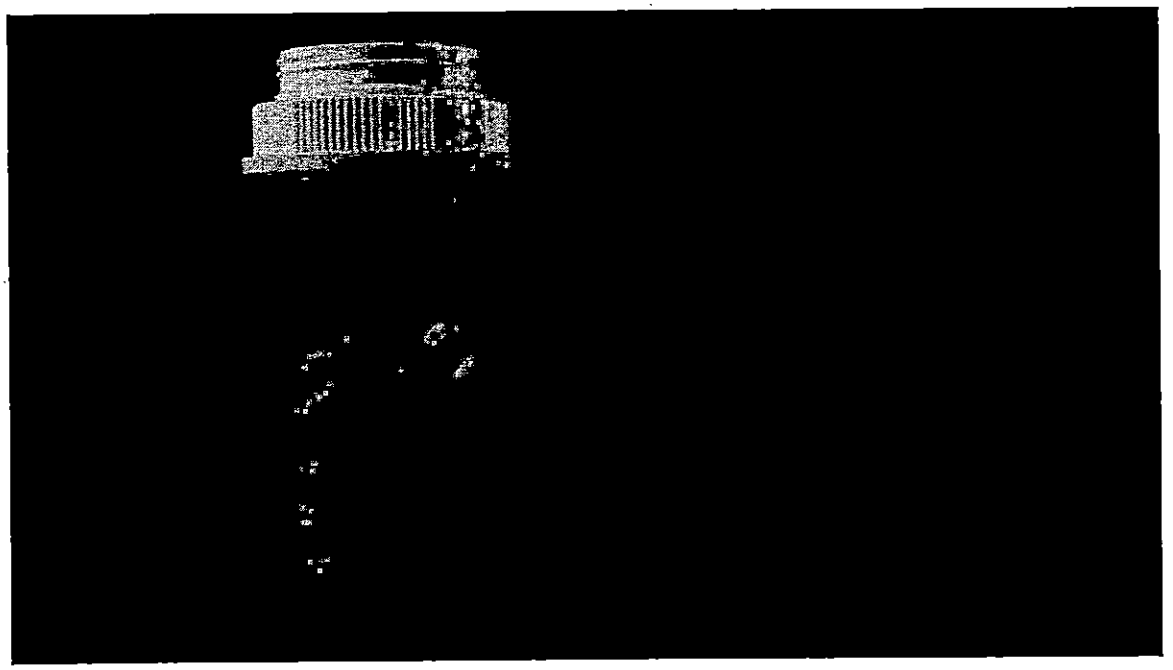
The pharmacies are located across Ohio, from a large group based in an urban area to a medium-sized group in another part of the state to individual stores in large suburbs, smaller exurbs and rural counties.

The Dispatch then took what Ohio Medicaid paid CVS Caremark (via the managed-care organizations that hired the company) for each type of drug transaction on a per-pill basis, and compared it with what CVS Caremark paid each pharmacy for each pill. The difference between those two totals is the "price spread" — which critics say indicates that the pharmacy-benefit manager overcharged the state/taxpayers, and/or underpaid the pharmacies, some of which have gone out of business in recent years.

The analysis did not include prescribed liquids, powders, gels or other drugs not in pill form, so that the units were defined the same by both the state and the pharmacies. But it did include nearly 11 million pills, more than 125,000 transactions and more than $7.5 million in pharmacy reimbursements.

Examples of what PBMs profit from one drug dosage from one pharmacy

DRUG: Vyvanse, treats ADHD - 30mg capsule



Photos by Joshua A. Bickel

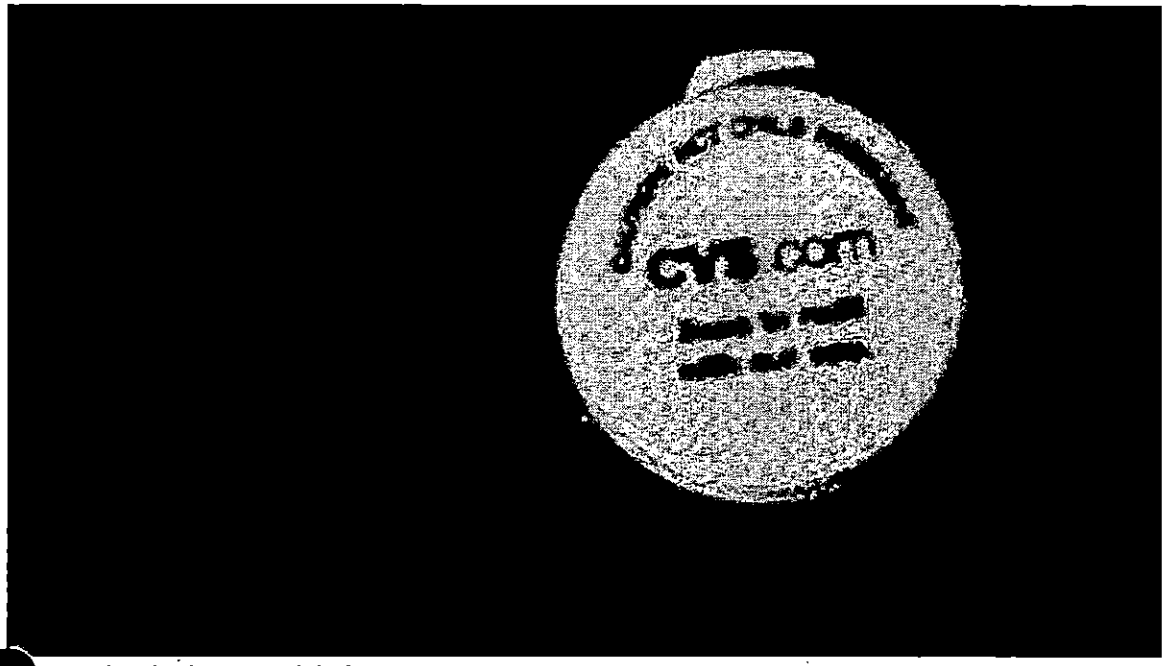
DRUG: Quetiapine Fumarate, treats schizophrenia - 50mg tablet

State paid PBM	$3.24 a unit
PBM paid pharmacy	$.66 a unit
PBM profits	$2.58 a unit
Units pharmacy sold	150
Net revenue for PBM	$387

DRUG: Budesonide, treats Crohn's disease - 3mg capsule

Units pharmacy sold	90
Net revenue for PBM	$526

DRUG: Raloxifene Hydrochloride, treats osteoporosis - 60mg tablet

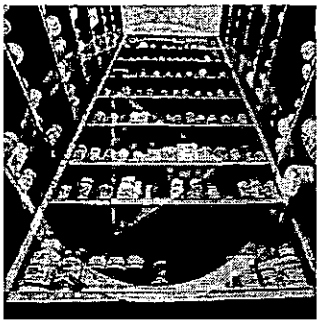


Photos by Joshua A. Bickel

DRUG: Aripiprazole, anti-psychotic - 10mg pill

State paid PBM	$5.80 a unit
PBM paid pharmacy	$.30 a unit
PBM profits	$5.50 a unit
Units pharmacy sold	1900
Net revenue for PBM	$10,450

Sources: Dispatch analysis of national drug utilization database and data from Ohio pharmacies



From the Newsroom: The Columbus Dispatch

Inside the black box

00:00 / 11:52

Testimony of Dudley Burdge
to the
New Hampshire Senate Commerce Committee
January 28, 2020

Chairman Cavanaugh and Members of the Commerce Committee,

My name is Dudley Burdge. I serve as a Commissioner of the New Jersey State Health Benefits Commission. I have served as a commissioner for over a decade. In this capacity, I have participated directly in New Jersey's effort to manage the rising costs of our over $2 billion yearly purchase of prescription drugs for our State and local government workers, dependents, and retirees before and after the landmark year of 2017, the year we replaced our traditional RFP process for selecting a pharmacy benefit manager or "PBM" with a dynamically competitive PBM reverse auction selection process.

Last year, I served, also, as a member of the State Health Benefits Plan PBM Selection Committee, which evaluated PBM prescription drug benefit pricing proposals through each bidding round in New Jersey's PBM reverse auction. Our committee selected the PBM winner of the reverse auction for award of the State pharmacy benefits contract.

It is an honor to appear before the Senate Commerce Committee, today, to discuss the PBM reverse auction process in which I've been involved firsthand, both in my capacity as a State Health Benefits Plan Commissioner and as a member of our PBM Selection Committee during our reverse auction of 2019. In New Jersey like here in New Hampshire we were desperate to end the 7, 8 and over 10% annual price increase. In 2016 we began to here about and investigate a method of prescription drug purchase that was becoming popular with large private sector employers – the reverse on-line auction

It is a privilege to share with this Committee the results of two successive PBM reverse auction processes that we conducted in 2017 and 2019. The first reverse auction produced unprecedented reductions in cost of prescription drugs for New Jersey public employees, retirees, and dependents. The second reverse auction deepened and extended those savings over a second, successor PBM contract. Total savings to our State for the total 5-year period under PBM contracts awarded through our two reverse auction processes are projected at **$2.5 billion** – an average annual reduction in prescription drug spending of **$500 million per year**. As we enter the third plan year (on January 1, 2020) since adopting the PBM reverse auction process, I am pleased to report that we are on track to meeting our 5-year $2.5 billion drug savings projection.

The prescription drug savings realized by New Jersey in our first two years of experience actually exceeded our initial projections. The combination of historic

reductions in prescription drug pricing achieved through our first PBM reverse auction in 2017 and our conduct of ongoing, automated review of PBM invoices reduced our overall State public employee prescription drug spending by **$822 million** in 2018. In 2019, the second plan year following our 2017 PBM reverse auction, state prescription drug spending was reduced by an additional **$578 million.**

Prescription drug savings of this magnitude, achieved *without* reliance on cuts to public employee health benefits, are without precedent in our state. Although the level of State fiscal savings produced by adoption of the PBM reverse auction is remarkable in real dollar terms, I'd also like to provide this committee a measure of the rate or percentage of prescription drug spending reductions that we've achieved, so you may, if you choose, apply our experience to calculating potential prescription drug savings for the State of New Hampshire:

In New Jersey, the State Health Benefits Commission on which I serve sets pharmacy benefits premiums based on the prescription drug cost experience of the previous year. Therefore, the rate of change in our pharmacy benefit plan premiums is a direct measure of the change of in our State Health Benefits Plan prescription drug spending during the previous year. For example, the reduction in prescription drug spending we achieved in 2018, the first plan year after we conducted our first PBM reverse auction, is reflected in the following pharmacy plan premium reductions for 2019:

Premium decrease of **-25.4%** for active State employees
Premium decrease of **-17.9%** for our early retirees
Premium decrease **-18%** for our Medicare retirees

In 2019, after a second year of under the PBM contract resulting from our 2017 reverse auction, our State Health Benefits Plan prescription drug spending fell even further. These spending reductions are reflected in further reductions to our pharmacy benefits premiums in 2020.

Further premium decrease **-4.5%** for active State employees
Premium increase of **+0.2%** for early retirees
Further premium decrease of **-13.7%** for Medicare retirees

Savings of this magnitude have benefitted both taxpayers and public employees, retirees, and their families who pay a share of our State Health Benefits Plan premiums.

The initial PBM reverse auction we conducted in 2017 engaged the nations "big three" PBMs -- Express Scripts International or "ESI" (our incumbent PBM in 2017), CVS Caremark, and OptumRx – in an unprecedented State process of competitive bidding to win the New Jersey public employee account. OptumRx won the competition, underbidding Express Scripts and CVS Caremark in the course of two rounds of bidding. As we entered the second year under the new OptumRx contract, State leaders became confident that an early reopening of the PBM contract to a

second reverse auction would capture even deeper savings for State taxpayers and public employees. In 2019, we conducted a second PBM reverse auction.

The outcome confirmed our hypothesis.

Competition did, indeed, deepen and extend the historic prescription drug savings achieved two year earlier in our first reverse auction. OptumRx (our new PBM incumbent) Express Scripts, CVS Caremark, and Prime Therapeutics competed in the second PBM reverse auction of 2019. Over three intensively competitive rounds of bidding the historic savings achieved in the 2017 reverse auction was deepened by an additional 8% over the three years of a successor PBM contract.

Prior to 2017, the New Jersey's State Employees Health Benefits Plan and the School Employees Health Benefits Plan selected our PBM through a traditional RFP process still used commonly by most state health benefits plans. The difference between that process and the dynamically competitive PBM reverse auction could not be more fundamental. The traditional RFP process for selecting a PBM had compelled our public employee health plans to choose between diverse and highly complex PBM prescription drug pricing proposals, each one requiring adoption of a PBM-specific formulary. Contracts proposed by PBMs each contained PBM drug classifications, definitions, and other terms prescribed by PBMs. As a purchaser, the State Health Benefits Plan was unable to make "apples to apples" comparisons based on value or cost comparisons between diverse PBM proposals. In fact, we had to rely ultimately on PBMs' own projections of the savings they would deliver to us. The savings were rarely realized. Year after year, prescription drug costs rose more rapidly than any other component of our health care spend.

The PBM reverse auction process we adopted in 2017 changed the dynamic fundamentally in the favor of our State Health Benefits Plan as purchaser of pharmacy benefits:

- It created a technology-enabled pharmacy benefits marketplace in which competition between PBMs drove value in the form of better pricing to our State Health Benefits Plan. As a member of the reverse auction PBM Selection Committee, I observed as PBMs submitted detailed online bids conforming to the required terms of our contract, rather than to terms of their contracts, as in the past.
- Within a few hours, our pharmacy data analytics platform translated the competing bids into reliable projections of the expected costs of each bid. We had never before been able to make such "apple-to-apple" comparisons based on value of PBM proposals.
- The lowest projected costs in each PBM bidding round were shown to all the PBM competitors, in addition to the projected costs of their own bids. That was meaningful transparency of cost that was without precedent in my own experience.
- After each round of bidding, our data analytics platform produced an automated analysis of each PBM's bid. We observed as the projected bid

costs fell over three rounds of bidding. We were witnessing dynamic competition driving value to the State purchaser – a process that simply does not occur in the traditional, relatively static RFP process.

Our Selection Committee reviewed the final PBM bids after the final round of bidding. We ranked the bids based on both the financial costs of each and weighted qualitative factors that were also important to our State employee health plans. As the complex PBM bids were submitted digitally, they populated the PBM contract and the final contract terms were generated almost instantaneously. There was, in fact, very little left to negotiate. The entire PBM reverse auction process from initial posting to award of contract was competed within approximately 12 weeks...with average State prescription drug savings amounting to approximately a half billion dollars per year.

In conclusion, I'd like to say a brief word about the multiple use of the pharmaceutical pricing data analytics technology platform we used to conduct our PBM reverse auction . Following the reverse auction, we redeployed the same technology to review PBM invoices that are submitted by the PBM every two weeks and must be paid within 48 hours. The technology platform enables us to adjudicate 100% of claims to confirm compliance with the specific terms of our PBM contract and flag deviations from those terms within a matter of a few hours. This automated, ongoing PBM bill review has enabled our State health plans to quickly reconcile overcharges. As a matter of fact, using the technology to conduct automated, ongoing, and real time bill review enabled us over the past two years to identify and recover an *additional* **$46 million** in prescription claims overcharges by the incumbent PBM who won award of contract through the reverse auction. By holding our PBM's "feet to the fire" in complying with the terms of our "best-in-class" PBM contract, we have captured tens of millions of additional dollars that would likely have been lost to the New Jersey State Treasury. For us, this is real money!

Thank you for the opportunity to share our experience in deploying 21st century technology to transform the State of New Jersey into a modern, disciplined, high-value pharmacy benefits purchaser. Our PBM reverse auction solution was adopted with overwhelming bipartisan support. Our success in harnessing dynamic market competition to drive prescription drug savings back to New Jersey taxpayers and public employees has had a profoundly positive impact on the fiscal wellbeing of our State, and it has helped secure a level of health benefits at affordable cost that our public employees, retirees, and their families deserve. I hope, above all, that our experience in New Jersey can inform the important decisions you will make on behalf of the good people of New Hampshire.

Respectfully,

Dudley Burdge
Commissioner
NJ State Health Benefits Commission

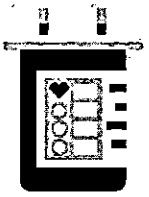
Millions of times a day, close to home and across the country, we're helping people on their path to better health.

CVS Pharmacy®

We're reinventing pharmacy to provide an accessible, supportive and personalized health care experience.

48
retail pharmacy locations

4.2M
CVS Pharmacy prescriptions filled



Aetna™

Aetna is one of the nation's leading diversified health care benefits companies, serving an estimated 38.8 million people.

22.6K
Aetna medical members

8.7K
Aetna provider network

MinuteClinic®

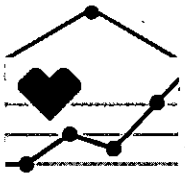
Our walk-in clinics offer convenient, high-quality care for common family illnesses and provide wellness services.

5
walk-in MinuteClinic locations

CVS Caremark®

Our leading clinical and management programs help keep medications affordable and improve health outcomes.

6.7M
CVS Caremark claims



Medicare

A comprehensive approach to your health and wellness.

1.2K
Medicare Advantage plans

11K
Part D plans

Community Giving

We support a range of local health care related causes.

$97K
in community giving

$5.6M
in tax contributions

CVS Specialty™

We provide specialty pharmacy services for patients who require treatment for rare or complex conditions.

1M+
patients treated nationally

Omnicare®

We provide pharmacy and consulting services aimed at achieving optimal and cost-effective medication therapy.

1M
seniors treated in long-term care facilities

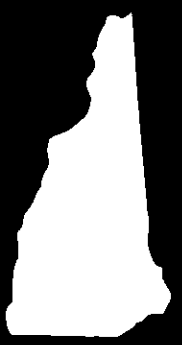
47
states have access to Omnicare services

Coram®

We provide home infusion therapies to patients annually through home visits and our national network.

100K+
patients treated annually

156
total Coram locations and ambulatory infusion suites nationwide



Fast Facts

1.1K
total employees

126
total pharmacists

12
total nurse practitioners

In-State Presence

48
Retail pharmacy locations

1
Regional business offices

1
Omnicare facilities

CVSHealth.

Dear Senate Commerce Committee members,

Please accept this written testimony for Tuesday's hearing on Senate Bill 686.

The Josiah Bartlett Center for Public Policy, New Hampshire's free-market think tank, appreciates this committee's bipartisan interest in pursuing savings for consumers of pharmaceutical products. Though the Bartlett Center has many concerns with the regulatory approach taken in Senate Bill 686, we think a proposed amendment is worth your serious consideration for the savings and efficiencies it could generate.

An amendment offered by Sens. Cindy Rosenwald and Bob Giuda would authorize New Hampshire's public sector to participate in electronic reverse auctions for the procurement of pharmacy benefits management services. This has the potential to generate significant savings for state and local taxpayers and significant efficiencies for government agencies.

Electronic reverse auctions have been used by the private sector since the mid-1990s and have become a common cost-saving practice. The federal government has incorporated these auctions into some procurement processes and also found real savings. A U.S. Government Accountability Office review in 2018, for example, found that electronic reverse auctions "may have saved the government up to $100 million in 2016."

Researchers have built a strong case over the years for the public-sector adoption of electronic reverse auctions. "The business case for employing eRAs has been categorized 'compelling' for the public sector, citing the documented savings of between 5 and 40 percent typically unearthed through the competition," a 2011 Southeastern Louisiana University study concluded.

In addition to cost savings, research has shown that buyers value electronic reverse auctions for creating efficiencies in procurement systems, saving time, increasing bidding transparency, stimulating competition, and increasing the number of suppliers.

Allowing the state and its municipalities to use electronic reverse auctions for PBM service procurement has the potential to generate significant savings for taxpayers and consumers while producing operational efficiencies for government. By creating a more competitive bidding process, electronic reverse auctions use market forces, not regulations, to drive down prices.

We see no reason why legislators of both parties would not want to allow the state and local governments to use a tool that has proven so effective at producing cost savings in the private sector and the federal government.

Sincerely,

Andrew Cline
President
Josiah Bartlett Center for Public Policy

The Senate of the State of New Hampshire

107 North Main Street, Concord, N.H. 03301-4951

MEMORANDUM

Date: October 31, 2018

To: Honorable Chris Sununu, Governor
Honorable Chuck Morse, President of the Senate
Honorable Gene Chandler, Speaker of the House
Honorable Tammy Wright, Senate Clerk
Honorable Paul Smith, House Clerk
Michael York, State Librarian

From: Senator Donna Soucy, Chair

Subject: Final Report of SB481, Chapter 143:2, Laws of 2018

Pursuant to SB481, Chapter 143:2, Laws of 2018, enclosed please find the final report of the committee to study the impact of pharmacy benefit manager operations on cost, administration, and distribution of prescription drugs.

Should you have any questions or comments regarding the report, please don't hesitate to contact me.

Enclosure

cc: committee members

COMMITTEE TO STUDY THE IMPACT OF PHARMACY BENEFIT MANAGER OPERATIONS ON COST, ADMINISTRATION, AND DISTRIBUTION OF PRESCRIPTION DRUGS.

SB481, Chapter 143:2, Laws of 2018

FINAL REPORT

Members:
Senator Donna Soucy
Representative Erin Hennessey
Representative Valerie Fraser
Representative David Luneau

Charge of the study:
I. Study the role pharmacy benefit managers (PBM) play in the cost, administration, and distribution of prescription drugs. The committee's study shall include, but not be limited to:

(a) The effects of PBMs on the overall costs of health insurers.

(b) PBMs use of "clawbacks" and "gag clauses" and the impact on consumer costs and rebates.

(c) The impact of PBMs with respect to retail pharmacy pricing decisions.

(d) A review of appropriate PBM oversight and the potential for such oversight to aid in lowering drug costs to consumers.

(e) A review of the potential differences in costs for insurers that use PBMs to manage pharmacy benefits and insurers that independently manage this benefit.

(f) Access to pharmacies.

The Committee received testimony from the following:
Tyler Brannen - NH Insurance Dept. (handout)
April Alexander - PCMA (handout)
Kelly Ryan - PhRMA (handout)
Robert Popovian - Pfizer (handout)
Richard Cohen - Pharmacists (handout)
Charlie Arlinghaus and Joyce Pitman (Dept. of Administrative Services) (handout)

Robert Stoker - (handout)
Corey Greenblatt - Global Healthy Living Foundation (handout)
Holly Stevens - New Futures (handout)
Daniel Nam - AHIP (handout)
Paula Rogers - Anthem (handout)
Lucy Hodder - UNH Law (handout)
Rep. Dianne Schuett

All handouts can be found under the documents section on the committee's webpage at http://www.gencourt.state.nh.us/statstudcomm/committees/1383/.

Summary of discussion:

1. Pharmacy benefit managers are regulated by the Board of Pharmacy when dispensing prescriptions. In addition, some NH insurance laws apply to pharmacy benefit managers as a third party administrator.
2. Pharmacy benefit managers are hired to manage the prescription drug benefit programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.
3. Pharmacy benefit manager services include: developing and maintaining the formulary, contracting with pharmacies, mail service pharmacy, negotiating discounts and rebates with drug manufacturers, processing and paying prescription drug claims, drug utilization review programs.
4. A clawback is a pharmacy benefit manager claims processing function that results in overpayment by the patient and a reduction in what the pharmacy receives for payment of the drug. Clawbacks are now prohibited by law.
5. In 2018, legislation was passed prohibiting gag clauses, which is when pharmacists are prohibited, by pharmacy benefit managers, from telling a patient they are paying a higher price for a drug covered by their insurance than if they had just paid cash without billing the insurance company.
6. Spread price is the difference between what the pharmacy benefit manager charges the health plan and what they reimburse the pharmacy.
7. With regard to high drug prices, the challenge is that brand drug manufacturers sell drugs in a way that gives them a monopoly for that drug. It's very difficult to get discounts on products when there's no competition. Manufacturers have shown they will charge whatever the market will bear.
8. Copay coupons are provided by a drug manufacturer directly to the patient. They are often associated with higher priced brand name drugs. While they do help patients access medications, some argue that they ultimately drive prices higher and contribute to higher overall costs because they give the patient incentive to opt for the more expensive drugs. They are prohibited for use with Medicaid and Medicare by the federal government.

Recommendations

1. The committee recommends that legislation be filed to establish a registration requirement for pharmacy benefit managers with the Department of Insurance. The committee further recommends increased reporting by pharmacy benefit managers to the Department of Insurance in order to increase transparency. NH should look at what other states have done in this regard when developing the legislation.
2. The committee recommends that a more robust and distinct consumer complaint process be developed to address issues with pharmacy benefit managers.
3. The committee recommends that the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs, established by HB1418 in 2018, continue as a standing commission and that they monitor any developments at the federal level.

Senator Soucy (Chair)

Rep. Fraser

Rep. Hennessey

Rep. Luneau

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

John Elias
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

Bulletin

Docket No: INS 19-028-AB

To: All entities operating as Pharmacy Benefits Managers

From: John Elias, Commissioner

Date: December 19, 2019

Re: Registration of all Pharmacy Benefits Managers

During its 2019 session, the legislature enacted a new chapter, RSA 402-N, for the registration and regulation of pharmacy benefits managers. The Department is currently in the process of amending administrative rules Ins 2704 to include registration requirements. A draft of the proposed rules can be found on the Department's website at https://www.nh.gov/insurance/legal/index.htm.

RSA 402-N becomes effective January 1, 2020. All persons or entities acting as a pharmacy benefits manager in New Hampshire must register with the Department no later than **March 1, 2020**. Registration forms are now available on the Department's website at https://www.nh.gov/insurance/companies/applications/index.htm. The pharmacy benefits manager does not need to fill out page 3 of that application or provide biographical information or organizational documents if it is already licensed in New Hampshire as a third party administrator.

Who Must Register: All pharmacy benefits managers operating in New Hampshire.

"Pharmacy benefits manager" is defined as a person, business, or other entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that, pursuant to a contract with a heath carrier, manages the prescription drug coverage provided by the health carrier, including, but not limited to, providing claims processing services for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudication of grievances or appeals related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs. RSA 402-N:1, VIII (a).

"Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services. RSA 402-N:1, III and 420-J:3, XIX.

"Pharmacy benefits manager" does not include any:

(1) Health care facility licensed in this state;

(2) Health care professional licensed in this state;

(3) Consultant who only provides advice as to the selection or performance of a pharmacy benefits manager;

(4) Service provided to the Centers for Medicare and Medicaid Services; or

(5) Health insurer licensed in this state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds.

RSA 402-N:1, VIII (b).

Renewal: All PBMs must renew their registration annually by March 1. Beginning in 2021, all PBMs must submit an annual report prior to March 1 in order to renew their registration. Annual data reports must be filed in an electronic workbook as discussed in proposed administrative rule Ins 2704.04 (c). Registrations will not be renewed unless the annual data report has been submitted.

CURTIS J. BARRY

TO: **Senate Commerce Committee**

FROM: **Curtis J. Barry, on behalf of the Pharmaceutical Care Management Association (PCMA)**

RE: **Senate Bills 686, 689, 690**

DATE: **February 27, 2020**

To follow up and letters to the committee from Sam Hallemeier of PCMA, I wanted to pass along a few very brief notes on these bills.

SB 686

Please refer the attached chart with brief comments on each section of the bill. The PCMA position is that either many of these subject areas were negotiated in good faith in recent sessions, or the subject is covered by pending legislation or a study. One particular area of contention, the concept of "fiduciary", is controversial and has a long history of litigation.

Additionally, as pointed out by Jodi Grimbilas in her testimony on behalf of CVS, there are differences in definitions between SB 686 and current statutes.

PCMA has no position on the proposed "reverse auction" amendment for state procurement as it would maintain a competitive bidding structure for the state.

SB 689 relative to the pharmacy anti-steering law

In addition to the comments in Mr. Hallemeier's letter to the committee on this bill, I note that anti-steering provisions were included in recent Oklahoma legislation that is currently being challenged by PCMA in United States District Court, filed October 25th, 2019.

SB 690 relative to prescription drug formulary changes

PCMA commissioned an independent study on this subject, also referred to as "frozen formulary". I have attached the executive summary from that study, conducted by Milliman, which describes the increased costs to those paying premiums this policy would trigger.

I thank you for considering these points. Please feel free to reach out with questions.

(603) 496-4564 / CURTIS@BARRYGR.COM

SB 686 section by section PCMA comments

402-O:2 Oversight and Contracting Responsibilities.	**PCMA Comments**
I - oversight by carrier	This is unnecessary; carriers have contractual oversight over a contracted PBM, and SB 226 requires an annual report to the commissioner regarding health plans administered;
II - fiduciary	PCMA adamantly objects to deeming a PBM as "a fiduciary". This is an area that has seen lenghty litigation and is possible again. The State of Maine has a long history on this subject, enacting it, repealing it, then enacting it again recenlty, and the rules are still being lfushed out. Moreover the U.S. 4th Circuit Court of Appeals issued a ruling in favor of PCMA on the subject of "fiduciary" in 2009. PLease refer to Mr. Hallemeir's letter to the committee for more detail and references.
III - "gag clause"	this issue was addressed in 2018 HB 1791
IV - loswest cost for consumers	this is included in 2019 SB 226 (402-N:4 Prescription Drugs)
V - network adequacy	this is unnecessary; New Hampshire is an "any willing provider" state via RSA 420-B:12 V and the N.H. Dept. of Insurance has relatively new network adequacy requirements.
402-O:3 Prescription Drug Pricing; Maximum Allowable Cost	this subject is enacted via 2016 HB 1664 - relative to contracts between carriers or pharmacy benefit managers and certain pharmacies (MAC Pricing) Rep. David Luneau

SB 686 section by section PCMA comments

402-O:4 Responsibility to Use Compensation for Benefit of Covered Persons.	
	the issue of rebates is covered in SB 63 which has passed the House with amendment and coming back to the Senate for concurrance
	2019 SB 226 also requires reporting on rebates
	the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs in ongoing
402-O:5 Prescription Drug Formularies; Pharmacy and Therapeutics Committee	Conflict of interest is covered in Center for Medicare and Medicaid Services accreditation standards of the National Committee for Quality Assurance or other independent accrediting organizations, particularly URAC. State statutes on this subject may create inconsistencies and limit a PBM's function in that state.
402-O:6 Access to Records; Audits	This subject seems duplicative with 2019 HB 670, which requires health insurance carriers to maintain certain information relative to prescription drug costs within their data systems for purposes of the managed care law.
402-O:7 Treatment of Pharmacy Benefits Manager Compensation.	PCMA objects to this section; 2019 SB 226 intentionally did not include confidential / proprietary information and should stand to address this area.

Voting Sheets

Senate Commerce Committee
EXECUTIVE SESSION RECORD
2019-2020 Session

Bill # SB 686-FN

Hearing date: 1/28/20

Executive Session date: 3/3/20

Motion of: Amendment (09688) **Vote:** 3-2

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh, Chair	☐	☑	☑	☐
Sen. Morgan, V- Chair	☑	☐	☑	☐
Sen. French	☐	☐	☐	☑
Sen. Morse	☐	☐	☐	☑
Sen. Soucy	☐	☐	☑	☐

Motion of: OTP-A **Vote:** 3-2

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh, Chair	☐	☐	☑	☐
Sen. Morgan, V-Chair	☑	☐	☑	☐
Sen. French	☐	☐	☐	☑
Sen. Morse	☐	☑	☐	☑
Sen. Soucy	☐	☑	☑	☐

Motion of: _____ **Vote:** _____

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh, Chair	☐	☐	☐	☐
Sen. Morgan, V- Chair	☐	☐	☐	☐
Sen. French	☐	☐	☐	☐
Sen. Morse	☐	☐	☐	☐
Sen. Soucy	☐	☐	☐	☐

Reported out by: Sen. Morgan

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 4, 2020

THE COMMITTEE ON Commerce

to which was referred **SB 686-FN**

AN ACT relative to rebates paid to pharmacy benefits managers.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 3-2

AMENDMENT # 1063s

Senator Jon Morgan
For the Committee

Aaron Jones 271-1403

COMMERCE

SB 686-FN, relative to rebates paid to pharmacy benefits managers.
Ought to Pass with Amendment, Vote 3-2.
Senator Jon Morgan for the committee.

General Court of New Hampshire - Bill Status System

Docket of SB686

Docket Abbreviations

Bill Title: (New Title) relative to prescription drug benefits paid by health plans and establishing the New Hampshire prescription drug competitive marketplace.

Official Docket of **SB686.**:

Date	Body	Description
1/14/2020	S	**Introduced** 01/08/2020 and Referred to Commerce; **SJ 2**
1/16/2020	S	==RECESSED== **Hearing:** 01/21/2020, Room 100, SH, 02:15 pm; **SC 3**
1/24/2020	S	==RECONVENE== **Hearing:** 01/28/2020, Room 100, SH, 01:00 pm; **SC 4**
3/4/2020	S	Committee Report: Ought to Pass with Amendment **#2020-1063s**, 03/11/2020; **SC 10**
3/11/2020	S	Sen. Carson Moved to divide the Question on Committee Amendment **#2020-1063s**: Sections 1, 2 and 5 I, and Sections 3, 4 and 5, II; 03/11/2020; **SJ 6**
3/11/2020	S	Sen. Carson Withdraws the motion to divide the Question; 03/11/2020; **SJ 6**
3/11/2020	S	Committee Amendment **#2020-1063s**, AA, VV; 03/11/2020; **SJ 6**
3/11/2020	S	**Ought to Pass with Amendment** 2020-1063s, **RC** 14Y-10N, MA; OT3rdg; 03/11/2020; **SJ 6**
6/30/2020	H	Introduced and Laid on Table MA VV 06/30/2020

NH House | NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 486-FN **Senate Committee:** Commerce

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee
X All Calendar Notices
X Hearing Sign-up sheet(s)
X Prepared testimony, presentations, & other submissions handed in at the public hearing
X Hearing Report
X Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

X - amendment # 0117s X - amendment # 0968s
X - amendment # 0113s X - amendment # 1063s

X Executive Session Sheet
X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # _____ ___ - amendment # _____
___ - amendment # _____ ___ - amendment # _____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):
___ Enrolled Bill Amendment(s)
___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house
___ final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Aaron Jones 7/8/20

Committee Aide **Date**

Senate Clerk's Office _____