Examples of Benchmark Enforcement and Pharmacy Cost Mitigation Policies in Other States

Office of Health Strategy

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Tables 1-3 below describe policies enacted in other states related to cost growth benchmark and primary care spending target enforcement mechanisms (Tables 1 and 2, respectively) and polices that are similar to those recommended by the Pharmacy Cost Mitigation Strategies Work Group (Table 3).

Table 1: State Cost Growth Benchmark Enforcement Mechanisms

State	Details
California	• California statute specifies a series of actions that the state may take when an entity exceeds the state's cost growth benchmark. The first step is providing technical assistance to a violating entity. The state could, if necessary, require or compel public testimony regarding the entity's failure to meet the cost growth benchmark. The state may then require the entity to develop and implement a performance improvement plan (PIP) that identifies the causes of spending growth and strategies the entity will take to address them. • Entities that are not compliant with the PIP process may be assessed administrative penalties "commensurate with the failure" of the entity to meet the cost growth benchmark. Entities that are repeatedly non-compliant with the PIP process may be assessed additional and escalating penalties based on the nature, number, and gravity of the offenses, fiscal condition of the entity, and market impact of the entity. • The state can require a cost and market impact review be performed on any entity "if data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures."
Delaware	• Delaware established the Diamond State Hospital Cost Review Board in 2024. Beginning in 2026, if the Board determines that a hospital's actual annual cost growth has exceeded the spending benchmark, the Board may require a Performance Improvement Plan. • If the PIP is unsuccessful, the Board may require the hospital to participate in a budget approval process whereby the hospital budget must, for at least three consecutive years, adhere as closely to the health

State	Details
	care spending benchmark "as is reasonable given the hospital's financial position and associated economic factors."
Massachusetts	• For entities that exceed the healthcare cost growth benchmark in any given year, the Health Policy Commission (HPC) can require the entity to file and implement a PIP, per the legislation establishing the benchmark program. PIPs must identify the causes of cost growth, specific strategies to improve cost performance, and measurable expected outcomes. • The HPC can assess a civil penalty of up to $500,000 if any entity neglects to submit an acceptable PIP (or neglects to submit a PIP at all), fails to implement the PIP in good faith, or otherwise knowingly falsifies or fails to provide information required by statute.
Oregon	• Oregon can require payers and providers that exceed the healthcare cost growth benchmark in a given year to implement a PIP. Oregon requires that PIPs identify key cost drivers and the actions an entity will take to address them, including a time frame for doing so, as well as "clear measurements of success." • Oregon possesses the additional authority to apply financial penalties to any entity that either does not participate in the program or that exceeds the cost growth benchmark in three out of five calendar years. OHA can also issue civil penalties of up to $500 per day to any entity that fails to report data or to develop and implement a PIP. • The state promulgated regulations governing application of PIPs and financial penalties in July 2024.

Tabel 2: State Primary Care Spending Target Enforcement Mechanisms

State	Details
Colorado	Colorado carriers were required to increase the proportion of total medical expenditures allocated to primary care by 1 percentage point in each of 2022 and 2023. The Colorado Division of Insurance may respond to noncompliance with "any of the sanctions made available in the Colorado statutes including fines, cease-and-desist orders, and revocation of the health plan's license."
Delaware	Delaware requires carriers to spend at least 7% on primary care in 2022, 8.5% in 2023, 10% in 2024 and 11.5% in 2025. The Department of Insurance developed regulations allowing the Department to carry out a market conduct exam as necessary, report on carrier compliance, and in response to non-compliance, the Department can: • return a rate filing for amendments and correction of deficiencies; • require a corrective action plan; • create carrier-specific reporting and monitoring requirements for two years, and

State	Details
	• impose administrative penalties.
Oregon	Oregon's private health plans, state employee benefit plans, and Medicaid plans were all required to allocate at least 12% of health care expenditures (not including prescription drugs, vision, and dental care) to primary care by 2023. The Oregon Health Authority can require carriers that do not meet this target to "submit with each rate filing a plan to increase spending on payments for primary care as a percentage of total medical expenditures by at least one percent each plan year."
Rhode Island	Rhode Island's "affordability standards" require each commercial health insurer's primary care expenses to make up at least 10.7% of its annual medical expenses for all insured lines of business. The Office of the Health Insurance Commissioner's enforcement powers include "approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation."

Table 3: State Policy Examples Related to the Pharmacy Cost Mitigation Strategies Work Group Recommendations

Recommendation	State Example(s)
1. Advance legislation to establish **reference-based payment limits** (a cap on the amount that can be paid for a prescription drug based on prices paid by payers elsewhere)	None identified
2. Advance legislation to **penalize excessive pharmaceutical price increases**	Minnesota's SF 2744 prohibits price increases that, after adjusting for inflation using the Consumer Price Index, exceed: • 15% of the wholesale acquisition cost from the year prior; • 40% of the wholesale acquisition cost from three years prior; • $30 for a 30-day supply of the drug or a course of treatment lasting less than 30 days. For essential off-patent or generic drugs that exceed $20, Illinois' HB 3957 prohibits price increases that result in the wholesale acquisition cost of a 30-day supply rising by: • 30% or more within the preceding year;

Recommendation	State Example(s)
	• 50% or more within the preceding three years; • 75% or more within the preceding 5 years; • Or is "otherwise excessive and unduly burdens consumers because of the importance of the essential off-patent or generic drug to their health and because of insufficient competition in the marketplace."
3. **Expand the** current state law **definition of drug rebates** to capture the complexity of rebate relationships and how they are funneled through various layers within and adjacent to a Pharmaceutical Benefit Manager (PBM)	In Colorado, the Center for Improving Value in Health Care (CIVHC) is charged with maintaining the state's All-Payer Claims Database (APCD), including through updating the CO APCD Rule and Data Submission Guide each year. The drug rebate data that CIVHC requires can be found in the latest Data Submission Guide.
4. Advance legislation to **prohibit PBMs from** engaging in the practice of **spread pricing** (when a PBM charges a health plan or employer a higher price for a prescription drug than what the PBM actually pays the pharmacy for that prescription, and the PBM retains the difference as profit)	At least 15 states have such legislation. Examples include: • Arkansas: SB 520 • Florida: SB 1550 • Delaware: HB 219 • Idaho: H 596 • Louisiana: SB 41 and SB 130 • Michigan: HB 4348 • New York: SB 1507 • Pennsylvania: HB 941 • Vermont: H 233 • Virginia: HB 1291 • Washington: SB 5213
5. Explore expanding **PBM transparency** and reporting requirements to potentially include: a. Drug-specific rebate information b. Average PBM per member per month administrative fees c. Conflicts of interest d. Information differentiating payments to pharmacies owned or controlled by the PBM and payments to those not affiliated with the PBM e. Contract arrangements between PBMs and other	**5a:** • New Jersey: S1615 • Maine: 90-590 Chapter 570 • Minnesota: 62J.84 **5b:** The below states all require reporting of PBM administrative fees. • California: AB 315 • Louisiana: SB 283 • Michigan: HB 4276 • New Jersey: S 249 • Oregon: HB 4149 • Utah: HB 370 • Virginia: HB 1402 / SB 660

Recommendation	State Example(s)
parties relating to the services PBMs provide to health plans (e.g., "rebate aggregators")	Selected examples of 5c-5e follow below. **5c:** • New York requires PBMs to disclose financial information and the terms and conditions of any contract they have with any party in writing, including dispensing fees paid to the pharmacies; and any activity or policy that directly or indirectly presents any conflict of interest with the PBM's relationship with the health plan. (N.Y. Pub. Health Law § 280-A) **5d:** • Minnesota requires PBMs give information to plan sponsors that differentiates between payments made to pharmacies owned or controlled by the PBMs and those not affiliated with the PBM (Minn. Stat. § 62W) **5e** • Florida requires PBMs to disclose all organizations with which they are affiliated, including any affiliated pharmacies or companies within their corporate umbrella (Ch. 2023-30)

6. Explore **requiring PBMs to be licensed** with the state	At least 25 states require PBM licensure. Examples include: Arkansas: HB 1010 Indiana: SB 241 Kansas: SB 28 Louisiana: SB 41 and SB 283 Michigan: HB 4348 Minnesota: SF 278 Montana: SB 395 New Jersey: A 536 North Carolina: S 257 South Carolina: S 359 South Dakota: HB 1135 Tennessee: SB 1852 Utah: HB 370 Vermont: H 233 Virginia: HB 251 and HB 1291 West Virginia: HB 2263 Wisconsin: SB 3
7. Explore establishing **upper payment limits for generic drugs**	None identified
8. Explore opportunities for the state to provide capital investment to **fund the development, production, and/or distribution of generic drugs**	• California: SB 852 enables the California Health and Human Services Agency to enter into partnerships "to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs." In March 2023, California entered into a 10-year, $50 million contract with nonprofit drugmaker Civica Rx to contribute funding to the development and production of interchangeable biosimilar insulin products. • Washington also passed legislation, but the work stalled due to lack of funding.
9. Explore strategies related to **including pharmacy expenses in total cost of care (TCOC) risk sharing contracts** between insurers and provider organizations, including: a. A legislative mandate on the fully-insured market requiring that TCOC contracts be inclusive of pharmacy spending	None identified

b. Developing statewide targets guiding payers to use more and increasingly advanced payment models each year with a requirement for contracts to include pharmacy spending	