SUBJECT: Requirements for maximum allowable cost lists regarding prescriptions

COMMITTEE: Insurance — favorable, without amendment

VOTE: 8 ayes — Frullo, Muñoz, G. Bonnen, Meyer, Paul, Sheets, Vo, Workman

0 nays

1 absent — Guerra

SENATE VOTE: On final passage, April 9 — 31-0

WITNESSES: No public hearing

BACKGROUND: Insurance Code, sec. 4151.151 defines a "pharmacy benefit manager" as a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits.

Managed care organizations use pharmacy benefit managers (PBMs) to administer claims and reimbursements for participating pharmacies. PBMs reimburse pharmacies for certain prescription drugs according to a proprietary maximum allowable cost formula.

DIGEST: SB 332 would require a health benefit plan issuer or PBM to disclose to a pharmacist or pharmacy the sources of the pricing data used in formulating maximum allowable cost prices. The health benefit plan issuer or the PBM would have to disclose the pricing information on the date the issuer or the PBM entered into a contract with a pharmacist or pharmacy and, after the contract date, on the request of the pharmacist or pharmacy.

A health benefit plan issuer or PBM would review and update maximum allowable cost price information for each drug at least once every seven days to reflect any modification of maximum allowable cost pricing. A health benefit plan issuer or PBM would establish a process that would eliminate drugs in a timely manner from maximum allowable cost lists or

modify maximum allowable cost prices to remain consistent with changes in pricing data used to formulate maximum allowable cost prices and product availability.

The bill would require a health benefit plan issuer or PBM to provide to each pharmacist or pharmacy under contract a process for readily accessing the maximum allowable cost list that would apply to the pharmacist or pharmacy.

A maximum allowable cost list that applied to a pharmacist or pharmacy and was maintained by a health benefit plan issuer or PBM would be confidential. The bill would specify that this provision could not be construed to alter a health benefit plan issuer's or PBM's obligations to provide a contracted pharmacy or pharmacist with a process to readily access a maximum allowable cost list.

A health benefit plan issuer or pharmacy benefit manager would be prohibited from including a drug on a maximum allowable cost list unless the drug:

- had an "A" or "B" rating in the most recent version of the U.S. Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or was rated "NR" or "NA" or had a similar rating by a nationally recognized reference; and
- was generally available for purchase by pharmacists and pharmacies in Texas from a national or regional wholesaler and was not obsolete.

The bill would specify that, in formulating the maximum allowable cost price for a drug, a health benefit plan issuer or PBM could only use the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the Food and Drug Administration's Orange Book. If a therapeutically equivalent generic drug was unavailable or had limited market presence, a health benefit plan issuer or PBM could place certain drugs on a maximum allowable cost list if the drug had a "B"

rating in the Orange Book or an "NR" or "NA" rating or a similar rating by a nationally recognized reference.

A health benefit plan issuer or PBM would be required to include in their contracts with each pharmacist or pharmacy a procedure for the pharmacist or pharmacy to appeal a maximum allowable cost price of a drug within 10 days after the date a pharmacy benefit claim for the drug was made. The health benefit plan issuer or PBM would be required to respond to an appeal by a pharmacist or pharmacy within 10 days of receiving the appeal.

If the pharmacy or pharmacist's appeal was successful, the bill would require the health benefit plan issuer or PBM to:

- adjust the maximum allowable cost price that was subject to the appeal, effective on the date after the date the appeal was decided;
- apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health benefit plan issuer or PBM; and
- allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefit claim to which the appeal applied.

If the appeal was not successful, the bill would require the health benefit plan issuer or PBM to disclose to the pharmacist or pharmacy:

- each reason the appeal was denied; and
- the national drug code number from the national or regional wholesalers from which the drug would be generally available for purchase by pharmacists and pharmacies in Texas at the maximum allowable cost price that was the subject of the appeal.

The following types of plans would be excluded from the provisions of the bill regarding maximum allowable costs:

- Medicaid and Medicaid managed care plans;

- Children's Health Insurance Program (CHIP);
- the state's health insurance program for qualified alien (legal immigrant) children;
- state employee health insurance under the Employees Retirement System;
- Texas school employees' health insurance under TRS-Care or TRS-ActiveCare; and
- state-provided health insurance for employees of the University of Texas System and the Texas A&M University System.

The bill would specify that it would be the intent of the Legislature that the requirements contained in the bill would apply to all health benefit plan issuers and PBMs except for those specifically excluded under the bill and unless otherwise prohibited by federal law.

The bill would specify that the provisions of the bill could not be waived, voided, or nullified by a contract and could not be construed to waive a legal remedy available to a pharmacist or a pharmacy. The commissioner of the Texas Department of Insurance would enforce the provisions of the bill

The bill would take effect January 1, 2016. The provisions of the bill would apply only to a contract between a health benefit plan issuer or PBM and a pharmacist or pharmacy entered into or renewed on or after that date.

SUPPORTERS SAY:

SB 332 would increase transparency in the method by which a PBM determines which drugs can be reimbursed using a maximum allowable cost formula. Each PBM currently uses the PBM's own formula based on maximum allowable cost to reimburse pharmacies for dispensing generic medications, but there is little transparency as to what the price will be, when the price will change, and which sources can be used to determine the maximum allowable cost prices.

The bill represents a compromise between PBMs and pharmacies on how to address this lack of transparency by creating a process for a pharmacy

under contract with a PBM to access the maximum allowable cost list and to appeal the price of a drug.

OPPONENTS SAY:

No apparent opposition.