BILL ANALYSIS

Senate Research Center
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S.B. 1106
By: Schwertner
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As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1106 provides transparency into the methodology used by pharmacy benefit managers (PBM) to reimburse pharmacies participating in the Medicaid managed care program for dispensing generic prescription drugs to Medicaid patients. In these reimbursements, PBMs use a formula based on Maximum Allowable Cost (MAC). However, there is no transparency in how a PBM determines which drugs will be reimbursed using a MAC formula, what the price will be, when the price will change, and what factors are used to determine MAC prices or price changes.

Often, PBM reimbursements are less than the cost to the pharmacy to obtain these drugs from wholesalers. This usually occurs when the wholesale price for generic drugs rises but PBM reimbursements lag.

Transparency is needed for MAC-based reimbursements to clarify how PBMs determine and change their MAC pricing. Transparency will ensure that payments to pharmacies for dispensing generic prescription drugs to Medicaid patients are not so low as to drive pharmacies out of the Medicaid managed care program and, thereby, reduce Medicaid patient access to prescription medication. Transparency may also provide the Health and Human Services Commission (HHSC) with a mechanism to ensure that it is saving the maximum amount of money in generic drug spending by identifying the difference between the rate HHSC reimburses managed care organizations for generic drugs and the rate the subcontracted PBMs reimburse pharmacy providers.

As proposed, S.B. 1106 amends current law relating to the use of maximum allowable cost lists under a Medicaid managed care pharmacy benefit plan.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 533.005(a), Government Code, as follows:

> (a) Requires that a contract between a managed care organization and the Health and Human Services Commission (HHSC) or an agency operating part of the state Medicaid managed care program, as appropriate, for the organization to provide health care services to recipients contain:
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> > (1)-(22) Makes no change to these subdivisions;
> >
> > (23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:
> >
> > > (A)-(J) Makes no changes to these paragraphs; and

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, is required to ensure that the drug has at least two generic and one brand name nationally available, therapeutically equivalent, multiple source drugs; the drug is listed as therapeutically and pharmaceutically equivalent or "A" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; and the drug is available for purchase without limitation by all pharmacies in the state from national or regional wholesalers and is not obsolete or temporarily unavailable;

(ii) is required to disclose in a timely manner, upon request of a network pharmacy provider or HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to its network pharmacy providers and to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, the basis of the maximum allowable cost price for each drug on the list and the methodology and sources used to determine that price;

(iii) is required to update maximum allowable cost price information at least every seven days and establish a process to allow for the prompt notification of network pharmacy providers and HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, of pricing updates;

(iv) is required to establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(v) is required to provide a procedure approved by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug; respond to a challenge not later than the 15th day after the date the challenge is made; make an adjustment in the drug price applicable to all network pharmacy providers, if the challenge is successful; if the challenge is denied, provide the reason for the denial and notify the network pharmacy provider of where the drug may be purchased at a price at or below the maximum allowable cost price for the relevant time period; and report to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, every 90 days, and to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, and any network pharmacy provider upon request, the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vi) is required to notify HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail;

(vii) is required to disclose to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in a

timely manner on the HHSC's or an agency's operating part of the state Medicaid managed care program, as appropriate, request whether the maximum allowable cost list used with respect to reporting to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, is the same as the list used when reimbursing network pharmacy providers and, if not, disclose to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, any variance between amounts paid to network pharmacy providers and amounts reported to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate; and

(viii) is required to provide each of its network pharmacy providers with a unique identifier that the provider may use to access the maximum allowable cost list specific to that provider through the Internet website of the managed care organization or pharmacy benefit manager, as applicable; and

(24) Makes no change to this subdivision.

SECTION 2. (a) Requires HHSC to, in a contract between HHSC and a managed care organization under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code, that is entered into or renewed on or after the effective date of this Act, require that the managed care organization comply with Section 533.005(a), Government Code, as amended by this Act.

(b) Requires HHSC to seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to require those managed care organizations to comply with Section 533.005(a), Government Code, as amended by this Act. Provides that, to the extent of a conflict between that subsection and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

SECTION 3. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 4. Effective date: September 1, 2013.