BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1106
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Health & Human Services
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.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.

C.S.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, Government Code, by amending Subsection (a) and adding Subsection (a-2), 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 change 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 is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating by Medi-Span, or has a similar rating by a nationally recognized reference; and the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) is required to provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

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

(iv) is required to, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent 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;

(v) 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;

(vi) is required to provide a procedure 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; if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved, and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate; if the challenge is denied, provide the reason for the denial; and report to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, every 90 days 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;

(vii) 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; and

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

(24) Makes no change to this subdivision.

(a-2) Provides that, except as provided by Subsection (a)(23)(K)(viii), a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager is confidential.

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. (a) Effective date, except as provided by Subsection (b) of this section: September 1, 2013.

(b) Effective date, Section 533.005(a)(23)(K)(viii), Government Code, as added by this Act: March 1, 2014.