BILL ANALYSIS

S.B. 1106
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Public Health
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Under the state's Medicaid managed care program, pharmacy benefit managers use a formula based on the maximum allowable cost price for a drug to determine reimbursement rates for pharmacies providing drugs to Medicaid recipients under the program. Interested parties assert that increased transparency is needed regarding the process by which a pharmacy benefit manager determines which drugs will be reimbursed using the formula, what the price of a drug will be, when the price will change, and what factors are used to determine maximum allowable cost prices or price changes. Noting that reimbursements often are less than the amount it costs a pharmacy to obtain the drugs from wholesalers, the parties assert that increased transparency will help 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, thereby reducing Medicaid patient access to prescription medication services, and will help to provide the state with a mechanism to ensure maximum cost savings by identifying the difference between the rate managed care organizations and pharmacies are reimbursed for the provision of certain drugs under the program. S.B. 1106 seeks to address this issue by amending current law relating to the use of maximum allowable cost lists under a Medicaid managed care pharmacy benefit plan.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

S.B. 1106 amends the Government Code to require a contract between a managed care organization and the Health and Human Services Commission (HHSC) for the organization to provide health care services to Medicaid recipients under the Medicaid managed care program to contain a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients under which the managed care organization or pharmacy benefit manager, as applicable, must meet the following requirements:

- in order to place a drug on a maximum allowable cost list, 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, has an "NR" or "NA" rating by Medi-Span, or has a similar rating by a nationally recognized reference and ensure that the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;
- 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;
- review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

- 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;
- 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;
- 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 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;
- notify HHSC 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
- effective March 1, 2014, provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider.

S.B. 1106 specifies that a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager is confidential, except as otherwise provided by the bill's provisions.

S.B. 1106 requires HHSC, in a contract between HHSC and a managed care organization that is entered into or renewed on or after the bill's effective date, to require that the managed care organization comply with the bill's provisions. The bill requires HHSC to seek to amend contracts entered into with managed care organizations before the bill's effective date to require those managed care organizations to comply with the bill's provisions. The bill specifies that, to the extent of a conflict between the bill's provisions and a provision of a contract entered into before the bill's effective date, the contract provision prevails.

EFFECTIVE DATE

Except as otherwise provided, September 1, 2013.