

HCS HB 95 -- PRESCRIPTION DRUGS AND PHARMACY BENEFIT MANAGERS
(Schaaf)

COMMITTEE OF ORIGIN: Committee on Healthcare Transformation

This substitute changes the laws regarding co-payments for prescription drugs and establishes regulations regarding pharmacy benefit managers.

CO-PAYMENTS FOR PRESCRIPTION DRUGS

When the usual and customary retail price of a prescription drug is less than the co-payment applied by a health maintenance organization or health insurer, the enrollee will only be required to pay the usual and customary retail price of the prescription drug and there will be no further charge to the enrollee or plan sponsor for the prescription.

PHARMACY BENEFIT MANAGERS

The substitute establishes regulations regarding pharmacy benefit managers. The substitute:

- (1) Requires pharmacy benefit managers to disclose on a monthly basis to the plan sponsor a summary of all information pertaining to each claim submitted to the pharmacy benefit manager;
- (2) Prohibits pharmacy benefit managers from enrolling pharmacies in contracts or modifying an existing contract without a written affirmation from the pharmacy or pharmacist, from requiring pharmacies or pharmacists from participating in a contract in order to participate in another, and from discriminating between pharmacies or pharmacists on the basis of co-payments or days of supply;
- (3) Requires prescriptions or modifications to a prescription to remain with the original pharmacy within the pharmacy benefit manager's network and not be reassigned to a different pharmacy;
- (4) Prohibits health benefit plans which provide prescription coverage from reducing, limiting, or denying coverage for immunosuppressive drugs in certain situations;
- (5) Specifies that an insurer is allowed to make uniform changes in its benefit design that apply to all covered drugs, uniformly remove a drug from the formulary list for all insureds, or increase cost-sharing obligations only due to a percentage co-insurance payment that necessarily increases with an increase in the underlying drug prices;

(6) Requires all switch communications to clearly identify the originally prescribed medication and disclose any financial interest that the health care insurer, pharmacy benefit manager, or prescribing physician has in the patient's decision to switch medications. The patient must also be advised of his or her rights regarding the proposed change and any cost-sharing changes for which he or she is responsible. Any person who issues or delivers or causes to be issued or delivered a switch communication that has not been approved, provides a misrepresentation or false statement in a switch communication, or commits any other material violation of these provisions will be subject to a fine of up to \$25,000; and

(7) Allows the prescribing physician to override any step therapy or fail first protocol when, based on sound clinical evidence, the treatment has been ineffective in treating the patient's disease or medical condition or based on sound clinical evidence and medical and scientific evidence is expected to be ineffective or is likely to cause an adverse reaction or other harm. The duration of any step therapy or fail first protocol cannot last longer than 14 days. However, if the health carrier or pharmacy benefit manager can show the originally prescribed medication is likely to require more than two weeks to provide relief, the step therapy or fail first protocol can be extended up to seven additional days.

FISCAL NOTE: No impact on General Revenue Fund in FY 2010, FY 2011, and FY 2012. Estimated Cost on Other State Funds of Unknown, could exceed \$240,719 in FY 2010; Unknown, could exceed \$437,029 in FY 2011; and Unknown, could exceed \$438,619 in FY 2012.