HB 780 with HCA 1 -- PHARMACY BENEFIT MANAGERS

SPONSOR: Morris

COMMITTEE ACTION: Voted "Do Pass with Amendments" by the Standing Committee on Health Insurance by a vote of 11 to 0.

This bill changes the laws regarding pharmacy benefit managers.

The bill defines pharmacy benefit manager (PBM), as an entity not licensed by the Department of Insurance, Financial Institutions and Professional Registration that contracts with pharmacies on behalf of plan sponsor. Before a PBM places or continues a particular drug on a maximum allowable cost list (MAC list), the drug must:

(1) Be listed as therapeutically equivalent and pharmaceutically equivalent in the United States Food and Drug Administration's most recent version of the "Orange Book" or its successor and eligible to be substituted by a pharmacist;

(2) Be available for purchase by a pharmacy contracted with the PBM, in the state from national or regional wholesalers operating in Missouri; and

(3) Not be obsolete or only temporarily available.

The bill requires that for every drug for which the PBM establishes a maximum allowable cost to determine the drug product reimbursement, the PBM must:

(1) Make available to a contracted pharmacy the drug products subject to the MAC list and the actual maximum allowable cost for each drug;

(2) Provide to each pharmacy with a contract with a PBM, subject to the MAC list access to current date of service MAC list; and

(3) Provide an appeal procedure to allow pharmacies to challenge maximum allowable costs for a specific drug or drugs as:

(a) Not meeting the requirements of these provisions; or

(b) Being below the cost at which the pharmacy may obtain the drug.

A process to appeal regarding the maximum allowable cost amount must include the following provisions:

(1) The right to appeal must be limited to 30 days following the

initial claim;

(2) The appeal process and decision notification by the PBM must not exceed a 10 day period; and

(3) If the appeal is denied, the PBM must provide the reason for the denial and identify the 11 digit national drug code of a drug product that may be purchased in accordance with the provisions of the bill.

The bill requires that if a determination is made based on an appeal under these provisions that an additional reimbursement for a drug product is required, then the amount must be paid to the pharmacy at the next regular payment cycle from the PBM to the pharmacy.

If a PBM utilizes a MAC list for drugs dispensed at retail but does not utilize the same list for drugs dispensed at mail, and the result to the plan sponsor is a higher cost to the plan sponsor or their employees, this fact must be disclosed to the plan sponsor in writing no later than 21 days prior to utilizing the list in the plan sponsor's benefit. The provisions of the bill do not apply to a MAC list maintained by the MO HealthNet program. A PBM must have a fiduciary responsibility to the plan sponsor and a PBM must disclose to the plan sponsor which drugs are defined as generic or brand differently than as defined by the United States Food and Drug Administration.

The bill requires that any PBM who fails to comply with these provisions must be subject to penalties under Section 374.049, RSMo.

HCA 1: Removes the provisions requiring the PBM to have a fiduciary responsibility; removes the requirement that a PBM has to disclose to the plan sponsor which drugs they have defined as generic or brand that differs from the USFDA definition

PROPONENTS: Supporters say that the bill does not change what the drug plan will cover or the copay or deductible the patient pays. Supporters are not asking for a change in what the patient pays, they're just asking the PBM who is the middle man between the pharmacy and insurance company to pay the actual cost of the medication. Every day pharmacies fill prescriptions for amounts below cost. Pharmacists know whether they'll lose or make money on a prescription. PBMs used to only have one price increase a year, now they have three or four increases a year. If pharmacies cannot get a fair price on the cost, they will consistently lose money. Pharmacists sign agreements that state they'll take all subscribers to a certain plan. They make a cost analysis for each patient and

look to see if they made money on the patient, even after filling scripts below cost. The bill allows a PBM to update prices quickly. Pharmacies, especially smaller pharmacies, are only able to stay in business because of the volume of prescriptions. If they don't have volume, they'll go out of business. The way the process currently exists is going to drive the small independent pharmacies out of business. Most businesses don't consistently sell below cost because it is not a sustainable or profitable business model. Many times when a pharmacy gets quoted a price from the PBM for a drug the price is very low and is allegedly available out there somewhere but pharmacies cannot find them. This bill requires the PBM to identify where or who is selling at that very low cost.

Testifying for the bill were Representative Morris; Scott Hartwig, Red Cross Pharmacy Inc.; and Christian Tadrus.

OPPONENTS: Those who oppose the bill say that what they think is reasonable and good policy is to give pharmacies access to the MAC list, updated every seven days at a minimum and requiring the elimination of products in a timely manner. There should be an appeals process available for up to 10 days after a fill with a 10 day response time for the PBM. If the appeal is upheld, the PBM must update the MAC list the next day. If denied, the PBM must give the pharmacy the National Drug Code to show that this is the price in the market. These are all common elements in the legislation in other states. When products are priced at a generic price, the PBM wants a pharmacy to go out and aggressively shop for the best price. MAC came about at the advent of generics. Manufacturers set the average wholesale price for name brand drugs. There are still brand name drugs on the market, but generic drugs create greater fluctuation in cost. Pharmacies at first were making a killing because they charged name brand prices for generics bought at generic prices. Mac lists were created by state Medicaid programs to control prescription costs.

Testifying against the bill were United Health Group; CVS Health; and Express Scripts.