KANSAS LEGISLATIVE RESEARCH DEPARTMENT

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2015 PBM LEGISLATION

This memorandum provides background information related to a study topic assigned by the Legislative Coordinating Council (LCC) to the Special Committee on Insurance. In addition to the bill specified in the requested topic (2015 SB 103), this memorandum also provides similar summary information for 2015 HB 2176. Additional memoranda outline prior consideration of PBM legislation in Kansas and past audit report findings, as well as comparative state information on legislation introduced or enacted with similarities to Kansas SB 103.

Assigned Study Topic

The charge and topic assigned by the LCC follows:

> **Review Pharmacy Benefits Management Legislation.** In February, the Senate Committee on Financial Institutions and Insurance reviewed 2015 SB 103, a bill that would enact new law establishing requirements for Pharmacy Benefits Managers (PBMs), including publication of price lists and the drugs included on the lists, an appeals process for network pharmacies requesting reimbursement for drugs subject to MAC, and penalties for PBMs found to be in violation of the act, and would amend the Pharmacy Benefits Manager Registration Act to update the definition of "pharmacy benefits manager."
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> The Committee is to review 2015 SB 103 and relevant issues associated with pharmacy benefits management, including maximum allowable cost (MAC) pricing of generic drugs, and the implications for Kansas pharmacies and health plans. [Topic requested by Senate FI&I Committee]

SB 103—Summary of Contents

SB 103, as introduced, would amend the Pharmacy Benefits Manager Registration Act (Act). Under current law, PBMs must obtain a valid certificate of registration issued by the Insurance Commissioner prior to operating as a PBM in the state. Most insurance plans, Medicare, and Medicaid use PBMs to process payments for prescription medications. The PBMs then use MAC lists to reimburse pharmacies for generic drugs.

SB 103 would place restrictions on the drugs PBMs may place on MAC lists, require the PBMs to update each MAC list every seven business days, make the updated lists available to network pharmacies in a readily accessible and usable format, and require PBMs to implement an appeal process for network pharmacies regarding the reimbursements of drugs subject to MAC pricing.

A section-by-section analysis of the bill is included in a separate memorandum addressing similar PBM legislation in other states.

SB 103—Bill Hearing and Testimony

The bill was introduced by the Senate Committee on FI&I. The Senate Committee held a hearing on the bill on February 12, 2015. Proponents of the bill included representatives of the Kansas Pharmacists Association, Funk Pharmacy, and Sabetha Health Mart. Written testimony was submitted by representatives of Genoa Healthcare and the National Community Pharmacists Association. A private citizen also submitted written testimony. The proponents generally stated the bill would create transparency and predictability of multiple source drugs and their reimbursement rates on the MAC list. One pharmacist conferee explained pharmacies have no prior knowledge of reimbursement from the PBM until a claim is processed. This process occurs just prior to the sale of the prescription drug to the patient and with a “take-it-or-leave-it” contract with a PBM, the pharmacy cannot refuse to fill the prescription based on reimbursement that is below its acquisition cost.

Opponents appearing before the Senate Committee on the bill included representatives of Express Scripts, America’s Health Insurance Plans (AHIP), CVS Health, and Prime Therapeutics. Written testimony was submitted by the President of the Kansas Chamber of Commerce. The opponents generally stated the bill minimizes the effectiveness of the MAC list pricing tool and removes incentives for pharmacies to negotiate competitive purchase prices for generic drugs from manufacturers and wholesalers. One PBM representative further explained MAC pricing was developed by State Medicaid programs after audits indicated there were overpayments for generic medications. The representative indicated, at present, 46 Medicaid programs, multiple federal programs, and most private payers use their own MAC processes.

According to the fiscal note prepared by the Division of the Budget, the Kansas Insurance Department states any additional workload that would result from the enactment of the bill could be absorbed by the agency’s current staff and budget. The Kansas Board of Pharmacy states the bill would have no fiscal effect on the agency. The Kansas Department of Health and Environment (KDHE) indicates the bill would reduce the flexibility of PBMs using MAC pricing for generic drugs, an effective mechanism to control prices for the state’s healthcare plan. By restricting the use of MAC pricing, KDHE estimates the bill would have the potential to increase the cost of the state’s healthcare plans by $3,145,976 in FY 2016 and $3,350,923 in FY 2017. Additionally, KDHE indicates the other state funded healthcare plans, KanCare and SCHIP, could experience similar cost increases, but KDHE could not provide an accurate fiscal impact because the managed care organizations have their own PBMs for those plans.

Other PBM Legislation—2015 HB 2176

HB 2176—Summary

HB 2176 would require individual and group health insurance policies that provide prescription drug coverage in the state to permit and apply a prorated daily cost-sharing rate to prescriptions dispensed by a network pharmacy for less than a 30 days' supply if the prescriber or pharmacist determines the fill or refill would be in the best interest of the patient and the patient requests and agrees to the reduced supply for the purpose of synchronizing the patient's medications.

No individual or group health insurance policies providing prescription drug coverage would be allowed to deny coverage for the dispensing of chronic medication made according to a plan for the purpose of synchronizing the filling or refilling of multiple prescriptions for the insured. Additionally, for the purpose of medication synchronization, the individual or group health plan would be required to allow a pharmacy to override any denial codes indicating a prescription is being refilled too soon.

The bill would prohibit payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions would be required to be paid in full for each prescription dispensed, regardless of any prorated copay for the beneficiary or fee paid for alignment services.

The bill would void any provision in an accident and health insurance policy that violates the provisions of Section 1 of the bill. However, the bill would provide an exception for policies, plans, contracts, or agreements operating pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA). The Kansas Insurance Department would be responsible for the enforcement of the provisions of Section 1 of the bill.

The provisions of Section 1 of the bill would not be subject to KSA 40-2249a, the test track statute requiring new mandated health benefits to be first applied only to the State Employee Health Plan for a one-year period. Additionally, the bill would add Section 1 to the statutory lists of insurance mandates applicable to all insurance policies, subscriber contracts or certificates of insurance (KSA 2014 Supp. 40-2,103), and corporations organized under the Nonprofit Medical and Hospital Service Corporation Act (KSA 2014 Supp. 40-19c09).

HB 2176—Bill Hearing and Testimony

HB 2176 was introduced by the House Committee on Health and Human Services and was referred to that Committee. The bill then was withdrawn from the House Committee on Health and Human Services and referred to the House Committee on Insurance. The House Committee on Insurance held a hearing on the bill on February 18, 2015. The bill was considered for final action on February 23, 2015. One Committee member expressed concern regarding a statement made in the fiscal note on the bill indicating the potential cost of the mandate could not be estimated. Staff was asked about the potential cost, but could not provide a response on the issue. A motion was made to pass the bill out favorably, but the motion failed for lack of a second.

At the hearing on the bill before the House Committee on Insurance, proponents of the bill included representatives of the Kansas Pharmacists Association, Sabetha Health Mart (also

a pharmacist), and the Kansas Association of Chain Drug Stores. Written testimony in favor of the bill was submitted by representatives of Pfizer, Inc., Balls Food Stores (including testimony from a pharmacist), Genoa Healthcare Company, the American Cancer Society Cancer Action Network, the American Lung Association, the Midwest Rheumatology Association, and the National Stroke Association. The proponents generally testified medication synchronization is recognized as a tool that can improve adherence for patients on a regular chronic medication regimen and pointed to health care savings for patients who adhere to prescribed medications. Additionally, several proponents noted projected cost-savings to the federal government in Medicare Part D of approximately $1.8 billion through the use of medication synchronization, at a cost of $500,000. Proponents cited barriers to medication synchronization, including “refill too soon” restrictions in which some insurers allow only 1 claim per 30-day period, and patients being charged a full month’s copay for just a partial refill to synchronize medication. Proponents noted medication synchronization assists patients by reducing the burden of frequent trips to the pharmacy and provides pharmacists with the opportunity to help increase proper medication use and adherence through monthly scheduled medication appointments, while also improving pharmacy efficiency.

A representative of America’s Health Insurance Plans provided testimony before the House Committee in opposition to the bill. Written testimony in opposition to the bill was submitted by representatives of Aetna, Inc., Express Scripts, and Prime Therapeutics. The opponents generally stated medication synchronization is not appropriate for most patients; should be restricted only to medication taken for longer than three months; and should not be used for certain drugs. Additionally, opponents indicated synchronization has not been proven to be cost-effective and legislation is not necessary for plans to offer synchronization, as some plans already provide this option. Opponents noted the synchronization program does not work for patients who cannot afford to pay for all prescriptions at the same time and patients on specialty medications often need more frequent monitoring and advanced counseling. Opponents noted the bill does not allow for many of the restrictions necessary to ensure safety, reduce prescription waste, and keep unnecessary costs down. Opponent testimony noted synchronization has a significant impact on benefit design cost control measures, such as pharmacy audits, which can result in unnecessary cost to the plan and ultimately the consumer. Opponents also noted payment of the full dispensing fee for each full or partial prescription filled would increase costs to plan sponsors and would have fiscal impacts to state-funded health plans and patients.

Written neutral testimony was provided by a representative of the KDHE. The representative stated allowing a prorated daily cost-sharing rate would have no impact on KanCare managed care organizations (MCOs), as they have no co-pays. For the Kansas Medicaid fee-for-service, patients would be required to pay prorated co-pays. Since a patient’s copay is deducted from the final amount, the State pays the pharmacy for a claim; if the patient’s co-pays are reduced, the State would have to pay slightly more for the claim resulting in a very minimal impact to fee-for-service Medicaid.

With regard to allowing for the overriding of refill-too-soon codes, the KDHE representative indicated if the agency policy were altered to allow for early refill for purposes of medication synchronization, less money would probably be recouped from pharmacy audits related to refill-too-soon overrides. However, those costs may be offset by better patient compliance with medications and associated lowered medical costs. The KDHE representative also stated its system currently pays the full dispensing fee for each claim, regardless of whether it is for a full or partial fill. The representative indicated an increase in providers billing for less than a 30-day supply might be seen if the practice were tacitly sanctioned by law, which could have a fairly significant fiscal impact. The representative suggested the addition of

language regarding dispensing fees to stipulate partial fill requests by providers should only be used for medication synchronization (or other such patient convenience or compliance reasons) and not for routine dispensing of maintenance medications. The KDHE representative also indicated a final version of the bill should include language supporting the agency's right to audit and recoup claims from providers who routinely dispense scripts for smaller quantities when full supplies could be dispensed.

According to the fiscal note prepared by the Division of the Budget, the Kansas Insurance Department states the bill would require it to enforce the provisions of the bill. Provider contracts currently are not required to be submitted to the Department and the bill does not add that requirement. It is unknown whether the bill would cause a fiscal effect for government entities. The bill appears to create a mandate on insurers that would have to be funded by the state of Kansas pursuant to federal law. The potential cost of the mandate cannot be estimated. Any fiscal affect associated with the bill is not reflected in *The 2016 Governor's Budget Report*.

For more information, please contact Melissa Calderwood-Renick, Iraida Orr, or Whitney Howard.

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