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BILL ANALYSIS

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Senate Bill 656 (Substitute S-4 as passed by the Senate) *(enrolled version)*
Sponsor: Senator Bruce Caswell
Committee: Reforms, Restructuring and Reinventing

Date Completed: 12-18-13

RATIONALE

When a pharmacist dispenses a prescription for a generic drug to a Medicaid recipient, the pharmacy benefits manager for the Department of Community Health, or for the health maintenance organization (HMO) that is the contracted health plan, reimburses the pharmacist for the cost of the drug based on maximum allowable cost (MAC) pricing. Pharmacy benefits managers (PBMs) calculate MAC pricing for generic drugs by researching and analyzing drug prices, drug availability, industry data, and information from pharmacies. As the cost of generic drugs has increased, however, concerns have been raised about the availability of drugs from wholesalers at the prices set by the PBMs. In some cases, pharmacists may request pricing reconsiderations according to a PBM's internal policies, but there is no statutory requirement for PBMs to allow appeals or to provide pharmacists with MAC pricing procedures.

It also has been suggested that some PBMs do not update MAC pricing data frequently enough, resulting in reimbursements that either are too low, in which case a pharmacist takes a loss, or too high, in which case the Medicaid reimbursement pays more than the drug is worth. Although this might not be a problem when prices fluctuate around a small average increase, some drug prices evidently have increased steeply in the past year due to consolidations within the generic drug industry. As a result, the timeliness of MAC pricing can be a significant issue.

To address these concerns, it has been suggested that the Department and contracted health plans should be required to provide MAC pricing reconsideration policies to pharmacists, and to complete pricing reconsiderations within a set time frame.

CONTENT

The bill would amend the Social Welfare Act to require the Department of Community Health (DCH) and contracted health plans to use a process for maximum allowable cost pricing reconsiderations that would have to be available and provided to providers and pharmacists.

The MAC pricing reconsideration process would have to include identification of three national drug codes for the drug in question if there were at least three available. If there were fewer than three, the policy would have to include all available national codes. All codes would have to be actually available and deliverable by a State-licensed wholesaler or manufacturer and fall into the DCH's or contracted health plans' MAC pricing.

A contracted health plan or the DCH would have to complete the reconsideration process in 10 business days, with all notification to the pharmacy in written or electronic form.

The bill states, "The department of community health and contracted health plans cannot be held accountable for failing to provide information for which they do not have access."

Proposed MCL 400.109l

BACKGROUND

MAC Pricing[1]

Medicaid recipients typically receive covered prescription drugs through pharmacies, which are reimbursed by state Medicaid agencies. With certain exceptions, Federal regulations require that each state's reimbursement for a covered outpatient drug not exceed, in the aggregate, the lower of 1) the estimated acquisition cost plus a reasonable dispensing fee, or 2) the provider's usual and customary charge to the public for the drug. States have flexibility in defining estimated acquisition cost, and typically base their calculation on list prices published in national compendia. For certain multiple-source drugs, states also reimburse on the basis of the Federal upper limit (FUL) program or the states' maximum allowable pricing programs, or both.

The FUL program was established to ensure that Medicaid takes advantage of lower market prices for certain multiple-source drugs (i.e., generic drugs and brand-name drugs for which generic alternatives are available). This program is federally administered and Federal law sets payment amounts and inclusion criteria.

States have the option of developing their own MAC programs to establish maximum reimbursement amounts for multiple-source drugs. Unlike the FUL program, MAC programs give states latitude to select the drugs covered by their programs and set the reimbursement amounts for them.

State MAC programs are designed to standardize reimbursement for chemically equivalent drugs in the same strength, dosage, and package size. The MAC price typically applies to all brand and generic drugs for each multiple-source drug. Because pharmacy reimbursement is based on a single MAC price, the program creates a financial incentive to substitute lower-cost generic equivalents for their brand-name counterparts. In general, states will not reimburse pharmacies more than a drug's MAC price. Many states, however, give pharmacies the option to appeal or dispute the MAC price if it is lower than the purchase price.

National Drug Code[2]

Federal law requires registered drug establishments to provide the Food and Drug Administration with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by the establishments for commercial distribution. The products are identified and reported by use of a unique, three-segment, 10- or 11-digit number, called the National Drug Code. The first segment identifies the labeler, which is any firm that manufactures the drug (including a repacker or relabeler) or distributes it. The second segment, called the product code, identifies a specific strength, dosage form, and formulation of a drug for a particular firm. The third segment, the package code, identifies package sizes and types.

MAC Pricing in Michigan

The Department of Community Health contracts with a pharmacy benefits manager, Magellan Medicaid Administration, Inc., which performs maximum allowable cost rate-setting and other functions with respect to Michigan's fee-for-service Medicaid pharmaceutical program. The majority of Medicaid recipients are not in the fee-for-service program (which directly reimburses providers), and instead receive services from contracted health plans (health maintenance organizations) that are selected through competitive bidding. Although most contracted health plans retain a pharmacy benefits manager, some perform their own price-setting, claims processing, and other functions that a PBM would handle.

[1] Levinson, Daniel, Inspector General, "Medicaid Drug Pricing in State Maximum Allowable Cost Programs", U.S. Department of Health and Human Services Office of Inspector General, August 2013.
[2] U.S. Food and Drug Administration website, http://www.fda.gov/Drugs/InformationonDrugs/ucm142438.htm, retrieved 12-3-13.

Magellan Medicaid Administration has a process that allows providers to request the PBM to research the Michigan Medicaid MAC list price of a particular drug and respond about product availability or a price modification. Other PBMs may have their own formal or informal process that gives pharmacies an opportunity to request a pricing reconsideration or information about price setting.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bill would help ensure that pharmacists could obtain generic drugs at MAC rates, by requiring the DCH and Medicaid HMOs to provide a pricing reconsideration process that would include a minimum number of national drug codes that were actually available and deliverable in the State at MAC pricing. Although the wholesalers themselves would not have to be identified, access to the drug codes would enable pharmacists to verify MAC pricing information against actual market conditions, and give them a point of reference when they researched drug availability and cost.

In addition, the bill would require pricing reconsiderations to be completed in 10 business days. This would address concerns regarding the frequency of updates to MAC pricing data. Some have suggested that PBMs adjust MAC pricing quickly when market prices fall, but are slow to respond when prices rise, which results in losses for pharmacists seeking reimbursement. When drug costs escalate rapidly, however, timely reconsideration is essential to prevent sizeable losses. A 10-business-day review deadline would require PBMs to make MAC pricing calculations, based on current information, without delay.

These measures would allow pharmacies to be both more efficient and more competitive. Otherwise, if they are losing money because they cannot find generic drugs at MAC rates, or because MAC pricing does not provide adequate reimbursement, pharmacies risk going out of business. The bill would help maintain Medicaid patients' and other customers' access to essential medications, especially in rural areas where pharmacies might be independent and sparsely located.

Opposing Argument

The bill should include a penalty for a PBM's failure to provide MAC pricing reconsiderations to a pharmacist or provider. If Medicaid PBMs were not forced to comply with disclosure or reconsideration requirements, it is questionable whether they would do so.

Response: Adding penalties for noncompliance would be premature at this time. There is no indication that a Medicaid PBM would act in bad faith and actively refuse to disclose information to pharmacists or provide reconsideration unless it were under the threat of penalty. If Medicaid PBMs failed to comply with the bill's provisions, the Legislature could revisit the issue and act accordingly.

Legislative Analyst: Suzanne Lowe
Glenn Steffens

FISCAL IMPACT

The bill would have an indeterminate fiscal impact on State government, with the possibility of a slight increase in costs if present trends in generic pharmaceutical prices continue.

The bill would create a price reconsideration process in concert with a longstanding section of boilerplate in the Department of Community Health budget bill, Section 1629. Section 1629 provides that, for Medicaid fee-for-service clients, the DCH must use maximum allowable cost pricing for generic drugs based on wholesale prices from at least two wholesalers that deliver in the State. The section effectively bases Medicaid fee-for-service reimbursement to pharmacies on the two lowest prices available to wholesalers. The entity handling this reimbursement

process is the pharmacy benefits manager that the DCH has contracted with, at present Magellan Medicaid Administration.

The bill would create a MAC price reconsideration process for all Medicaid clients, whether fee-for-service or managed care. (Most Medicaid managed care entities contract with PBMs although some handle the services in-house.) It also would require that price reconsiderations be concluded within 10 business days.

There have been concerns that PBM reimbursements are not based on the most-recent prices. The price reconsideration process would help to address lack of timeliness in pricing updates. To give an example, if the reimbursement set by the PBM is based on the price on November 1, 2013, and has not been updated, and the price increases on November 15, 2013, then the pharmacy will face a loss after November 15, 2013, as it will spend more on the pharmaceutical than it will be reimbursed.

The timeliness of pricing is less of an issue in a noninflationary situation because prices can either increase or decrease, so the pharmacy may see benefits as well as costs due to a lack of timely price updates. However, in the current year, there has reportedly been some significant inflation in wholesale generic drug prices. Without timely updates to the prices, pharmacies could face losses on at least some of their generic products.

The 10-day price reconsideration process would appear to address this issue. There is the potential for a fiscal impact as more up-to-date prices, in an inflationary situation, would lead to a short-term reimbursement increase to pharmacies. (If the MAC price for a product increased from $50 to $60 and the update occurred within seven days rather than one month, for example, there would be a small short-term cost increase as the legislation would ensure that the pharmacy received a more accurate reimbursement.)

This possible increased cost would be reflected both in the fee-for-service pharmaceutical reimbursement and in the eventual actuarially sound adjustments to Medicaid managed care rates. It does appear, though, that these adjustments would be short-term due to more accurate pricing and thus not large in absolute terms. It is also the case that, in a noninflationary environment, the updated prices could be larger or smaller.

Fiscal Analyst: Steve Angelotti

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