Legislative Analysis

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PHARMACY BENEFIT MANAGERS

House Bill 4276 (proposed substitute H-2)
Sponsor: Rep. Alabas A. Farhat
Committee: Health Policy
Complete to 10-12-23

SUMMARY:

House Bill 4276 would require that, if the Department of Health and Human Services (DHHS) enters into a contract with a Medicaid managed care organization that relies on a pharmacy benefit manager, the pharmacy benefit manager must do all of the following:

- For pharmacies with seven or fewer retail outlets, use a pharmacy reimbursement methodology of the lesser of national average drug acquisition cost plus a professional dispensing fee that is at least equal to to the applicable professional dispensing fee provided through section 1620 of Article 6 of 2020 PA 166 (see **Background**, below), wholesale acquisition cost plus a professional dispensing fee provided through that section, or the usual and customary charge by the pharmacy. The pharmacy benefit manager or the involved pharmacy services administrative organization could not receive any portion of the professional dispensing fee. DHHS would have to identify the pharmacies this provision applies to and provide the list of applicable pharmacies to the Medicaid managed care organizations.
- Reimburse for a legally valid claim at a rate that is not less than the rate in effect at the time the original claim adjudication was submitted at the point of sale.
- Agree to move to a transparent pass-through pricing model, in which the pharmacy benefit manager discloses the administrative fee as a percentage of the professional dispensing costs to DHHS.
- Agree to not create new pharmacy administration fees and to not increase current fees more than the rate of inflation. This provision would not apply to any federal rule or action that creates a new fee.
- Agree to not terminate an existing contract with a pharmacy with seven or fewer retail outlets for the sole reason of the additional professional dispensing fee authorized under the bill.

Reporting

The bill also would require each pharmacy benefit manager that receives reimbursement for medical services, either directly or through a Medicaid contracted health plan, to submit to DHHS all of the following information for the previous fiscal year by January 15 of 2024 and every following year:

- The total number of prescriptions that were dispensed.
- The aggregate wholesale acquisition cost for each drug on its formulary.
- The aggregate amount of rebates, discounts, and price concessions that the pharmacy benefit manager received for each drug on its formulary. The amount of rebates would have to include any utilization discounts the pharmacy benefit manager receives from a manufacturer.

- The aggregate amount identified in the above two items that was retained by the pharmacy benefit manager and did not pass through to DHHS or the Medicaid contracted health plan.
- The aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers.
- The aggregate amount of reimbursements the pharmacy benefit manager pays to contracting pharmacies.
- Any other information considered necessary by DHHS.

By March 1 of 2024 and every following year, DHHS would have to submit the information provided above to the House and Senate appropriations subcommittees on the DHHS budget, the House and Senate fiscal agencies, the House and Senate policy offices, and the State Budget Office.

Any nonaggregated information submitted under the above provisions would be confidential and could not be disclosed to any person by DHHS, and the information received would not be a public record of DHHS.

Proposed MCL 333.105i and 333.105j

BACKGROUND:

Section 1620 of Article 6 of 2020 PA 166, cited in the bill, reads as follows:

> Sec. 1620. (1) For fee-for-service Medicaid claims, the professional dispensing fee for drugs indicated as specialty medications on the Michigan pharmaceutical products list is $20.02 or the pharmacy's usual or customary cash charge, whichever is less.
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> (2) For fee-for-service Medicaid claims, for drugs not indicated as specialty drugs on the Michigan pharmaceutical products list, the professional dispensing fee for medications is as follows:
>
> > (a) For medications indicated as preferred on the department's [DHHS's] preferred drug list, $10.80 or the pharmacy's usual or customary cash charge, whichever is less.
> >
> > (b) For medications not on the department's preferred drug list, $10.64 or the pharmacy's usual or customary cash charge, whichever is less.
> >
> > (c) For medications indicated as nonpreferred on the department's preferred drug list, $9.00 or the pharmacy's usual or customary cash charge, whichever is less.
>
> (3) The department shall require a prescription co-payment for Medicaid recipients not enrolled in the Healthy Michigan plan or with an income less than 100% of the federal poverty level of $1.00 for a generic drug indicated as preferred on the department's preferred drug list and $3.00 for a brand-name drug indicated as nonpreferred on the

department's preferred drug list, except as prohibited by federal or state law or regulation.

(4) The department shall require a prescription co-payment for Medicaid recipients enrolled in the Healthy Michigan plan with an income of at least 100% of the federal poverty level of $4.00 for a generic drug indicated as preferred on the department's preferred drug list and $8.00 for a brand-name drug indicated as nonpreferred on the department's preferred drug list, except as prohibited by federal or state law or regulation.

Sections 1625 and 1626 of Article 6 of 2023 PA 119 read as follows:

Sec. 1625. The department shall not enter into any contract with a Medicaid managed care organization that relies on a pharmacy benefit manager that does not do all of the following:

(a) For pharmacies with not more than 7 retail outlets, utilizes a pharmacy reimbursement methodology of the national average drug acquisition cost plus a professional dispensing fee comparable to the applicable professional dispensing fee provided under section 1620 of this part. The pharmacy benefit manager or the involved pharmacy services administrative organization shall not receive any portion of the additional professional dispensing fee. The department shall identify the pharmacies this subdivision applies to and provide the list of applicable pharmacies to the Medicaid managed care organizations.

(b) For pharmacies with not more than 7 retail outlets, utilizes a pharmacy reimbursement methodology, when a national average drug acquisition cost price is not available, for brand drugs of the lesser of the wholesale acquisition cost, the average wholesale price less 16.7% plus a professional dispensing fee comparable to the applicable professional dispensing fee provided under section 1620 of this part, or the usual and customary charge by the pharmacy. The department shall identify the pharmacies this subdivision applies to and provide the list of applicable pharmacies to the Medicaid managed care organizations.

(c) For pharmacies with not more than 7 retail outlets, utilizes a pharmacy reimbursement methodology, when a national average drug acquisition cost price is not available, for generic drugs of the lesser of wholesale acquisition cost plus a professional dispensing fee comparable to the applicable professional dispensing fee provided under section 1620, average wholesale price less 30.0% plus a professional dispensing fee comparable to the applicable professional dispensing fee provided under section 1620 of this part, or the usual and customary charge by the pharmacy. The department shall identify the pharmacies this subdivision applies to and provide the list of applicable pharmacies to the Medicaid managed care organizations.

(d) Reimburses for a legally valid claim at a rate not less than the rate in effect at the time the original claim adjudication as submitted at the point of sale.

(e) Agrees to move to a transparent "pass-through" pricing model, in which the pharmacy benefit manager discloses the administrative fee as a percentage of the professional dispensing costs to the department.

(f) Agrees to not create new pharmacy administration fees and to not increase current fees more than the rate of inflation. This subdivision does not apply to any federal rule or action that creates a new fee.

(g) Agrees to not terminate an existing contract with a pharmacy with not more than 7 retail outlets for the sole reason of the additional professional dispensing fee authorized under this section.

Sec. 1626. (1) By January 15 of the current fiscal year, each pharmacy benefit manager that receives reimbursements, either directly or through a Medicaid health plan, from the funds appropriated in part 1 for medical services must submit all of the following information to the department for the previous fiscal year:

(a) The total number of prescriptions that were dispensed.

(b) The aggregate fiscal year paid pharmacy claims repriced using the wholesale acquisition cost for each drug on its formulary.

(c) The aggregate amount of rebates, discounts, and price concessions that the pharmacy benefit manager received for each drug on its formulary. The amount of rebates shall include any utilization discounts the pharmacy benefit manager receives from a manufacturer.

(d) The aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers.

(e) The aggregate amount identified in subdivisions (b) and (c) that were retained by the pharmacy benefit manager and did not pass through to the department or to the Medicaid health plan.

(f) The aggregate amount of reimbursements the pharmacy benefit manager pays to contracting pharmacies.

(g) Any other information considered necessary by the department.

(2) By March 1 of the current fiscal year, the department shall submit a report including the information provided under subsection (1) to the report recipients required in section 246 of this part.

(3) Any nonaggregated information submitted under this section shall be confidential and shall not be disclosed to any person by the department. Such information is not considered a public record of the department.

FISCAL IMPACT:

House Bill 4276 would reduce state costs, from lower reimbursements for pharmacy ingredient costs, by a range of $5.0 million Gross ($1.25 million GF/GP) to $12.0 million Gross ($3.0 million GF/GP) and would have no fiscal impact on local units of government. The non-state portion of the Gross represents federal Medicaid reimbursements, for which the federal reimbursement rate is 64.94% for fiscal year 2023-24. The primary fiscal driver would be that the reimbursement of pharmacies for the ingredient cost would no longer be solely based on the national average drug acquisition cost (NADAC), if the drug has a NADAC price, as currently required in DHHS boilerplate section 1625, but instead the NADAC pricing would be one of three indices used by Medicaid managed care organizations to determine the reimbursement amount for ingredient costs (the other two being the wholesale acquisition cost and the usual and customary charge), with the determination being the lesser of the three cost indices.

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