



# Senate

General Assembly

**File No. 448**

January Session, 2015

Senate Bill No. 1052

*Senate, April 2, 2015*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

***AN ACT CONCERNING MAXIMUM ALLOWABLE COST LISTS AND DISCLOSURES BY PHARMACY BENEFIT MANAGERS.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2015*) (a) As used in this  
2 section, (1) "maximum allowable cost" means the maximum amount a  
3 pharmacy benefits manager will reimburse a pharmacy for a  
4 prescription drug, and (2) "maximum allowable cost list" means a list  
5 of prescription drugs for which a maximum allowable cost has been  
6 established by a pharmacy benefits manager.

7 (b) (1) Each pharmacy benefits manager shall, prior to placing a  
8 prescription drug on a maximum allowable cost list, determine that  
9 (A) there are at least three nationally available generic drugs that are  
10 therapeutically equivalent to such drug, (B) such drug has been  
11 designated as therapeutically equivalent to other pharmaceutically  
12 equivalent products with an "A" code or as "AB" in the most recent  
13 edition or supplement of the federal Food and Drug Administration's  
14 Approved Drug Products With Therapeutic Equivalence Evaluations,

15 and (C) such drug is available for purchase by pharmacies in this state  
16 from national or regional wholesalers and is not obsolete or  
17 temporarily unavailable. As used in this subparagraph, "obsolete"  
18 means a prescription drug that may be listed in national drug pricing  
19 compendia but is no longer actively marketed by the manufacturer or  
20 labeler.

21 (2) Each pharmacy benefits manager shall remove a prescription  
22 drug from a maximum allowable cost list not later than three business  
23 days after such drug no longer meets or the pharmacy benefits  
24 manager becomes aware that such drug no longer meets a requirement  
25 under subdivision (1) of this subsection.

26 (c) Each contract entered into, renewed or amended on or after  
27 October 1, 2015, between a pharmacy benefits manager and a  
28 pharmacy or a pharmacy's contracting representative or agent shall  
29 disclose (1) the methodology and sources used by such pharmacy  
30 benefits manager to determine the maximum allowable costs for  
31 prescription drugs on each maximum allowable cost list for such  
32 pharmacy, (2) the process used by the pharmacy benefits manager to  
33 notify such pharmacy of any updates to the maximum allowable cost  
34 lists for such pharmacy, and (3) the procedures for the pharmacy to  
35 contest the maximum allowable cost of a prescription drug.

36 (d) Each contract entered into, renewed or amended on or after  
37 October 1, 2015, between a pharmacy benefits manager and a plan  
38 sponsor shall disclose (1) the methodology and sources used by such  
39 pharmacy benefits manager to determine the maximum allowable  
40 costs for prescription drugs on each maximum allowable cost list for  
41 such plan, and (2) if the pharmacy benefits manager uses a maximum  
42 allowable cost list for prescription drugs dispensed at retail but not for  
43 prescription drugs dispensed through a mail order pharmacy, such  
44 fact.

45 (e) Each pharmacy benefits manager shall:

46 (1) Provide an updated maximum allowable cost list to a plan

47 sponsor whenever there is a change to any such list under such plan;

48 (2) Disclose to a plan sponsor in writing, if a pharmacy benefits  
49 manager implements the use of a maximum allowable cost list other  
50 than as was disclosed to such plan sponsor under subdivision (2) of  
51 subsection (d) of this section, the implementation of such use not later  
52 than twenty-one business days after such implementation;

53 (3) Disclose to a plan sponsor whether such pharmacy benefits  
54 manager uses the identical maximum allowable cost list to bill the plan  
55 sponsor as when such manager reimburses in-network pharmacies. If  
56 the pharmacy benefits manager uses multiple maximum allowable cost  
57 lists for such purposes, such manager shall disclose to a plan sponsor  
58 any difference between the amount such manager bills the plan  
59 sponsor for a prescription drug and the amount such manager  
60 reimburses to any pharmacy for such drug;

61 (4) Update each maximum allowable cost list at least every seven  
62 calendar days and promptly notify and make available to each in-  
63 network pharmacy any updated list applicable to such pharmacy; and

64 (5) Establish an appeals process for a pharmacy to contest the  
65 maximum allowable cost of a prescription drug in accordance with the  
66 provisions of subsection (f) of this section. Each pharmacy benefits  
67 manager shall provide to each in-network pharmacy information  
68 concerning the appeals process, including the telephone number and  
69 other contact information of an individual who is responsible for  
70 processing such appeals for such manager.

71 (f) (1) A pharmacy may contest the maximum allowable cost of a  
72 prescription drug based on one or both of the following grounds:

73 (A) The prescription drug does not meet a requirement under  
74 subdivision (1) of subsection (b) of this section; or

75 (B) The maximum allowable cost established by the pharmacy  
76 benefits manager for the prescription drug is below the cost at which  
77 such drug is available for purchase from national or regional

78 wholesalers.

79 (2) A pharmacy contesting the maximum allowable cost of a  
80 prescription drug shall file an appeal with the pharmacy benefits  
81 manager not later than sixty calendar days after filing its submission  
82 for the initial claim for reimbursement for such drug. The pharmacy  
83 benefits manager shall investigate and issue a determination of such  
84 appeal not later than seven calendar days after such manager receives  
85 such appeal.

86 (A) If the pharmacy benefits manager determines the appeal is  
87 denied, such manager shall provide to the pharmacy the reason for the  
88 denial and the national drug code of a therapeutically equivalent  
89 prescription drug that is available for purchase by pharmacies in this  
90 state from national or regional wholesalers at a price that is equal to or  
91 less than the maximum allowable cost for the prescription drug that is  
92 the subject of the appeal.

93 (B) If the pharmacy benefits manager determines the appeal is valid,  
94 such manager shall (i) adjust the maximum allowable cost for such  
95 prescription drug retroactively to the date of the initial claim  
96 submission, and (ii) adjust such maximum allowable cost for all  
97 similarly situated in-network pharmacies not later than five business  
98 days after making such determination.

99 (g) In addition to any other penalty provided by law, a pharmacy  
100 benefits manager that violates any provision of this section may be  
101 fined not less than one thousand dollars for each violation.

102 Sec. 2. Section 38a-479aaa of the general statutes is repealed and the  
103 following is substituted in lieu thereof (*Effective October 1, 2015*):

104 As used in this section and sections 38a-479bbb to 38a-479iii,  
105 inclusive, and section 1 of this act:

106 (1) "Commissioner" means the Insurance Commissioner;

107 (2) "Department" means the Insurance Department;

108 (3) "Drug" means drug, as defined in section 21a-92;

109 (4) "Person" means person, as defined in section 38a-1;

110 (5) "Pharmacist services" includes (A) drug therapy and other  
111 patient care services provided by a licensed pharmacist intended to  
112 achieve outcomes related to the cure or prevention of a disease,  
113 elimination or reduction of a patient's symptoms, and (B) education or  
114 intervention by a licensed pharmacist intended to arrest or slow a  
115 disease process;

116 (6) "Pharmacist" means an individual licensed to practice pharmacy  
117 under section 20-590, 20-591, 20-592 or 20-593, and who is thereby  
118 recognized as a health care provider by the state of Connecticut;

119 (7) "Pharmacy" means a place of business where drugs may be sold  
120 at retail and for which a pharmacy license has been issued to an  
121 applicant pursuant to section 20-594; and

122 (8) "Pharmacy benefits manager" or "manager" means any person  
123 that administers the prescription drug, prescription device, pharmacist  
124 services or prescription drug and device and pharmacist services  
125 portion of a health benefit plan on behalf of plan sponsors such as self-  
126 insured employers, insurance companies, labor unions and health care  
127 centers.

128 Sec. 3. Section 38a-479hhh of the general statutes is repealed and the  
129 following is substituted in lieu thereof (*Effective October 1, 2015*):

130 (a) The commissioner may conduct investigations and hold hearings  
131 on any matter under the provisions of sections 38a-479aaa to 38a-479iii,  
132 inclusive, as amended by this act, and section 1 of this act. The  
133 commissioner may issue subpoenas, administer oaths, compel  
134 testimony and order the production of books, records and documents.  
135 If any person refuses to appear, to testify or to produce any book,  
136 record, paper or document when so ordered, upon application of the  
137 commissioner, a judge of the Superior Court may make such order as  
138 may be appropriate to aid in the enforcement of this section.

139 (b) Any person aggrieved by an order or decision of the  
140 commissioner under sections 38a-479aaa to 38a-479iii, inclusive, as  
141 amended by this act, and section 1 of this act may appeal therefrom in  
142 accordance with the provisions of section 4-183.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	New section
Sec. 2	<i>October 1, 2015</i>	38a-479aaa
Sec. 3	<i>October 1, 2015</i>	38a-479hhh

**INS**      *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 16 \$</b>	<b>FY 17 \$</b>
State Comptroller - Fringe Benefits (State Employee and Retiree Health Accounts)	GF, TF - Cost	See Below	See Below

**Municipal Impact:**

<b>Municipalities</b>	<b>Effect</b>	<b>FY 16 \$</b>	<b>FY 17 \$</b>
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

**Explanation**

The bill sets certain requirements concerning pharmacy benefit managers (PBM) and criteria for maximum allowable cost (MAC) lists. The appeals process in Section 1 will result in a cost to the state and self-insured municipal health plans by requiring the PBM to reduce the cost of the drug retroactive to the date of the initial claim for the appealing pharmacy and adjust the MAC for all “similarly situated” in-network pharmacies. The retroactive adjustment of the claim by the PBM will result in a transfer of the additional cost to the state and municipal self-insured plans. The cost will depend on the value of the retroactive adjustment.

There may be an impact to the state and municipal health plans to the extent that the bill’s criteria for including and excluding drugs from MAC price lists change what the plans have to pay for generic prescriptions. The impact will depend on which drugs are excluded from the list which otherwise would not be and what the price is

relative to what it would have been.

***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis****SB 1052*****AN ACT CONCERNING MAXIMUM ALLOWABLE COST LISTS AND DISCLOSURES BY PHARMACY BENEFIT MANAGERS.*****SUMMARY:**

This bill establishes requirements for a pharmacy benefit manager's (PBM) use of maximum allowable cost (MAC) lists. A "PBM" administers the prescription drug and pharmacy services portion of a health benefit plan on behalf of plan sponsors, including insurers, HMOs, labor unions, and self-insured employers. A "MAC list" is a list of prescription drugs for which a PBM has set the maximum amount it will reimburse a pharmacy per prescription.

The bill sets criteria for a PBM to include a prescription drug on a MAC list and requires PBMs that use MAC lists to (1) give certain disclosures about them to pharmacies and plan sponsors, (2) update MAC lists every seven days, and (3) establish an appeals process for pharmacies to contest a prescription drug's MAC.

Under the bill, a PBM that violates the bill is subject to a fine of at least \$1,000 for each violation, in addition to any other penalties allowed by law.

The bill extends the insurance commissioner's authority to investigate matters related to PBMs to include matters related to PBM's compliance with the bill. Anyone aggrieved by an order or decision of the commissioner may appeal to Superior Court.

EFFECTIVE DATE: October 1, 2015

**MAC LIST CRITERIA**

Under the bill, a PBM may not place a prescription drug on a MAC list unless the PBM has determined that:

1. there are at least three nationally available, therapeutically equivalent generic drugs;
2. the drug has been designated as therapeutically equivalent to pharmaceuticals rated as an “A” or “AB” drug in the U.S. Food and Drug Administration’s most recent *Approved Drug Products with Therapeutic Equivalence Evaluations*; and
3. the drug is available for purchase by pharmacies in Connecticut from national or regional wholesalers and is not temporarily unavailable or obsolete (i.e., no longer actively marketed).

The bill requires a PBM to remove from a MAC list any prescription drug that no longer meets the above requirements. It must do so within three business days after the drug no longer meets the requirements or the PBM becomes aware of this fact.

#### **REQUIRED DISCLOSURES**

The bill requires a PBM to include certain information in any contracts it enters into, renews, or amends on or after October 1, 2015 with a pharmacy, its contracting representative, or a plan sponsor.

#### ***Pharmacy***

Under the bill, a PBM must disclose in its contract with a pharmacy:

1. the methodology and sources the PBM used to determine the MAC for prescription drugs included on each MAC list,
2. the process the PBM uses to notify the pharmacy of updates to MAC lists, and
3. how the pharmacy can contest a prescription drug’s MAC (see appeals, below).

The bill requires a PBM to update each MAC list at least every seven days. It must promptly notify and make available to each in-network pharmacy any updated list applicable to the pharmacy.

**Plan Sponsor**

The bill requires a PBM to disclose in its contract with a plan sponsor:

1. the methodology and sources the PBM used to determine the MAC for prescription drugs included on each MAC list and
2. if the PBM uses a MAC list for prescription drugs dispensed at retail but not when dispensed through a mail order pharmacy.

The bill requires a PBM to give a plan sponsor (1) an updated MAC list whenever the list changes and (2) written disclosure within 21 business days of implementing a new MAC list that was not disclosed in the contract.

Additionally, under the bill, the PBM must disclose to a plan sponsor if the PBM uses the same MAC list to bill the plan sponsor as it does when it reimburses in-network pharmacies. If not, the PBM must also disclose any difference between the amount the PBM bills the plan sponsor and the amount the PBM reimburses the pharmacy.

**APPEALS PROCESS**

The bill requires a PBM to establish an appeals process for a pharmacy to contest a prescription drug's MAC. The PBM must give each in-network pharmacy information on the appeals process, including the telephone number and other contact information for the person responsible for processing appeals.

**Grounds for Appeal**

Under the bill, a pharmacy may appeal on one or both of the following grounds:

1. the prescription drug does not meet the criteria required for it to be included on a MAC list (see above) or
2. the PBM's MAC for the prescription drug is below the cost a national or regional wholesaler charges for the drug.

**Appeal Process**

A pharmacy must file an appeal with the PBM within 60 days after filing its initial claim for reimbursement for the prescription drug. The PBM must investigate and issue a decision on the appeal within seven calendar days after receiving it.

If the PBM denies the appeal, it must give the pharmacy the (1) reason for the denial and (2) national drug code of a therapeutically equivalent prescription drug Connecticut pharmacies can purchase from national or regional wholesalers at a price equal to or less than the MAC for the drug that is the subject of the appeal.

If the PBM upholds the appeal, it must adjust the MAC for (1) the prescription drug that was the subject of the appeal retroactively to the date the pharmacy filed its initial claim for reimbursement and (2) all similarly situated in-network pharmacies within five business days after upholding the appeal.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 14 Nay 5 (03/19/2015)