HB 3388
Public Health Committee Meeting

April 3rd, 2019
Minutes: Link
Witness List: Link
Video: Link (Starts at 3hrs and 58mins)

Acronyms

PBM: Pharmacy Benefit Management
MCO: Managed Care Organizations
FFS: Fee-For-Service Medicare

Committee Summary

According to the representative who brought the bill, Dr. J.D. Sheffield, the goal of HB 3388 is to remove the "monopolistic control" that PBMs and MCOs have over independent pharmacists. HB 3388 supporters argue that independent pharmacies have no ability to negotiate with PBMs and MCOs regarding reimbursement and approval of prescription drugs causing the independent pharmacies to close and negatively affect the poorest and most vulnerable Texans. A lack of transparency was repeatedly discussed concerning MCOs that own the PBMs. The witnesses against HB 3388 argued that it is possible to get better rates with self-owned PBMs because of their business relationship.

Witnesses in favor of HB 3388 also discussed the impact that MCOs are having on extremely ill children, saying that 58% of kids in the Star Kids Managed Care program have experienced major denials since switching to MCOs. Louis Rumsey (an independent pharmacy owner) said that poor sick children became the most challenging population to serve as reimbursement for medications for adults are just better. The witnesses against HB 3388 countered saying that PBMs are denying medications because they follow the state formulary which is updated twice a year. They also argued that the reason for the life-threatening delays is that Medicaid will only pay for what commercial insurance will not as per federal regulations which means that every claim must go to the state and then go through an auditing process.

Louis Rumsey, a witness in favor of HB 3388, cited to West Virginia as an example of a pharmacy benefit carve out benefitting the state. He cites to a National Community Pharmacy Association study that said when West Virginia moved to this model they saved almost double what they expected- $54 million. It was $6.41 more per claim to administer with managed care. (Note: the study was released by NCPA but actually performed by the West Virginia Bureau of Medical Services.

According to the Rider 60 report Texas paid $190 million to MCOs and PBMs in 2017. By going to a single processer, it is theorized that Texas can save as much as $90 million per year which is a 4.9% decrease in total net pharmacy costs. The same report also concluded that there could be a $73 million cost to general revenue but that was not taking into consideration that $450 million in federal funds would be saved during years 3, 4, and 5 which is a significant tax cut for Texans.

Opponents of HB 3388 countered with the fact that the Deloitte report shows a possible 2.2% increase to gross pharmacy costs under an FFS program. They also cited that currently MCOs take all the financial risk which would be shifted to the state if the FFS model were to be reinstated. They also argued that MCOs need control of prescription drugs because of the data they can provide and that the bill would make it more difficult for doctors to provide care and monitor patient compliance. They said that there has been a 24% reduction in ER visits under MCO control and a 25% reduction in opioid use due to the pharmacy data that they can supply.

Pro HB 3388	Against HB 3388
Independent pharmacies have zero ability to negotiate with PBMs and MCOs	The state would take on the financial risk of providing medications
Texas can save $90 million per year by going to a single processor	The current model has reduced the prior authorization burden by 40%
MCOs have differing requirements	States that utilize managed care have 14% lower costs in their prescription drug programs
MCOs make up 54% of the money Medicaid spends in Texas but there's still inadequate access to medication	Deloitte Report shows a 2.2% increase under FFS
Independent pharmacies close every day because there is no reimbursement for necessary medications	PBMs aren't allowing certain medications because the state changes covered drugs 2x a year
Adults have better prescription drug coverage vs. children causing a financial burden for pharmacies to take care of children	MCOs can provide quick authorization and communication. HHSC is only available 8-5 whereas PBMs are available 24/7
Texas paid approximately $190 million in upcharges to MCOs and PBMs (Ryder 60 study)	2400 Primary Care Physician recommendations led to $3k in member savings which would not have happened without pharmacy data
West Virginia moved to the FFS model and saved almost double of what they expected ($54 million)	MCO/PBM control has reduced ER visits by 24%
During years 3, 4, 5 Texas would save $450 million dollars in federal funds	MCO/PBM control has reduced opioid use by 25% due to the sharing of pharmacy data

Speakers

FOR:
Galligher, Duane (Texas Independent Pharmacies Association)
Mehta, Hannah (Self; Protect TX Fragile Kids)
Rumsey, Louis (Self; Alliance of Independent Pharmacist)
Wyatt, Anjanette (Self; Clinical Care Pharmacy/ Texas Association of Independent Pharmacy Owners)

AGAINST:
Chambers, Daniel (Cigna-Healthspring)
Ghahremani, Kay (Texas Association of Community Health Plans)
Tran-Tan, Khang (Cook Children Health Plan)
Vanhoose, Laurie (Texas Association of Health Plans)

Studies

Deloitte Report: Link
Rider 60 Report: Link
Rider 61 Report: Link
West Virginia Medicaid Pharmacy Savings Report: Link

Public Health Committee

Committee Members

Q&A Transcription (Witnesses Against HB 3388)

Rep. Frank B. James: You're representing the 11 community health plans that don't own PBMs because frankly one of my biggest problems with the health plans when they own PBMs and are doing cost sharing. Where's the money being made? It's a shell game and that's a problem. You don't own your PBM do you have a financial relationship other than a contract as a vendor?

Kay Gharemani: None whatsoever

Rep. Frank B. James: So, if the PBM – because we're doing two things in the bill, taking out the MCO and the PBM, if you took just the PBM out what would be the result of that? Would you be negotiating with the pharmacies?

Kay Gharemani: The health plans, because drugs are really different than any other type of service, the way in which the pricing works in really complicated. The health plans would not be able to do that without the expertise of the PBMs and Kang and Dan could probably verify that as well, but it would be very very difficult for the MCO to become the PBM. I think that's what you're suggesting, correct?

Rep. Frank B. James: I wasn't suggesting. I was asking because it's a convoluted system and honestly its especially convoluted when you have MCO's that have ownership of PBMs. To me that is very problematic and the way that you can play with where the money is is very concerning. That's why I was asking you because your 11 companies don't own your PBM but at the same time if we do this with the state than the state has to become the PBM.

Kay Gharemani: It's my understanding that the state contracts a conduit that is a PBM

Daniel Chambers (interjecting): I don't want to speak on behalf of the community health plans but structure functions much like a credit card and when you hit a button you get a ping and a response immediately back to paid claim. That infrastructure and negotiation I don't think could be handled at a community health plan level. Larger health plans that would have a problem with doing that. At the same time what you see in pharmacy is that if you build a network and rates going back the rates are similar

across all lines of business you're actually being leveraged for inefficiencies. Your commercial book of business, your Medicare book of business, your Medicaid book of Business, it's all on the same pipeline. It's all through similar contracts and negotiations in order to roll that out there. I completely understand from your perspective as far as transparency. I think at the same time Cigna and what we operate on is not a PBM.

Rep. Frank B. James: Honestly, I'm less concerned about your model than when the MCOs own the PBMS as far as transparency. Left pocket right pocket.

Daniel Chambers: I think you'll see that it's possible to get better rates with a self-owned PBM than you get when carving out because the profit goes somewhere. Navitus isn't doing it for free. Not arguing with transparency but the flip side is there is an opportunity to get a better rate (to) get something lower for the Texan and for the tax payer dollars because you're able to get a competitive rate from the PBM that you own.

Kay Gharemani: All of the community health plans do contract with Navitus. Each MCO has to have a direct contract with a PBM but they get better prices because of that relationship. There are economies of scale.

Rep. Bill Zedler: I appreciate what y'all are saying but somehow what you're saying doesn't square with what we were hearing with the panel before where we have an independent pharm being driven out of business. You're (a) huge operation but that doesn't justify squeezing people who are doing a service and don't have some huge operation. All you're saying about all these efficiencies doesn't square with people who have to go to the emergency room because they can't get their medication.

We didn't always have PBMs and MCOs. I don't mind a profit being made I just don't want it to be made on the backs of small independent pharmacies and on the backs of patients. And when I hear patients are being forced to go into emergency rooms because their medication is denied, and nobody called them to tell them why. Something's amiss here and it might take more than the night to get through it all. But I'll tell you this something needs to be changed because I think ultimately when you have patients being hurt and when you have operations say: OK we're going to bribe the little guy out of business, I don't think people benefit from that because there might be a larger chain pharmacy further away (and) if they're not in the same neighborhood you're going to hurt the customers

Daniel Chambers: NCPA published there are more community pharmacies open in Texas today than there were in 2011 so what I'm trying to understand is when we look at the data and we look at cause and effect how do we make those numbers reconcile. We need to have strong providers in the Medicaid network. I'm not disagreeing with you, I'm also saying that when we look at issues and items that happen, we have to compare it to a standard. So, when we say someone got denied we're assuming that there were no denials ever in FFS and there won't be in FFS going forward. There are mistakes that happen, and we'll review things and we'll make them right.

We're at risk for admissions and financially paying for stuff so we're motivated to not let that happen. As a pharmacist I want to make sure that things are followed by the letter

of the law and we have robust audit processes. My concern is when you start moving the responsibility and the end game of if someone doesn't get their medication and admission happens its concerning. I want to come collectively together and share numbers so we can get to a solution because I think clearly what we hear today is that we need to find a solution and we're here to be partners in that.

Rep. J. D. Sheffield (brought the bill): Did you say that you have more community pharmacies in business?

Daniel Chambers: That's what NCPA published from 2011 to 2017

Rep. J. D. Sheffield (brought the bill): I would surely like to see their definition of a community pharmacy vs an independent pharmacy.

Daniel Chambers: Glad to provide that

Rep. J. D. Sheffield (brought the bill): This is the third session we've been working on this bill. We don't hear about independent pharmacies opening up, we hear about them closing down.

Daniel Chambers: All I'm saying is I hear the same thing and when I look at the data it doesn't match.

Rep. J. D. Sheffield (brought the bill): When you're a doctor like me and the data doesn't fit you take a look at the patient and what's wrong with the patient. And we've got a problem here with independent pharmacies and they're not getting paid right and it's from the MCOs and it's from the PBMs that whole business arrangement. I never hear anything different but that when I speak to the pharmacist I work with and the other pharmacist I'm in contact with.