

BILL ANALYSIS

Senate Research Center

S.B. 1076
By: Schwertner
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

A “clawback” is a health insurance practice in which a pharmacy benefit manager (PBM) instructs a network pharmacy to collect an elevated copayment amount from a patient and subsequently recoups the excess amount from the pharmacy. The PBM assigns a copayment for a prescription drug that is much higher than the pharmacy’s acquisition charge, then reduces future payments to the pharmacy to recoup most of the copayment. Clawbacks are more often applied on lower-cost generics where there is greater potential to raise the copayment. Neither the initial amount paid by the patient, nor the amount clawed back by the PBM, appear to have any basis in Average Wholesale Price, Wholesale Acquisition Cost, or any other reimbursement or cost standard commonly used by PBMs to set drug prices or reimburse pharmacies.

A pharmacist survey conducted by the National Community Pharmacists Association found that 83 percent of surveyed pharmacists said they experience clawbacks 10 or more times a month.

S.B. 1076 amends Section 1369.001, Insurance Code, to prohibit a health plan issuer or its PBM subcontractor from requiring a covered patient to make a copayment for a covered prescription drug at the point of sale in an amount greater than the reimbursement the pharmacy will retain from the health plan or its PBM.

Allowing pharmacies to sell medications at a cash price lower than the assigned copayment would reduce prescription drug costs in both government and private health plans. It would improve patient adherence by ensuring that medications are sold at their most affordable price, reducing more expensive interventions and hospitalizations.

Prohibiting the practice of clawbacks would allow pharmacies to charge a fair cost for a drug that is still less than the assigned copayment. (Original Author's / Sponsor's Statement of Intent)

S.B. 1076 amends current law relating to amounts charged to an enrollee in a health benefit plan for prescription drugs covered by the plan.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1369.001, Insurance Code, by adding Subdivision (2-a) to define "enrollee."

SECTION 2. Amends Subchapter A, Chapter 1369, Insurance Code, by adding Section 1369.0041, as follows:

Sec. 1369.0041. CERTAIN PAYMENTS AND REFILLS. (a) Prohibits a health benefit plan issuer (issuer) that covers prescription drugs from requiring an enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of the applicable copayment, the allowable claim amount for the prescription drug, or the

amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

(b) Requires that a health benefit plan that covers prescription eye drops to treat a chronic eye disease or condition allow the refill of prescription eye drops if the enrollee timely pays at the point of sale the maximum amount allowed by Subsection (a) and:

(1) the original prescription states that additional quantities of the eye drops are needed;

(2) the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and

(3) the refill is dispensed on or before the last day of the prescribed dosage period and not earlier than certain dates for certain amounts of daily supply.

SECTION 3. Makes application of Section 1369.0041, Insurance Code, as added by this Act, prospective to January 1, 2018.

SECTION 4. Effective date: September 1, 2017.