Summary of PBM Bills Passed by Georgia Legislature

PBM Reform

HB 946 (Rep. Knight) & SB 313 (Sen. Burke) represent a comprehensive rewrite of Georgia's PBM code section (Chapter 64 of Title 33) that include some belt and suspenders changes to strengthen oversight and enforcement as well as innovative first in the nation changes designed to increase transparency, level the playing field and protect patients. Set forth below are highlights of the changes this bill contemplates.

Licensing and oversight

- Increases licensing fee from $500 to $2,000 and renewal fee from $400 to $1,000.
- Provides the Commissioner of Insurance ("Commissioner") the power to suspend PBM licenses for violation of the law.
- Increases monetary fines from $1,000 to $2,000 per violation and up to $10,000 per violation when a PBM knew or should have reasonably known it was in violation.
- Removes barriers on Commissioner enforcement.
- Gives the Commissioner the authority to conduct financial examinations and compliance audits; issue cease and desist orders; order reimbursement to a pharmacy or insured when a monetary loss has been incurred as a result of a PBM violation; and order payment of a fine up to $1,000 to go to a pharmacy or insured.
- Requires a PBM to make its records available to the Commissioner.
- Empowers the Commissioner to conduct audits following a violation to identify any similar violations.
- Requires PBMs to file MAC methodologies with the Commissioner's office to enable Commissioner to investigate MAC complaints.

Transparency

- Requires reporting of drugs paid 10% above and 10% below NADAC every four months and making the reports available to the public via a website.
- Prohibits differential treatment of 340b pharmacies.
- Prohibits PBMs from basing reimbursement of a drug on patient scores or outcomes.
- Prohibits PBMs from imposing point of sale or retroactive fees.
- Requires PBMs offer plans the ability to receive 100% of all rebates (broad definition of rebate).
- Requires PBMs offer plans non-spread pricing options.
- Prohibits PBMs from engaging in the practice of spread pricing in state, county, and municipality plans.

Patient Protections

- Requires PBM contracted or employed physicians who make prior authorization and step therapy decisions in connection with appeals to practice in same specialty area in which they are advising.
- Prohibits PBMs from deriving revenue from a pharmacy or patient.
- Requires PBMs to apply accepted copay assistance where there is only a brand name drug available to a patient's copay and deductible.
- Strengthens ability of retail pharmacies to provide delivery services to their patients.
- Strengthens steering prohibition to prohibit penalizing patients and plans when a patient uses a non-PBM affiliated in network pharmacy of their choice and prohibits PBM to PBM cross referral arrangements.
- Prohibits PBMs from withholding coverage or requiring a prior authorization for a lower cost therapeutically equivalent drug.
- Prohibits PBMs from removing a drug from a formulary for the purpose of incentivizing an insured to seek coverage elsewhere.
- Applies protections to patients of physician dispensers as well

PBM Surcharge

- Imposes a first in the nation surcharge on PBMs and insurer clients on all claims administered when the PBM engages in the practices of steering or imposing retroactive fees. This surcharge is imposed for the purpose of encouraging payors to use PBMs that are not engaging in these prohibited practices.

Applicability to Medicaid managed care

- Removes Medicaid managed care company exemptions so that all prohibitions and patient protections apply in the Medicaid managed care market.

Pharmacy Steering & Audits

Building off of HB 233 which was passed in 2019, HB 918 (Rep. Sharon Cooper) strengthens anti-steering provisions which prohibit pharmacies affiliated with PBMs from filling and billing for prescriptions illegally referred and also remove certain exemptions and loopholes. In addition, this bill makes significant improvements to the Pharmacy Audit Bill of Rights.

Steering

- Removes language relied upon by DCH and CVS as justification for continued steering. This language also exempted PBM affiliated pharmacies from other pharmacy requirements.
- Strengthens anti-steering law by prohibiting steering via monetary penalties including withholding coverage/requiring patients to pay full cost of drug & prohibiting PBM to PBM pharmacy referral arrangements.

- Applies anti-steering protections to limited distribution drugs not commonly carried at pharmacies or oncology clinics.
- Applies anti-steering law to Medicaid managed care companies.

Pharmacy Audit Bill of Rights

- Applies protections to desk audits as well as on-site audits.
- Limits audits to no more than 100 prescriptions and no more than 200 prescriptions in a year (refills count as 1 prescription).
- Broadens "clerical error" to include omission errors.
- Expands period to correct a clerical error from 20 to 60 days.
- Expedites period preliminary audit report must be delivered from 120 day up to 30 days.
- Prohibits a PBM from imposing a penalty or fee in connection with an audit.
- Prohibits recoupment from a pharmacy except in cases of fraud; overpayment (limited to amount over paid); and mis-fill. Provides that when a patient receives the correct drug in the correct dosage and quantity pursuant to a prescription drug order than no mis-fill shall be found to have occurred.
- Provides that a PBM shall not audit a pharmacy more than once every six months.
- Increases Commissioner of Insurance oversight and ability to impose fines and restitution.
- * Medicaid fee for service audits and recoupments are still subject to O.C.G.A. 49-4-151.1

State Oversight

HB 991 (Rep. Hatchett) creates the Healthcare Transparency and Accountability Act which seeks to shine a light on the practices of state healthcare plans via the creation of an oversight committee; ensuring the committee has broad access to plan records; and requiring certain mandatory reporting.

- Creates oversight committee to oversee state healthcare plans and is comprised of a physician, a pharmacist, a consumer member, and 6 members of the general assembly.
- Gives committees the power to:
    - Request and review records of state healthcare plan contractors and subcontractors (including PBMs); prepare public reports using aggregated data.
    - Submit written questions to departments, agencies, and contractors.
    - Make recommendations to departments and agencies.
    - Retain third-party consultants including attorneys and actuaries.
    - Request an audit of a state healthcare plan contractor or subcontractor (including PBMs) from the Department of Audits and Accounts.

- Requires contractors and subcontractors to make all books, documents, and records available to the Committee and the Department of Audits and Accounts.
- Requires a contractor to file an annual report to Committee which shall be available to the public including but not limited to amount paid by the state, MLRs, and dividends paid to shareholders or affiliates.
- Requires annual PBM report to Committee which shall be available to the public detailing, amongst other things:
    - Aggregate rebates and fees collected and the amount retained.
    - Aggregate pharmacy claims data.
    - Aggregate amount paid to affiliate pharmacies.
    - Names of 25 prescription drugs which were subject to most prior authorizations.
- Provides that an amount paid to a contractor and subcontractor is subject to disclosure to the public and is not confidential or a trade secret.
- Provides the Commissioner of Insurance with oversight and the ability to institute fines.

Medicaid Carveout Study

HB 947 (Rep. Knight) looked to, amongst other things, require DCH to engage a Medicaid actuary to conduct a study on the potential savings from carving out Rx benefits from the Medicaid managed care program and putting those benefits back into fee for service. Rep. Knight and GPhA agreed to press pause on the legislation after the Department went ahead and tasked its Medicaid actuary (the same company that conducted the West Virginia carve out study) with conducting the requested study. The study is scheduled to be completed by December of 2020. Note the midyear budget via HB 792 contained $175,000 for DCH to conduct the actuarial study.