Texas Association of Health Plans
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April 26, 2023

Dear Chairwoman Kolkhorst and Members of the Senate Committee on Health and Human Services,

The Texas Association of Health Plans is neutral on SB 1113. SB 1113 repeals the planned implementation of management of the state's preferred drug list (PDL) by Medicaid managed care organizations (MCOs), effectively allowing HHSC to permanently control the state's drug formulary.

Texas has delayed the adoption of the state's drug formulary by health plans for 10 years, prioritizing rebates over improved patient care and taxpayer savings. Under the state's management of the drug formulary, the PDL frequently changes based on the amount the state can receive in rebates on a drug, known as "rebate chasing." It also means the state's preferred list of drugs looks very different from what patients, pharmacists, and doctors are used to prescribing.

This unusual formulary design creates administrative burden for physicians, pharmacists, and health plans. Physicians often prescribe generics, but if that doesn't align with the PDL, the doctor will have to request a prior authorization or change the prescription. Pharmacists can't switch to alternative drugs for their Medicaid clients.

Additionally, managed care organizations (MCOs) must achieve 95% compliance with the state's PDL or face liquidated damages. This means that MCOs face contract damages if they do not force people off of drugs that are working for them, when they state signs a new rebate deal. This restricts Texans' access to medications prescribed by their physicians and can lead to serious health consequences delays and denials of care. Currently, about 30% of all drug denials are the result of the PDL. MCOs are now put in a situation where they have to choose between complying with rigid state requirements or prioritizing patient outcomes.

There is also evidence that drug makers have influenced the PDL, winning placement for brand drugs over cheaper generics at the expense of patient care. An investigation found drug companies have a history of paying physicians on state Medicaid drug boards. The Texas Drug Utilization Review Board (DUR) develops recommendations for the PDL, suggests clinical prior authorizations for outpatient prescription drugs, recommends educational interventions for Medicaid providers, and reviews drug utilization across the Medicaid program. Two MCO representatives participate on the DUR but do not have voting privileges and are not allowed to participate in executive meetings

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where decisions related to drug placement on the formulary, rebates, and other decisions are discussed.

The current Medicaid drug PDL prioritizes rebates over patient care, which results in delays or denials of care. In the last 10 years, we have seen patient care impeded by the state's rebate chasing requirements. Below are examples of decisions made by the state's drug board that are impacting patient outcomes.

- For several cycles, the PDL included an albuterol inhaler that didn't come with a dose counter for short term relief of asthma. Families could not tell when their inhaler was out of medication and children were sent to the ER and often hospitalized.
- The only preferred drugs for sleep disorders are controlled substances like brand-name Ambien, leading to potential abuse, negative drug interactions, and addiction. Safer, less addictive generic alternatives are available but not used.
- Regularly, the state's preferred list does not include medications for some common illnesses and diseases. For example, antibiotics on the current PDL do not treat all types of E.coli infections. Instead, treatments for these drugs are found on the non-preferred drug list. This subjects patients to sometimes painful, unnecessary delays as they wait for their prescribed medication to be approved.
- There are often no drugs on the PDL for certain conditions, such as hepatic encephalopathy (severe liver disease).

Shortages have also become a significant problem for brand-name drugs on the PDL. In 2022, rebate chasing led the state to switch back to brand name drugs like Adderall for the treatment of ADD/ADHD. When those brand drugs began having shortages, patients needed to switch back to the generic options they were previously on, which now required prior authorization.

Drug shortages are currently not an allowable exception to the state's preferred drug list. State rules dictate that MCOs should be denying these prior authorization requests in order to meet 95% compliance with the PDL; however, MCOs also have a responsibility to support healthy patient outcomes. As an example, MCOs face state mandated denials for physicians requesting prior authorization overrides for individuals with seizure disorders or behavioral health needs.

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Shortages are not the only challenge for pharmacists. Pharmacies may not routinely carry certain brand name drugs, which can be very expensive to stock, especially when there is a generic equivalent readily available. Prior to the 95% compliance rule, MCOs would override a prior authorization denial to allow the dispensing of a more available alternative, even though this is also not an allowable exception to the PDL.

Significant patient protections need to be incorporated into decisions involving Medicaid drug coverage, if the Legislature intends to allow HHSC to continue to manage the state's formulary. The Legislature should also address administratively burdensome requirements for providers and pharmacists.

Exceptions to the PDL that protect patients from non-medical switching are needed. Texas Medicaid patients should not be forced to change to a drug on the state's PDL if:

- The drug is contraindicated or will likely cause an adverse reaction
- The drug is expected to be ineffective
- The patient has tried and failed the drug
- The patient is stable on another drug
- The drug is not in the best interest of the patient
- A non-preferred drug was prescribed for a patient being discharged from an inpatient facility and the patient is stable
- The drug is experiencing shortages
- A pharmacy cannot easily stock the drug or the drug is cost-prohibitive to stock

Additionally, the Legislature should:

- Allow three voting members on the DUR Board for managed care plans and allowing those representatives to participate in executive committee meetings. MCOs assume full financial risk in exchange for providing all necessary care for the Texans they serve. The state hinders this effective advocacy of member outcomes by denying Medicaid health plans a voice in the most utilized benefit in Medicaid.

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- Require proactive review of new drugs coming to market, and off-cycle reviews of medications when there is a substantial safety or irregular utilization issue. Delaying drug reviews and failing to adjust guidance on medications is dangerous for patients and costly for health plans.
- Provide a searchable database of drugs on the PDL that will result in the need for fewer prior authorization requests from providers.
- Limit HHSC's management of the PDL to a 5 year period to determine if the improvements outlined above have produced greater drug stability for the state's most vulnerable Texans.

The Medicaid drug formulary carve-in was designed as a two-step process. The first step, which took place in 2011, involved the carve-in of prescription drug coverage into managed care. The aim was to slow down the rapid growth in Medicaid drug spending that had been occurring over the previous decade. At the time, Medicaid drug costs were spiraling out of control, almost doubling in ten years, and increasing by more than 6.5% on average per year. The carve-in was successful in reducing drug cost growth in Texas Medicaid by 50%.

If the Legislature decides to pass SB 1113, we strongly recommend that it includes additional patient protections and Vendor Drug Program changes, as outlined in this letter.

Sincerely,

Jamie Dudensing, RN
CEO
Texas Association of Health Plans