House Bill 2123

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires State Board of Pharmacy to license pharmacy benefit managers.

Imposes limits on audits of pharmacies by pharmacy benefit managers and other entities.

Requires pharmacy benefit managers that have contracted with provider of health care plan or that are under control of provider of health care plan to permit covered individuals to fill mail order prescriptions at retail community pharmacy in same manner and at similar price that individuals fill orders at mail order pharmacies.

Places restrictions on use of maximum allowable cost pricing index by pharmacy benefit managers.

A BILL FOR AN ACT

Relating to prescription drugs.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1)(a) As used in this section and sections 2 to 4 of this 2013 Act, "pharmacy benefit manager" means a nongovernmental entity that:

(A) Processes claims for pharmacies or pharmacists;

(B) Makes payments for claims for prescribed drugs to pharmacies or pharmacists; or

(C) Negotiates rebates with drug manufacturers for drugs paid for as described in subparagraphs (A) and (B) of this paragraph.

(b) "Pharmacy benefit manager" does not include a provider of a health benefit plan, as defined in ORS 743.730, that performs a service described in paragraph (a) of this subsection.

(2) To conduct business in this state, a pharmacy benefit manager must obtain a license from and annually renew a license with the State Board of Pharmacy.

(3) To obtain a license under this section, a pharmacy benefit manager must:

(a) Submit an application on a form prescribed by the board by rule.

(b) Pay a license fee adopted by the board by rule.

(4) To renew a license under this section, a pharmacy benefit manager must pay a renewal fee adopted by the board by rule.

(5) The board may refuse to issue or renew, or may suspend, revoke or restrict, the license of a pharmacy benefit manager that violates this section or sections 2 to 4 of this 2013 Act.

(6) The board shall deposit all moneys collected under this section into the State Board of Pharmacy Account established in ORS 689.139. Moneys collected under this section may be used only for the purpose of administering this section and sections 2 to 4 of this 2013 Act.

SECTION 2. (1) For purposes of this section:

(a) "Audit" means a review of the records of a pharmacy by or on behalf of an entity that

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

finances or reimburses the cost of health care services or prescription drugs.

(b) "Entity" includes:

(A) A pharmacy benefit manager;

(B) A health benefit plan as defined in ORS 743.730;

(C) A third party administrator as defined in ORS 414.841;

(D) A state agency or person that has contracted with a state agency; or

(E) An entity that represents or is employed by one of the entities described in subparagraphs (A) to (D) of this paragraph.

(2) When an entity conducts an audit under this section, the entity must conduct the audit in consultation with a licensed pharmacist.

(3) An entity may not conduct an audit:

(a) If a claim that is the subject of the audit was submitted more than 18 months prior to the date of the audit.

(b) Of more than 200 claims.

(4) If an entity is conducting an audit at a pharmacy, the entity:

(a) Must give the pharmacy 10 days advanced written notice of the audit. Written notice under this paragraph must include the range of prescription numbers subject to the audit or the date on which prescriptions subject to the audit were dispensed.

(b) May not conduct the audit during the first five business days of a month unless the pharmacy agrees to the audit being conducted during that period of time.

(5) An entity may not:

(a) In conducting an audit, include dispensing fees in the calculation of an overpayment unless the prescription was filled incorrectly;

(b) Recoup costs associated with clerical or recordkeeping errors; or

(c) Charge the pharmacy for a denied or disputed claim until the audit and the appeals process described in subsection (11) of this section are final.

(6) Information obtained during an audit is confidential and an entity may not disclose such information.

(7) For purposes of this section, a pharmacy may use the following records to validate a claim for filling or refilling a prescription or making a change to a prescription:

(a) An electronic or physical copy of the prescription from the health care provider that prescribed the drug; or

(b) Any prescription that complies with ORS chapter 689.

(8)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The report must be received by the pharmacy no later than 60 days after the date on which the audit was completed. A report may be sent by mail with return receipt requested or electronically with receipt confirmation requested.

(b) After receiving a report under paragraph (a) of this subsection, a pharmacy may respond to the report. In its response, the pharmacy may provide additional validating records and comment on or clarify the findings of the audit. The response must be sent by the pharmacy to the entity no later than 30 days after the date on which the pharmacy receives the report.

(9) If an audit results in a dispute or denial of a claim, the entity conducting the audit must allow the pharmacy to resubmit the claim using any commercially reasonable method

so long as the period of time during which the claim may be submitted under the terms of the health benefit plan has not expired.

(10) No later than 120 days after receiving a response under subsection (8)(b) of this section or, if a pharmacy makes an appeal under subsection (11) of this section, after the completion of the appeal process, an entity must provide the pharmacy that is the subject of the audit with a final report of the audit. The report must include a final accounting of all moneys to be recovered by the entity.

(11) An entity that conducts an audit under this section shall, prior to conducting an audit, establish a written appeal process by which a pharmacy may appeal a denied or disputed claim. At the time of conducting an audit, the entity shall provide the pharmacy with written notice of the appeal process.

(12) Notwithstanding this section, an entity may file an action for fraud against a pharmacy as otherwise allowed under the laws of this state.

(13) This section does not apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records of prescription drugs dispensed under the state Medicaid program.

SECTION 3. (1) As used in this section,

(a) "Covered individual" means an individual receiving prescription drug coverage under a health benefit plan, as defined in ORS 743.730, or from a government program or pharmacy benefit manager.

(b) "Mail order pharmacy" means a pharmacy that:

(A) Has the primary business of receiving prescriptions by mail or electronic transmission as defined in ORS 689.005;

(B) Dispenses prescribed drugs to patients through the use of the mail or a private delivery service; and

(C) Primarily consults with patients by mail or electronic means.

(c) "Retail community pharmacy" means a pharmacy that is open to the public, serves walk-in customers and allows individuals to whom a prescription drug is being dispensed the opportunity to consult with a pharmacist face to face.

(2) A pharmacy benefit manager that has contracted with the provider of a health benefit plan or that is under the control of a provider of a health benefit plan:

(a) Shall permit a covered individual to fill a mail order prescription at:

(A) Any mail order pharmacy; or

(B) Any retail community pharmacy that is part of the network of pharmacies served by the pharmacy benefit manager if the retail community pharmacy agrees to dispense the prescription drug for a price that is substantially the same as the price offered by a mail order pharmacy.

(b) May not impose a copayment, fee or other condition on a covered individual who elects to fill a prescription at a retail community pharmacy that is part of the network of pharmacies served by the pharmacy benefit manager that is different from a copayment, fee or other condition that the pharmacy benefit manager imposes on a covered individual who elects to fill a prescription at a mail order pharmacy.

(c) Shall utilize the same benchmarks, including the same average wholesale price, maximum allowable cost pricing index and prescription drug codes, to reimburse all pharmacies that are to be reimbursed under the same terms of a contract entered into between a phar-

macy and a provider of a health benefit plan regardless of whether the pharmacy is a mail order pharmacy or a retail community pharmacy.

(d) If the pharmacy benefit manager has entered into a contract with the provider of a health benefit plan, shall expressly disclose to the provider whether the pharmacy benefit manager, for prescription drugs dispensed through a mail order pharmacy owned by the pharmacy benefit manager:

(A) Retains a greater portion of a drug manufacturer rebate than for prescription drugs dispensed through a retail community pharmacy; or

(B) Receives additional remuneration from a third party.

SECTION 4. (1) As used in this section:

(a) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will pay toward the cost of a drug.

(b) "Nationally available" means that all pharmacies in this state can purchase the drug, without limitation, from regional or national wholesalers and that the product is not obsolete or temporarily available.

(c) "Therapeutically equivalent" means the drug is identified as therapeutically or pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

(2) A pharmacy benefit manager may not place a prescription drug on a maximum allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if the prescription drug does not have three or more nationally available and therapeutically equivalent drug substitutes.

(3) A pharmacy benefit manager shall remove a prescription drug from a maximum allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and modifications are necessary to remain consistent with changes in the national marketplace for prescription drugs. Eliminations and modifications made under this subsection must be made in a timely fashion.

(4)(a) A pharmacy benefit manager shall disclose to a pharmacy for which the pharmacy benefit manager processes claims, makes payment of claims or procures drugs:

(A) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefit manager.

(B) At least once every seven business days, the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefit manager.

(b) A pharmacy benefit manager shall give prompt written notification to a pharmacy described in paragraph (a) of this subsection of any change made to a maximum allowable cost pricing index or maximum allowable cost rates.

(5) A pharmacy benefit manager shall establish a procedure by which a pharmacy may contest a maximum allowable cost rate. A procedure established under this subsection must require a pharmacy benefit manager to respond to a pharmacy that has contested a maximum allowable cost within 15 calendar days. If the pharmacy benefit manager changes the rate, the change must:

(a) Become effective on the date on which the pharmacy initiated proceedings under this subsection; and

(b) Apply to all pharmacies in the network of pharmacies served by the pharmacy benefit

manager.

(6) A pharmacy benefit manager shall disclose to a provider of a health benefit plan, as defined in ORS 743.730, with which the pharmacy benefit manager has entered into a contract:

(a) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefit manager;

(b) As soon as practicable, any change made to a maximum allowable cost pricing index or maximum allowable cost rates;

(c) Not later than 21 business days after implementing the practice, the utilization of a maximum allowable cost pricing index or maximum allowable cost rates for prescription drugs dispensed at a retail community pharmacy, as defined in section 3 of this 2013 Act; and

(d) Whether the pharmacy benefit manager used identical maximum allowable cost rates for billing the provider of the health benefit plan and for reimbursing a pharmacy and, if the pharmacy benefit manager used different maximum allowable cost rates, the difference between the amount billed and the amount reimbursed.
