

House Bill 2716

Sponsored by Representative SCHARF, Senator HANSELL; Representatives DIEHL, LEVY B, MORGAN, WRIGHT, Senators DEMBROW, FINDLEY, PATTERSON, THATCHER (Presession filed.)

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**.

Prohibits specified practices by insurers and pharmacy benefit managers in reimbursing cost of prescription drugs.

A BILL FOR AN ACT

1
2 Relating to reimbursing the cost of prescription drugs; amending ORS 735.534 and 743A.062.

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

4 **SECTION 1.** ORS 735.534 is amended to read:

5 735.534. (1) As used in this section:

6 (a)(A) "Generally available for purchase" means a drug is available for purchase in this state
7 by a pharmacy from a national or regional wholesaler at the time a claim for reimbursement is
8 submitted by a network pharmacy.

9 (B) A drug is not "generally available for purchase" if the drug:

10 (i) May be dispensed only in a hospital or inpatient care facility;

11 (ii) Is unavailable due to a shortage of the product or an ingredient;

12 (iii) Is available to a pharmacy at a price that is at or below the maximum allowable cost only
13 if purchased in substantial quantities that are inconsistent with the business needs of a pharmacy;

14 (iv) Is sold at a discount due to a short expiration date on the drug; or

15 (v) Is the subject of an active or pending recall.

16 (b) "List" means the list of drugs for which maximum allowable costs have been established.

17 (c) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager
18 will reimburse a pharmacy for the cost of a drug.

19 (d) "Multiple source drug" means a therapeutically equivalent drug that is available from at
20 least two manufacturers.

21 (e) "Therapeutically equivalent" has the meaning given that term in ORS 689.515.

22 (2) A pharmacy benefit manager registered under ORS 735.532:

23 (a) May not place a drug on a list unless there are at least two multiple source drugs, or at least
24 one generic drug generally available for purchase.

25 (b) Shall ensure that all drugs on a list are generally available for purchase.

26 (c) Shall ensure that no drug on a list is obsolete.

27 (d) Shall make available to each network pharmacy at the beginning of the term of a contract,
28 and upon renewal of a contract, the specific authoritative industry sources, other than proprietary
29 sources, the pharmacy benefit manager uses to determine the maximum allowable cost set by the
30 pharmacy benefit manager.

31 (e) Shall make a list available to a network pharmacy upon request in a format 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.

- 1 (A) Is electronic;
- 2 (B) Is computer accessible and searchable;
- 3 (C) Identifies all drugs for which maximum allowable costs have been established; and
- 4 (D) For each drug specifies:
- 5 (i) The national drug code; and
- 6 (ii) The maximum allowable cost.
- 7 (f) Shall update each list maintained by the pharmacy benefit manager every seven business days
- 8 and make the updated lists, including all changes in the price of drugs, available to network phar-
- 9 macies in the format described in paragraph (e) of this subsection.
- 10 (g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable
- 11 cost.
- 12 (h) May not **discriminate against a 340B pharmacy in a manner that prevents or interferes**
- 13 **with an enrollee's choice to receive drugs from the pharmacy by [reimburse] reimbursing a**
- 14 **340B pharmacy [differently] less than any other network pharmacy or imposing a fee, charge-back**
- 15 **or other adjustment on a claim for reimbursement based on [its] a pharmacy's status as a 340B**
- 16 **pharmacy.**
- 17 (i) May not retroactively deny or reduce a claim for reimbursement of the cost of services after
- 18 the claim has been adjudicated by the pharmacy benefit manager unless the:
- 19 (A) Adjudicated claim was submitted fraudulently;
- 20 (B) Pharmacy benefit manager's payment on the adjudicated claim was incorrect because the
- 21 pharmacy or pharmacist had already been paid for the services;
- 22 (C) Services were improperly rendered by the pharmacy or pharmacist; or
- 23 (D) Pharmacy or pharmacist agrees to the denial or reduction prior to the pharmacy benefit
- 24 manager notifying the pharmacy or pharmacist that the claim has been denied or reduced.
- 25 (j) **May not reimburse a pharmacy or pharmacist an amount less than the pharmacy**
- 26 **benefit manager reimburses an affiliate of the pharmacy benefit manager for the same drug**
- 27 **or services.**
- 28 (k) **May not impose qualifications on pharmacies or pharmacists or otherwise limit or**
- 29 **restrict pharmacies or pharmacists from participating in the pharmacy benefit manager's**
- 30 **network based on a qualification that is beyond the requirements for licensing adopted by the**
- 31 **State Board of Pharmacy.**
- 32 (3) Subsection (2)(i) of this section may not be construed to limit pharmacy claim audits under
- 33 ORS 735.540 to 735.552.
- 34 (4) A pharmacy benefit manager must establish a process by which a network pharmacy may
- 35 appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network phar-
- 36 macy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net
- 37 amount that the network pharmacy paid to the supplier of the drug. The process must allow a net-
- 38 work pharmacy a period of no less than 60 days after a claim is reimbursed in which to file the
- 39 appeal. An appeal requested under this section must be completed within 30 calendar days of the
- 40 pharmacy making the claim for which appeal has been requested.
- 41 (5) A pharmacy benefit manager shall allow a network pharmacy to submit the documentation
- 42 in support of its appeal on paper or electronically and may not:
- 43 (a) Refuse to accept an appeal submitted by a person authorized to act on behalf of the network
- 44 pharmacy;
- 45 (b) Refuse to adjudicate an appeal for the reason that the appeal is submitted along with other

1 claims that are denied; or

2 (c) Impose requirements or establish procedures that have the effect of unduly obstructing or
3 delaying an appeal.

4 (6) A pharmacy benefit manager must provide as part of the appeals process established under
5 subsection (4) of this section:

6 (a) A telephone number at which a network pharmacy may contact the pharmacy benefit man-
7 ager and speak with an individual who is responsible for processing appeals;

8 (b) A final response to an appeal of a maximum allowable cost within seven business days; and

9 (c) If the appeal is denied, the reason for the denial and the national drug code of a drug that
10 may be purchased by similarly situated pharmacies at a price that is equal to or less than the
11 maximum allowable cost.

12 (7)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall:

13 (A) Make an adjustment for the pharmacy that requested the appeal from the date of initial
14 adjudication forward; and

15 (B) Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any addi-
16 tional charges.

17 (b) If the request for an adjustment has come from a critical access pharmacy, as defined by the
18 Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the
19 adjustment approved under paragraph (a) of this subsection shall apply only to critical access
20 pharmacies.

21 (8) This section does not apply to the state medical assistance program.

22 (9) The Department of Consumer and Business Services may adopt rules to carry out the pro-
23 visions of this section.

24 **SECTION 2.** ORS 743A.062 is amended to read:

25 743A.062. (1) As used in this section, “medical assistance program” means the state program
26 that provides medical assistance as defined in ORS 414.025.

27 (2) An insurance policy or contract providing coverage for a prescription drug to a resident of
28 this state may not:

29 (a) Exclude coverage of the drug for a particular indication solely on the grounds that the in-
30 dication has not been approved by the United States Food and Drug Administration if the Health
31 Evidence Review Commission established under ORS 414.688 or the Pharmacy and Therapeutics
32 Committee established under ORS 414.353 determines that the drug is recognized as effective for the
33 treatment of that indication:

34 (A) In publications that the commission or the committee determines to be equivalent to:

35 (i) The American Hospital Formulary Service drug information;

36 (ii) “Drug Facts and Comparisons” (Lippincott-Raven Publishers);

37 (iii) The United States Pharmacopoeia drug information; or

38 (iv) Other publications that have been identified by the United States Secretary of Health and
39 Human Services as authoritative;

40 (B) In the majority of relevant peer-reviewed medical literature; or

41 (C) By the United States Secretary of Health and Human Services; or

42 (b) For an insured who is enrolled in the medical assistance program:

43 (A) Except as provided in subsection (3) of this section, require a prescription for the drug to
44 be filled or refilled at a mail order pharmacy; or

45 (B) Require a prescription for the drug to be filled or refilled at a pharmacy that is not a local

1 pharmacy enrolled in the medical assistance program.

2 **(c) Reimburse a pharmacy or pharmacist an amount less than the reimbursement paid**
3 **to an affiliate of the issuer of the policy or the contractor for the same drug or service.**

4 **(d) Impose qualifications on pharmacies or pharmacists or otherwise limit or restrict**
5 **pharmacies or pharmacists from participating in the network based on a qualification that**
6 **is beyond the requirements for licensing adopted by the State Board of Pharmacy.**

7 (3) Subsection (2)(b)(A) of this section does not prohibit an insurer from requiring a medical as-
8 sistance recipient to fill or refill a prescription for a specialty drug at a mail order pharmacy that
9 is a specialty pharmacy.

10 (4) Required coverage of a prescription drug under this section shall include coverage for med-
11 ically necessary services associated with the administration of that drug.

12 (5) Nothing in this section requires coverage for any prescription drug if the United States Food
13 and Drug Administration has determined use of the drug to be contraindicated.

14 (6) Nothing in this section requires coverage for experimental drugs not approved for any indi-
15 cation by the United States Food and Drug Administration.

16 (7) This section is exempt from ORS 743A.001.
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