LC 155
2016 Regular Session
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D R A F T

SUMMARY

Authorizes Department of Consumer and Business Services to adopt by rule fees that are reasonably calculated to pay costs associated with administrating laws regulating pharmacy benefit managers.

Provides department with power to civilly enforce laws regulating pharmacy benefit managers.

Requires pharmacy benefit managers to reimburse network pharmacies for drugs at rate that is not less than price of drugs specified in most recently updated version of list establishing maximum allowable costs for drugs.

Updates and clarifies laws regulating pharmacy benefit managers.

A BILL FOR AN ACT

Relating to pharmacy benefit managers; creating new provisions; and amending ORS 735.530, 735.532, 735.534, 735.544 and 735.550.

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

FEES

SECTION 1. ORS 735.532 is amended to read:

735.532. (1) To conduct business in this state, a pharmacy benefit manager must register with the Department of Consumer and Business Services and annually renew the registration.

(2) To register under this section, a pharmacy benefit manager must:

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

(b) Pay a registration fee[*, not to exceed $50,*] adopted by the department by rule.

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.

(3) To renew a registration under this section, a pharmacy benefit manager must pay a renewal fee[*, not to exceed $50,*] adopted by the department by rule.

(4) Fees adopted under subsections (2)(b) and (3) of this section must be reasonably calculated to pay the costs incurred by the department under ORS 735.530 to 735.552.

[*(4)*] **(5)** The department shall deposit all moneys collected under this section into the Consumer and Business Services Fund created in ORS 705.145.

ENFORCEMENT

SECTION 2. Section 3 of this 2016 Act is added to and made a part of ORS 735.530 to 735.552.

SECTION 3. Subject to the provisions of ORS chapter 183, the Department of Consumer and Business Services, upon receiving a complaint or upon the department's own motion, may:

(1) Suspend, revoke or refuse to renew the registration of a pharmacy benefit manager under ORS 735.532 for violating a provision of ORS 735.530 to 735.552; or

(2) Impose a civil penalty not to exceed $10,000 on a pharmacy benefit manager for violating a provision of ORS 735.530 to 735.552.

MAXIMUM ALLOWABLE COSTS

SECTION 4. ORS 735.534 is amended to read:

735.534. (1) As used in this section:

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

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

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

(d) "Network pharmacy" means a retail drug outlet registered under ORS 689.305 that contracts with a pharmacy benefit manager.

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

(2) A pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent, multiple source drugs, or at least one generic drug available [*from*] **for sale by** only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

(b) Shall ensure that all drugs on a list are generally available for purchase by pharmacies in this state from national or regional wholesalers.

(c) Shall ensure that all drugs on a list are not obsolete.

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit manager.

(e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy.

(f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format.

(g) Shall reimburse a network pharmacy for a drug dispensed by the network pharmacy at a rate that is not less than the price of the drug specified in the most recently updated version of the list for which the pharmacy benefit manager has established the maximum allowable cost for that drug.

[*(g)*] **(h)** Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(3) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal [*its*] **the network pharmacy's** reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the [*net*] amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.

(4) A pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

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

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

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

(5)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall [*make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward.*] **adjust the reimbursement for the drug for each network pharmacy that received reimbursement for the drug. For each network pharmacy, the amount of the adjustment must equal the difference between the maximum allowable cost and the amount paid by the network pharmacy to the supplier of the drug. For each network pharmacy, the adjustment must be made for the day on which the appeal was initiated and each subsequent day that the maximum allowable cost was less than the amount paid by the network pharmacy to the supplier of the drug.**

(b) If the request [*for an adjustment has come from*] **to adjust the reimbursement made to the network pharmacy was initiated by** a critical

access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies.

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

SECTION 5. Section 6 of this 2016 Act is added to and made a part of ORS 735.530 to 735.552.

SECTION 6. (1) A pharmacy benefit manager shall provide to the Department of Consumer and Business Services, in a form and manner prescribed by the department, the telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals, as required by ORS 735.534 (4)(a).

(2) The department shall post on the department's website the telephone number provided to the department under subsection (1) of this section by each pharmacy benefit manager.

OTHER AMENDMENTS

SECTION 7. ORS 735.530 is amended to read:

735.530. As used in ORS 735.530 to 735.552:

(1) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or service.

(2) "Insurer" has the meaning given that term in ORS 731.106.

(3) "Pharmacist" has the meaning given that term in ORS 689.005.

[*(4)*] **(4)(a)** "Pharmacy" has the meaning given that term in ORS 689.005.

(b) "Pharmacy" includes an entity that provides or oversees administrative services for two or more pharmacies.

(5)(a) "Pharmacy benefit manager" means a person that contracts with pharmacies on behalf of an insurer, a third party administrator or the

Oregon Prescription Drug Program established in ORS 414.312 to:

(A) Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(B) Pay pharmacies or pharmacists for prescription drugs or medical supplies; or

(C) Negotiate rebates with manufacturers for drugs paid for or procured as described in this paragraph.

(b) "Pharmacy benefit manager" does not include a health care service contractor as defined in ORS 750.005.

(6) "Third party administrator" means a person licensed under ORS 744.702.

SECTION 8. ORS 735.544 is amended to read:

735.544. An [*entity's*] **entity or an independent third party that contracts with an entity must base a** finding that a claim was incorrectly presented or paid [*must be based*] on identified transactions and not [*based*] on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs.

SECTION 9. ORS 735.550 is amended to read:

735.550. (1)(a) After conducting an audit **or having an audit conducted**, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 45 days after the date on which the audit was completed and must be sent:

(A) By mail or common carrier with a return receipt requested; or

(B) Electronically with electronic receipt confirmation.

(b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than 45 days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under ORS 735.542 (1) and to provide additional documentation in support of the claim. The entity shall consider a reasonable

request for an extension of time to submit documentation to contest the report or any findings in the report.

(2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail.

(3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under ORS 735.542 (1). The final report must include a final accounting of all moneys to be recovered by the entity.

(4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under ORS 735.542 (1) are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under ORS 735.542 (1) are final.

UNIT CAPTIONS

SECTION 10. The unit captions used in this 2016 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2016 Act.
