HOUSE BILL NO. HB0035

Pharmacy benefit manager regulation.

Sponsored by: Joint Corporations, Elections & Political Subdivisions Interim Committee

A BILL

for

AN ACT relating to insurance; regulating the provision of pharmacy benefits; requiring licensure of pharmacy benefit managers; establishing a licensing fee; providing definitions; requiring the promulgation of rules; providing requirements for audits conducted by pharmacy benefit managers; providing requirements for drug maximum allowable cost lists; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-52-101 through 26-52-104 are created to read:

CHAPTER 52

PHARMACY BENEFIT MANAGERS

26-52-101. Licensure of pharmacy benefit managers.

No person shall act or hold himself out as a pharmacy benefit manager in this state unless he obtains a license from the department. The department shall through rules establish license requirements and procedures for the licensing of pharmacy benefit managers consistent with this article. The requirements shall only provide for the adequate identification of licensees and the payment of the required licensing fee.

26-52-102. Definitions.

(a) As used in this article:

(i) "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 device;

(ii) "Insurer" means the entity defined in W.S. 26-1-102(a)(xvi) and who provides health insurance coverage in this state;

(iii) "List" means the list of drugs for which a pharmacy benefit manager has established a maximum allowable cost;

(iv) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacist or pharmacy for the cost of a generic drug;

(v) "Network providers" means those pharmacies that provide covered health care services or supplies to an insured or a member pursuant to a contract with a network plan to act as a participating provider;

(vi) "Pharmacy" means an entity through which pharmacists or other persons practice pharmacy as specified in W.S. 33-24-124;

(vii) "Pharmacy benefit manager" means an entity that contracts with a pharmacy on behalf of an insurer or

third party administrator to administer or manage prescription drug benefits.

26-52-103. Pharmacy benefit manager audits.

(a) Any pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager who conducts an audit of a pharmacy shall follow the following procedures:

(i) Provide written notice to the pharmacy not less than ten (10) business days before conducting any on-site, initial audit;

(ii) Conduct any audit requiring clinical or professional judgment through or in consultation with a licensed pharmacist;

(iii) Limit the period covered by the audit to not more than two (2) years from the date that an audited claim was submitted or adjudicated, whichever date is earlier;

(iv) Accept verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician or other authorized practitioner, to validate the pharmacy record;

(v) Accept legal prescriptions, including medication administration records, faxes, electronic prescriptions or documented telephone calls from the prescriber or the prescriber's agent, to validate claims in connection with prescriptions, refills or changes in prescriptions;

(vi) Apply the same standards and parameters to each audited pharmacy as are applied to other similarly situated pharmacies in a pharmacy network contract in this state;

(vii) Not conduct any audit during the first seven (7) calendar days of any month without the consent of the audited pharmacy; and

(viii) Establish a written appeals process and provide a copy to every audited pharmacy.

(b) A pharmacy benefit manager or entity acting on behalf of a pharmacy benefit manager who conducts an audit of a pharmacy also shall comply with the following requirements:

(i) Any finding of overpayment or underpayment shall be based on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;

(ii) Any finding of an overpayment shall not include the dispensing fee amount unless:

(A) A prescription was not dispensed;

(B) The prescriber denied authorization;

(C) The prescription dispensed was a medication error by the pharmacy; or

(D) The identified overpayment is based solely on an extra dispensing fee.

(iii) No audit shall use extrapolation in calculating the recoupments or penalties for audits, unless required by state or federal contracts;

(iv) No payment for the performance of an audit shall be based on a percentage of the amount recovered;

(v) Interest shall not accrue during the audit period;

(vi) No audit shall consider any clerical or recordkeeping error, such as a typographical error, scrivener's error or computer error regarding a required document or record, as fraud. These errors may be subject to recoupment. No recovery shall be assessed for errors causing no financial harm to the patient or plan. Errors that are the result of a pharmacy failing to comply with a formal corrective action plan may be subject to recovery.

Any recoupment shall be based on the actual overpayment of a claim;

(vii) A preliminary audit report shall be delivered to the audited pharmacy within one hundred twenty (120) days after the conclusion of the audit;

(viii) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report to provide documentation addressing any audit finding, and a reasonable extension of time shall be granted upon request;

(ix) A final audit report shall be delivered to the pharmacy not more than one hundred twenty (120) days after the preliminary audit report is received by the pharmacy or disposition of any final appeal, whichever is later;

(x) No recoupment or repayment of disputed funds shall be due until all available appeals are exhausted and any other final internal dispositions are completed, and only then to the extent allowed by any applicable

contractual agreement. If the identified amount in dispute for a single audit exceeds fifteen thousand dollars ($15,000.00), any future payments to the pharmacy may be withheld pending full disposition of the audit;

(xi) No chargebacks, recoupment or other penalties may be assessed until the appeal process has been exhausted and the final report issued.

(c) Subsections (a) and (b) of this section shall not apply to:

(i) Audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data, statements or other investigative methods; or

(ii) Audits of claims paid for by federally funded programs.

(d) This section shall apply to audits of pharmacies arising from contracts between pharmacies and pharmacy benefit managers entered into, renewed or extended on or

after July 1, 2016, and to all audits of pharmacies on and after July 1, 2017.

26-52-104. Maximum allowable cost.

(a) To place a drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that the drug is:

(i) Rated "A" or "B" in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book); or

(ii) Rated "NR" or "NA," or has a similar rating, by a nationally recognized reference and is:

(A) Generally available for purchase by retail pharmacies in the state from national or regional wholesalers; and

(B) Not obsolete or temporarily unavailable.

(b) In formulating the maximum allowable cost price for a drug, a health benefit plan issuer or pharmacy benefit manager shall consider only the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).

(c) Notwithstanding subsection (b) of this section, if a therapeutically equivalent generic drug is unavailable or has limited market presence, a health benefit plan issuer or pharmacy benefit manager may place on a maximum allowable cost list a drug that has:

(i) A "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book); or

(ii) An "NR" or "NA" rating, or a similar rating, by a nationally recognized reference.

(d) A pharmacy benefit manager shall:

(i) Make available to each network provider at the beginning of the term of the network provider's contract, and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing;

(ii) Provide a telephone number at which a network pharmacy may contact an employee of the pharmacy benefit manager to discuss any pharmacy appeals;

(iii) Provide a process for network providers to readily access the maximum allowable cost applicable to that provider;

(iv) Review and update applicable maximum allowable cost price information at least once every seven (7) business days to reflect any modification of maximum allowable cost pricing; and

(v) Ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(e) A pharmacy benefit manager shall establish a process by which a contracted pharmacy, or the pharmacy's designee who holds a contract with the pharmacy benefit manager, can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. A contracted pharmacy, or the pharmacy's designee who holds a contract with the pharmacy benefit manager, shall have up to ten (10) business days after dispensing a drug subject to a maximum allowable cost rate in which to appeal the amount of the maximum allowable cost rate. A pharmacy benefit manager shall respond to the appeal within ten (10) business days after the contracted pharmacy makes the appeal.

(f) If a maximum allowable cost appeal is denied, the pharmacy benefit manager shall provide to the appealing pharmacy the reason for the denial and the national drug code number for the drug that is available for purchase by pharmacies in the state from national or regional wholesalers at a price at or below the maximum allowable cost.

(g) If an appeal is upheld, the pharmacy benefit manager shall make an adjustment to the applicable maximum allowable cost rate no later than one (1) day after the date of the determination and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the insurer or pharmacy benefit manager. The pharmacy benefit manager shall allow the appealing pharmacy to reverse and rebill the claim which was the subject of the appeal.

(h) This section shall apply to maximum allowable cost rates determined pursuant to contracts between pharmacies and pharmacy benefit managers entered into, renewed or extended on or after July 1, 2016, and to all maximum allowable cost rates on and after July 1, 2017.

Section 2. W.S. 26-4-101(a) by creating a new paragraph (xviii) is amended to read:

26-4-101. Fee schedule.

(a) The commissioner shall collect in advance or contemporaneously fees, licenses and miscellaneous charges

as specified in this subsection. Collection may include the acceptance of electronic funds transfer. All fees and other charges collected by the commissioner as specified in this subsection shall be nonrefundable:

(xviii) Pharmacy benefit manager (annually) $500.00

Section 3. This act is effective July 1, 2016.

(END)