HOUSE BILL NO. HB0191

Pharmacy benefit manager act enhancements.

Sponsored by: Representative(s) Banks, Allemand, Bear, Neiman and Winter and Senator(s) Biteman, Brennan and Hutchings

A BILL

for

AN ACT relating to pharmacy benefit managers; requiring reporting on pharmacy benefit manager audits; regulating the conduct of pharmacy benefit managers; providing monetary reimbursement level requirements; amending provisions governing pharmacy benefit manager audits; requiring fee transparency; amending provisions governing maximum allowable cost appeals; regulating pharmacy benefit managers regarding the state employees' and officials' group insurance program; allowing groups to contract with insurers, preferred provider organizations or health maintenance organizations as specified; clarifying application of the Health Care Reimbursement Reform Act of 1985 to pharmacy benefit managers; providing definitions; making conforming amendments; repealing unnecessary definitions; requiring rulemaking; amending rulemaking

authority; authorizing positions; providing appropriations; and providing for effective dates.

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

Section 1. W.S. 26-52-105, 26-52-106, 26-52-108 and 26-52-109 are created to read:

26-52-105. Pharmacy benefit manager audit appeals report.

(a) Each pharmacy benefit manager shall track, monitor and report to the commissioner within thirty (30) days of the close of each calendar quarter, the following information related to the drug reimbursement appeals process mandated under W.S. 26-52-104(e):

(i) The total number of appeals filed by contracted pharmacies or pharmacy designees who hold a contract with the pharmacy benefit manager and the number of appeals that were denied or where reimbursement was upheld on appeal by the pharmacy benefit manager;

(ii) For each appeal that the pharmacy benefit manager denied, the reasons for the denial and proof that the pharmacy benefit manager complied with the requirements imposed by W.S. 26-52-104(f); and

(iii) For each appeal that the pharmacy benefit manager upheld, the total amount of any cost adjustment made by the pharmacy benefit manager and the number of days taken to make the cost adjustment.

(b) In addition to the reporting requirement under subsection (a) of this section, upon the request of the commissioner, a pharmacy benefit manager shall provide any of the information required under this section if the commissioner believes the information is reasonably necessary to ensure compliance with this chapter and the Health Care Reimbursement Reform Act of 1985 under W.S. 26-22-501 through 26-22-505.

26-52-106. Retroactive claim denials or reductions prohibited; reimbursement restrictions; prohibited fees.

(a) A pharmacy benefit manager shall not directly or indirectly retroactively deny or reduce a claim or aggregate of claims for drug reimbursement by a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager after the claim or aggregate of claims has been finally adjudicated, unless the original claim was submitted fraudulently.

(b) A pharmacy benefit manager shall not charge a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager any fee related to the adjudication of a drug reimbursement claim, including any fee for:

(i) The receipt or processing of a pharmacy claim;

(ii) The development or management of a claim processing, appeals processing or adjudication network; or

(iii) Participating in a claim processing, appeal processing or claim adjudication network.

(c) A pharmacy benefit manager shall not engage in any practice that:

(i) In any way bases pharmacy or pharmacy designee reimbursement for a drug on patient outcomes, scores or metrics. Notwithstanding this prohibition, a pharmacy benefit manager may base pharmacy and pharmacy designee reimbursement for pharmacy care, including dispensing fees, on patient outcomes, scores or metrics if the patient outcomes, scores or metrics are disclosed to and agreed upon by the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager in advance;

(ii) Imposes upon a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager a point of sale fee or retroactive fee;

(iii) Derives any revenue in connection with performing pharmacy benefit management services from a pharmacy, the pharmacy's designee who holds a contract with the pharmacy benefit manager or a covered individual. This

paragraph shall not be construed to prohibit any pharmacy benefit manager from receiving deductibles or copayments;

(iv) Restricts the use or prescribing of any generic prescription drug approved by the federal food and drug administration as an alternative to a name brand prescription drug unless the prescribing physician includes a notation that the prescription shall be "dispensed as written" or other similar language; or

(v) Provides financial or other incentives for the use of a specific name brand prescription drug for any reason.

26-52-108. Network participation requirements.

No pharmacy benefit manager shall impose pharmacy accreditation standards or recertification requirements on a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager as a condition for participating in a network that are inconsistent with, more stringent than or in addition to applicable federal and state requirements for licensure in this state.

26-52-109. Prohibited activities; contractual changes; retaliation.

(a) No pharmacy benefit manager shall amend or otherwise change the terms of an existing contract between the pharmacy benefit manager and a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager unless:

(i) The change is disclosed by the pharmacy benefit manager to the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager at least forty-five (45) days before the effective date of the change in the contract and the change is agreed upon in writing by the pharmacy or the pharmacy's designee; or

(ii) The change is required to be made under state or federal law or by a governmental regulatory authority. If the change is required by law or regulatory authority, the pharmacy benefit manager shall provide the pharmacy or the pharmacy's designee who holds a contract

with the pharmacy benefit manager with a citation to the specific statute, order or regulation requiring the change.

(b) No pharmacy benefit manager shall retaliate in any way against a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager based on the pharmacy's or the pharmacy's designee's exercise of any right or remedy under this chapter. Retaliation under this subsection includes:

(i) Terminating or refusing to renew a contract with the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager;

(ii) Subjecting the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager to increased audits, as determined by the commissioner. An increase in audits shall include increases to the number of audits performed in a calendar year or significantly increasing the number of prescriptions included as part of a single audit; or

(iii) Failing to promptly pay the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager money owed by the pharmacy benefit manager.

(c) For purposes of this section, a pharmacy benefit manager shall not be considered to have retaliated against a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager if the pharmacy benefit manager:

(i) Takes an action in response to a credible allegation of fraud against the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager; and

(ii) Provides reasonable notice to the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager of the allegation of fraud and the basis of the allegation before taking the action.

(d) Any covered individual, pharmacy or the pharmacy's designee who holds a contract with the pharmacy

benefit manager injured by a violation of this section may bring a cause of action in a court of competent jurisdiction for damages or to enjoin the continuation of the violation.

(e) The commissioner may examine or audit the books and records of any pharmacy benefit manager to determine if the pharmacy benefit manager is in compliance with this section. Any information or data acquired during the examination or audit is not a public record and is not subject to the Public Records Act, W.S. 16-4-201 through 16-4-205.

Section 2. W.S. 26-52-107 is created to read:

26-52-107. Pharmacy reimbursement transparency.

No pharmacy benefit manager shall reimburse a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager for a prescription drug in an amount less than the national average drug acquisition cost at the time the drug is administered or dispensed plus the applicable dispensing fee. If the national average drug

acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager shall not reimburse in an amount that is less than the wholesale acquisition cost of the drug as defined by 42 U.S.C. § 1395w-3a(c)(6)(B) plus the applicable dispensing fee.

Section 3. W.S. 9-3-205 by creating a new subsection (f), 26-22-502(a)(iv), 26-52-101, 26-52-102(a)(intro) and by creating new paragraphs (viii) and (ix), 26-52-103(a)(iii), (b)(vii), (ix) and by creating a new paragraph (xii) and 26-52-104(d)(iv), (v), by creating a new paragraph (vi) and by creating new subsections (k) and (m) are amended to read:

9-3-205. Administration and management of group insurance program; powers and duties; adoption of rules and regulations; interfund borrowing authority; pharmacy benefit managers.

(f) Any contract governing a group insurance plan that involves the services of a pharmacy benefit manager or a claims administrator and that makes the pharmacy benefit manager or claims administrator responsible for

administering or managing covered prescription drugs dispensed to enrolled employees, officials and their dependents shall require that payment for the drugs and applicable administrative services be based on a pass through pricing model under which:

(i) Any payment made for a covered prescription drug to a pharmacy benefit manager or a claims administrator:

(A) Is limited to ingredient costs and a professional dispensing fee in an amount not less than that which would be paid under the group insurance plan if the fee was being paid directly under the plan and without the services of the pharmacy benefit manager or claims administrator; and

(B) Is passed through in its entirety to the pharmacy or the pharmacy designee that dispensed the drug.

(ii) Any payment for administrative services is limited to a reasonable fee that covers the cost of providing the administrative services;

(iii) Any form of spread pricing is prohibited. "Spread pricing" means any amount charged or claimed by the pharmacy benefit manager or claims administrator in excess of the amount paid to the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager on behalf of the state, including any post-sale or post-invoice fees, discounts or related adjustments, direct and indirect remuneration fees or assessments, after allowing for a reasonable administrative services fee as provided in paragraph (ii) of this subsection.

26-22-502. Definitions.

(a) As used in this article:

(iv) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts which reimburse for expenses of health care services. "Insurer" includes any

contracted agent or benefit manager of an insurance company or health service corporation that administers or manages prescription drug benefits in accordance with W.S. 26-52-101 through 26-52-109;

26-52-101. Licensure of pharmacy benefit managers; waiver prohibited.

(a) No person shall act or hold himself out as a pharmacy benefit manager in this state unless he obtains a license from the ~~department~~ commissioner. The ~~department~~ commissioner shall ~~through~~ adopt rules as necessary to carry out this chapter, including rules that 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~~ chapter.

(b) The provisions of this chapter shall not be waived, voided or nullified by contract or any other type of agreement.

26-52-102. Definitions.

(a) As used in this ~~article~~ chapter:

(viii) "Maximum allowable cost list" means a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, that establishes the maximum allowable reimbursement to a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager for a generic drug. "Maximum allowable cost list" includes:

(A) Average acquisition cost, including national average drug acquisition cost;

(B) Wholesale acquisition cost;

(C) Average manufacturer price;

(D) Average wholesale price;

(E) Generic effective rate;

(F) Discount indexing;

(G) Federal upper limits; and

(H) Any other factor that a pharmacy benefit manager or a health care insurer may use to establish reimbursement rates to a pharmacy or the pharmacy designee for pharmacist services.

(ix) "Pharmacist services" means any product, good or service, or any combination of products, goods or services, provided as a part of the practice of pharmacy.

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:

(iii) Limit the period covered by the audit to not more than ~~two (2) years~~ six (6) months from the date that an audited claim was adjudicated;

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

(vii) A preliminary audit report shall be delivered to the audited pharmacy within ~~one hundred twenty (120)~~ sixty (60) days after the conclusion of the audit;

(ix) A final audit report shall be delivered to the pharmacy not more than ~~one hundred twenty (120)~~ ninety (90) days after the preliminary audit report is received by the pharmacy or submission of final internal appeal, whichever is later;

(xii) If a contract between a pharmacy and a pharmacy benefit manager specifies a period of time within which a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager is allowed to withdraw and resubmit a claim and that period of time expires before the pharmacy benefit manager delivers a preliminary audit report that identifies a discrepancy, the pharmacy benefit manager shall allow the pharmacy or the

pharmacy's designee who holds a contract with the pharmacy benefit manager to withdraw and resubmit a claim within thirty (30) days after:

(A) The preliminary audit report is delivered if the pharmacy does not request an appeal under W.S. 26-52-104(e); or

(B) The conclusion of the appeals process under W.S. 26-52-104(e) if the pharmacy requests an appeal.

26-52-104. Maximum allowable cost; offering information and alternatives.

(d) A pharmacy benefit manager shall:

(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; ~~.~~ and

(vi) Reimburse the pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager for a drug using the price that was in effect on the date that the prescription drug was filled by the pharmacy.

(k) A pharmacy benefit manager shall not reimburse a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager for pharmacy services in an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager owned or pharmacy benefit manager affiliated pharmacy for providing the same pharmacist services. The amount shall be calculated per unit based on the same generic product identifier or generic code number.

(m) A pharmacy may decline to provide pharmacist services to a patient or pharmacy benefit manager if according to the maximum allowable cost list the pharmacy would be paid less than the pharmacy's acquisition cost for the pharmacist services.

Section 4. W.S. 26-22-503(c) is amended to read:

26-22-503. Policies with incentives or limits on reimbursement authorized; conditions.

(c) Any group may contract with an insurer, preferred provider organization or health maintenance organization for provision of ~~medical~~ health care services outside of Wyoming for the insureds of that group, provided the insureds are not restricted from utilizing any Wyoming provider who provides the same health care services.

Section 5. W.S. 26-52-102(a)(iii) and (iv) is repealed.

Section 6. On or before July 1, 2023, the insurance commissioner shall promulgate rules and regulations necessary to implement this act.

Section 7.

(a) The department of insurance is authorized one (1) full-time position and one (1) at-will contract position

for the purpose of implementing and administering this act. There is appropriated one hundred eighty-nine thousand dollars ($189,000.00) from revenue authorized in W.S. 26-2-204 to the department of insurance for the salary and benefits of employees authorized under this section. This appropriation shall be for the period beginning with the effective date of this section and ending June 30, 2024 and shall only be expended for the additional positions authorized under this section. This appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2024. It is the intent of the legislature that the one (1) at-will contract position authorized in this section not be included in the department's 2025-2026 standard budget request.

(b) There is appropriated two hundred fifty thousand dollars ($250,000.00) from revenue authorized in W.S. 26-2-204 to the department of insurance for the purposes of implementing and administering the regulatory program required under this act. This appropriation shall be for the period beginning with the effective date of this

section and ending June 30, 2024. This appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2024.

Section 8.

(a) Except as provided in subsections (b) and (c) of this section, this act is effective July 1, 2023.

(b) Sections 2 and 4 of this act are effective July 1, 2024.

(c) Sections 6 through 8 of this act are effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, Section 8 of the Wyoming Constitution.

(END)