Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

ESSB 6137

Brief Description: Regulating pharmacy benefit managers and pharmacy audits.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Conway, Pearson, Parlette and Keiser).

Brief Summary of Engrossed Substitute Bill

- Requires pharmacy benefit managers to register with the Department of Revenue.
- Establishes standards for pharmacy benefit managers, insurers, third-party payors, and state agencies to use when auditing pharmacy claims, including standards related to process, timing, and payment.
- Establishes standards for pharmacy benefit managers to use when developing lists of drugs with associated maximum allowable costs, including standards related to availability of drugs, distribution of the lists, and appeals of maximum allowable costs.

Hearing Date: 2/24/14

Staff: Chris Blake (786-7392).

Background:

Pharmacy benefits managers acquire prescription drugs for public and private entities and perform administrative services related to the administration of pharmacy benefits. These services may include mail order pharmacy, claims processing, payment of claims, formulary development, rebate contracting, and disease management activities. They act as an intermediary between the entities they contract with and pharmaceutical manufacturers to administer the drug benefit portion of a health plan.

Summary of Bill:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

"Pharmacy benefit managers" are defined as a person who contracts with pharmacies on behalf of an insurer, third-party payor, or the Prescription Drug Purchasing Consortium to provide services to process claims for prescription drugs or medical supplies, pay pharmacies for prescription drugs or medical supplies, or negotiate rebates with manufacturer for drugs that they pay for or procure.

Pharmacy Benefit Manager Registration.
Pharmacy benefit managers must register with the Department of Revenue. To register, a pharmacy benefit manager must submit an application and a registration fee of up to $200. The Department of Revenue may adopt rules to determine fees.

Auditing standards.
Entities, including pharmacy benefit managers, insurers, third party payors, and state agencies, that audit claims or an independent third party that contracts with an entity to audit claims must comply with several specified standards. These standards relate to:

- Procedures. Entities must maintain procedures for pharmacies to appeal findings regarding a claim and provide notice to the pharmacy. Entities must audit each pharmacy under the same standards used for other similar pharmacies. Entities may not conduct an audit of claims more than 24 months after the adjudication of the claim. If an audit involves clinical or professional judgment, the entity must conduct the audit in consultation with a licensed pharmacist. Except in cases of fraud, an entity may not conduct an audit of more than 250 unique prescriptions within a 12-month period.
- Timing. Entities must give pharmacies at least 15 days' written notice prior to an on-site audit and may not conduct an audit during the first five days of the month without the pharmacy's consent. Entities may not conduct more than one on-site audit of a pharmacy in any 12-month period.
- Payments. Entities may not charge a pharmacy for a denied or disputed claim until the audit and appeals procedures are final. Entities must pay outstanding claims of a pharmacy within 45 days of the conclusion of all appeals or the issuance of a final report. Entities may not include dispensing fees or interest in overpayment amounts, unless the overpaid claim was based on a prescription that was not filled correctly. Entities may not recoup costs related to clerical errors or errors that do not financially harm either the entity or a consumer.

An entity's finding that a claim was improper must be based on identified transactions, rather than probability sampling, extrapolation, or other methods of projecting errors.

If an entity contracts with a third party to conduct audits, the entity may not base compensation on a percentage of the amount of overpayments recovered or disclose information obtained during the audit, unless specifically authorized.

When conducting an audit, an entity or a third party conducting an audit must allow the following as evidence of validation of a claim:

- An electronic or physical copy of a prescription if it was picked up, delivered, or sent within 14 days of dispensing;
- Point of sale electronic register data; or
- Electronic records that are reasonably clear and accurate electronic documentation corresponding to a claim.

The act does not prohibit an entity from pursuing an action for fraud against a pharmacy. The auditing procedures do not apply in cases in which a physical review or review of claims indicate fraud or intentional and willful misrepresentation. The auditing procedures do not apply to state agencies conducting audits of pharmacy records for prescription drugs paid for by the state's medical assistance program.

Post-audit Reporting.
Within 45 days of an audit, an entity must provide the audited pharmacy with a preliminary report of the audit. Upon receiving the preliminary report, the pharmacy has 45 days to: (1) contest the report or any of its findings according to the appeals process; and (2) provide additional documentation in support of the claim.

The entity must provide the pharmacy with a final report of the audit within 60 days of receipt of the preliminary report or the date the pharmacy contested the report. The final report must include all of the money to be recovered by the entity. Recoupment of funds from a pharmacy will occur after the audit and the appeals procedures are final. If the identified discrepancy for an audit exceeds $40,000, the entity may withhold future payments until the audit and appeals procedure is complete.

Maximum Allowable Cost.
"Maximum allowable cost" is defined as the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug. The term "list" refers to a list of drugs that have maximum allowable costs established for them.

When developing lists, pharmacy benefit managers may not place drugs on the list unless there are at least two therapeutically equivalent drugs available from at least two manufacturers or at least one generic drug available from one manufacturer. All drugs on a list must be generally available for purchase from national or regional wholesalers and none of the drugs may be obsolete. Pharmacy benefit managers must make available to pharmacies the sources used to determine the maximum allowable cost pricing. Pharmacy benefit managers must make their list available to network pharmacies upon request. Each list must be updated every seven business days and made available to network pharmacies. Dispensing fees may not be included in the calculation of maximum allowable cost.

Pharmacy benefit managers must establish an appeals process to allow pharmacies to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the pharmacy paid to the supplier of the drug. If the appeal is upheld, the pharmacy benefit manager must adjust its lists for all similarly affected pharmacies within a day of the decision.

Appropriation: None.

Fiscal Note: Requested on February 17, 2014.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.