SENATE FILE NO. SF0036

Pharmacy benefit managers act enhancements.

Sponsored by: Joint Labor, Health & Social Services Interim Committee

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; 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 personnel; 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 through 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, and submit 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:

(i) The total number of appeals filed by contracted pharmacies or their designees and the number of appeals that were denied or upheld 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.

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 after the claim or aggregate of

claims have been finally adjudicated unless the original claim was submitted fraudulently or erroneously.

(b) A pharmacy benefit manager shall not charge a pharmacy or the pharmacy's designee 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 or adjudication network; or

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

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

(i) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores or metrics. Notwithstanding this prohibition, a pharmacy benefit

manager may base pharmacy 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 in advance;

(ii) Imposes upon a pharmacy or the pharmacy designee a point of sale fee or retroactive fee; or

(iii) Derives any revenue from a pharmacy or the pharmacy's designee or covered individual in connection with performing pharmacy benefit management services. This paragraph shall not be construed to prohibit any pharmacy benefit manager from receiving deductibles or copayments.

25-52-107. Pharmacy reimbursement transparency.

No pharmacy benefit manager shall reimburse a pharmacy or the pharmacy's designee for a pharmacist service in an amount less than the national average drug acquisition cost for the pharmacist service at the time the drug is administered or dispensed. 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).

26-52-108. Network participation requirements.

No pharmacy benefit manager or third-party payer shall impose pharmacy accreditation standards or recertification requirements on a pharmacy or the pharmacy's designee 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.

25-52-109. 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 unless:

(i) The change is disclosed by the pharmacy benefit manager to the pharmacy or the pharmacy's designee 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 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 based on the pharmacy's exercise of any right or remedy under this chapter. Prohibited retaliation includes:

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

(ii) Subjecting the pharmacy or the pharmacy's designee to increased audits. An increase in audits shall

include increases to the number of audits performed in a calendar year or exponentially 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 any money owed by the pharmacy benefit manager to the pharmacy.

(c) For purposes of this section, a pharmacy benefit manager is not considered to have retaliated against a pharmacy or the pharmacy's designee 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; and

(ii) Provides reasonable notice to the pharmacy or the pharmacy's designee of the allegation of fraud and the basis of the allegation before taking the action.

(d) Any covered individual, pharmacy or pharmacy designee injured by a violation of this section may bring a

cause of action in a court of competent jurisdiction 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. 9-3-205 by creating a new subsection (f), 26-22-502(a)(iv), 26-22-503(c), 26-52-101, 26-52-102(a) by creating new paragraphs (viii) through (x), 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.

(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, whereby any amount charged or claimed by the pharmacy benefit manager or claims administrator is in excess of the amount paid to the pharmacy or the pharmacy's designee 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, is prohibited.

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;

26-22-503. 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.

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 may not be waived, voided or nullified by contract or any other type of agreement.

26-52-102. Definitions.

(a) As used in this article:

(viii) "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health insurance carrier or disability insurer to provide, deliver, arrange for, pay for or reimburse any

of the costs of health care services. Health benefit plan does not include Medicare, Medicaid or other health benefit programs or coverages operated or maintained by the federal government;

(ix) "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 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.

(x) "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 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 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 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 in the state in an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate 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 3. W.S. 26-52-102(a)(iii) and (iv) are repealed.

Section 4. On or before July 1, 2022, the insurance commissioner shall promulgate rules and regulations necessary to implement this act.

Section 5.

(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, 2023 and shall only be expended for the additional positions authorized under this section. 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 2023-2024 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, 2023. This appropriation shall not be transferred or expended for any other purpose.

Section 6.

(a) Except as provided in subsection (b) of this section, this act is effective July 1, 2022.

(b) Sections 4 through 6 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)