

**PROPOSED AMENDMENTS TO  
A-ENGROSSED HOUSE BILL 2123**

1 On page 1 of the printed A-engrossed bill, delete lines 4 through 24 and  
2 delete pages 2 through 5 and insert:

3 **“SECTION 1. Sections 2 to 11 of this 2013 Act are added to and made  
4 a part of the Insurance Code.**

5 **“SECTION 2. As used in sections 2 to 11 of this 2013 Act:**

6 **“(1) ‘Claim’ means a request from a pharmacy or pharmacist to be  
7 reimbursed for the cost of filling or refilling a prescription for a drug  
8 or for providing a medical supply or service.**

9 **“(2) ‘Insurer’ has the meaning given that term in ORS 731.106.**

10 **“(3) ‘Pharmacist’ has the meaning given that term in ORS 689.005.**

11 **“(4) ‘Pharmacy’ has the meaning given that term in ORS 689.005.**

12 **“(5)(a) ‘Pharmacy benefit manager’ means a person that contracts  
13 with pharmacies on behalf of an insurer, a third party administrator  
14 or the Oregon Prescription Drug Program established in ORS 414.312  
15 to:**

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

18 **“(B) Pay pharmacies or pharmacists for prescription drugs or med-  
19 ical supplies; or**

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

22 **“(b) ‘Pharmacy benefit manager’ does not include a health care**

1 service contractor as defined in ORS 750.005.

2 “(6) ‘Third party administrator’ means a person licensed under ORS  
3 744.702.

4 **“SECTION 3. (1) To conduct business in this state, a pharmacy  
5 benefit manager must register with the Department of Consumer and  
6 Business Services and annually renew the registration.**

7 **“(2) To register under this section, a pharmacy benefit manager  
8 must:**

9 **“(a) Submit an application to the department on a form prescribed  
10 by the department by rule.**

11 **“(b) Pay a registration fee, not to exceed \$50, adopted by the de-  
12 partment by rule.**

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

16 **“(4) The department shall deposit all moneys collected under this  
17 section into the Consumer and Business Services Fund created in ORS  
18 705.145.**

19 **“SECTION 4. As used in sections 4 to 10 of this 2013 Act:**

20 **“(1) ‘Audit’ means an on-site or remote review of the records of a  
21 pharmacy by or on behalf of an entity.**

22 **“(2) ‘Clerical error’ means a minor error:**

23 **“(a) In the keeping, recording or transcribing of records or docu-  
24 ments or in the handling of electronic or hard copies of correspond-  
25 ence;**

26 **“(b) That does not result in financial harm to an entity; and**

27 **“(c) That does not involve dispensing an incorrect dose, amount or  
28 type of medication or dispensing a prescription drug to the wrong  
29 person.**

30 **“(3) ‘Entity’ includes:**

- 1       “(a) A pharmacy benefit manager;  
2       “(b) An insurer;  
3       “(c) A third party administrator;  
4       “(d) A state agency; or  
5       “(e) A person that represents or is employed by one of the entities  
6 described in this subsection.

7       “(4) ‘Fraud’ means knowingly and willfully executing or attempting  
8 to execute a scheme, in connection with the delivery of or payment for  
9 health care benefits, items or services, that uses false or misleading  
10 pretenses, representations or promises to obtain any money or prop-  
11 erty owned by or under the custody or control of any person.

12       “SECTION 5. An entity that audits claims or an independent third  
13 party that contracts with an entity to audit claims:

14       “(1) Must establish, in writing, a procedure for a pharmacy to ap-  
15 peal the entity’s findings with respect to a claim and must provide a  
16 pharmacy with a notice regarding the procedure, in writing or elec-  
17 tronically, prior to conducting an audit of the pharmacy’s claims;

18       “(2) May not conduct an audit of a claim more than 24 months after  
19 the date the claim was adjudicated by the entity;

20       “(3) Must give at least 15 days’ advance written notice of an on-site  
21 audit to the pharmacy or corporate headquarters of the pharmacy;

22       “(4) May not conduct an on-site audit during the first five days of  
23 any month without the pharmacy’s consent;

24       “(5) Must conduct the audit in consultation with a pharmacist who  
25 is licensed by this or another state if the audit involves clinical or  
26 professional judgment;

27       “(6) May not conduct an on-site audit of more than 200 unique  
28 prescriptions of a pharmacy in any 12-month period except in cases  
29 of alleged fraud;

30       “(7) May not conduct more than one on-site audit of a pharmacy

1 in any 12-month period;

2 “(8) Must audit each pharmacy under the same standards and pa-  
3 rameters that the entity uses to audit other similarly situated phar-  
4 macies;

5 “(9) Must pay any outstanding claims of a pharmacy no more than  
6 45 days after the earlier of the date all appeals are concluded or the  
7 date a final report is issued under section 9 (3) of this 2013 Act;

8 “(10) May not include dispensing fees or interest in the amount of  
9 any overpayment assessed on a claim unless the overpaid claim was  
10 for a prescription that was not filled correctly;

11 “(11) May not recoup costs associated with:

12 “(a) Clerical errors; or

13 “(b) Other errors that do not result in financial harm to the entity  
14 or a consumer; and

15 “(12) May not charge a pharmacy for a denied or disputed claim  
16 until the audit and the appeals procedure established under subsection  
17 (1) of this section are final.

18 “SECTION 6. An entity’s finding that a claim was incorrectly pre-  
19 sented or paid must be based on identified transactions and not based  
20 on probability sampling, extrapolation or other means that project an  
21 error using the number of patients served who have a similar diagnosis  
22 or the number of similar prescriptions or refills for similar drugs.

23 “SECTION 7. An entity that contracts with an independent third  
24 party to conduct audits may not:

25 “(1) Agree to compensate the independent third party based on a  
26 percentage of the amount of overpayments recovered; or

27 “(2) Disclose information obtained during an audit except to the  
28 contracting entity, the pharmacy subject to the audit or the holder  
29 of the policy or certificate of insurance that paid the claim.

30 “SECTION 8. For purposes of sections 4 to 10 of this 2013 Act, an

1 entity, or an independent third party that contracts with an entity to  
2 conduct audits, must allow as evidence of validation of a claim:

3 “(1) An electronic or physical copy of a prescription that complies  
4 with ORS chapter 689 if the prescribed drug was, within 14 days of the  
5 dispensing date:

6 “(a) Picked up by the patient or the patient’s designee;

7 “(b) Delivered by the pharmacy to the patient; or

8 “(c) Sent by the pharmacy to the patient using the United States  
9 Postal Service or other common carrier;

10 “(2) Point of sale electronic register data showing purchase of the  
11 prescribed drug, medical supply or service by the patient or the  
12 patient’s designee; or

13 “(3) Electronic records, including electronic beneficiary signature  
14 logs, electronically scanned and stored patient records maintained at  
15 or accessible to the audited pharmacy’s central operations and any  
16 other reasonably clear and accurate electronic documentation that  
17 corresponds to a claim.

18 **“SECTION 9. (1)(a) After conducting an audit, an entity must pro-**  
19 **vide the pharmacy that is the subject of the audit with a preliminary**  
20 **report of the audit. The preliminary report must be received by the**  
21 **pharmacy no later than 45 days after the date on which the audit was**  
22 **completed and must be sent:**

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

25 “(B) Electronically with electronic receipt confirmation.

26 “(b) An entity shall provide a pharmacy receiving a preliminary  
27 report under this subsection no fewer than 45 days after receiving the  
28 report to contest the report or any findings in the report in accordance  
29 with the appeals procedure established under section 5 (1) of this 2013  
30 Act and to provide additional documentation in support of the claim.

1 The entity shall consider a reasonable request for an extension of time  
2 to submit documentation to contest the report or any findings in the  
3 report.

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

8 “(3) An entity must provide a pharmacy that is the subject of an  
9 audit with a final report of the audit no later than 60 days after the  
10 later of the date the preliminary report was received or the date the  
11 pharmacy contested the report using the appeals procedure established  
12 under section 5 (1) of this 2013 Act. The final report must include a  
13 final accounting of all moneys to be recovered by the entity.

14 “(4) Recoupment of disputed funds from a pharmacy by an entity  
15 or repayment of funds to an entity by a pharmacy, unless otherwise  
16 agreed to by the entity and the pharmacy, shall occur after the audit  
17 and the appeals procedure established under section 5 (1) of this 2013  
18 Act are final. If the identified discrepancy for an individual audit ex-  
19 ceeds \$40,000, any future payments to the pharmacy may be withheld  
20 by the entity until the audit and the appeals procedure established  
21 under section 5 (1) of this 2013 Act are final.

22 **“SECTION 10.** Sections 4 to 10 of this 2013 Act do not:

23 “(1) Preclude an entity from instituting an action for fraud against  
24 a pharmacy;

25 “(2) Apply to an audit of pharmacy records when fraud or other  
26 intentional and willful misrepresentation is evidenced by physical re-  
27 view, review of claims data or statements or other investigative  
28 methods; or

29 “(3) Apply to a state agency that is conducting audits or a person  
30 that has contracted with a state agency to conduct audits of pharmacy

1 records for prescription drugs paid for by the state medical assistance  
2 program.

3 **“SECTION 11. (1) As used in this section:**

4 **“(a) ‘List’ means the list of drugs for which maximum allowable**  
5 **costs have been established.**

6 **“(b) ‘Maximum allowable cost’ means the maximum amount that**  
7 **a pharmacy benefit manager will reimburse a pharmacy for the cost**  
8 **of a drug.**

9 **“(c) ‘Multiple source drug’ means a therapeutically equivalent drug**  
10 **that is available from at least two manufacturers.**

11 **“(d) ‘Network pharmacy’ means a retail drug outlet registered un-**  
12 **der ORS 689.305 that contracts with a pharmacy benefit manager.**

13 **“(e) ‘Therapeutically equivalent’ has the meaning given that term**  
14 **in ORS 689.515.**

15 **“(2) A pharmacy benefit manager:**

16 **“(a) May not place a drug on a list unless there are at least two**  
17 **therapeutically equivalent, multiple source drugs, or at least one ge-**  
18 **neric drug available from only one manufacturer, generally available**  
19 **for purchase by network pharmacies from national or regional whole-**  
20 **salers.**

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

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

25 **“(d) Shall make available to each network pharmacy at the begin-**  
26 **ning of the term of a contract, and upon renewal of a contract, the**  
27 **sources utilized to determine the maximum allowable cost pricing of**  
28 **the pharmacy benefit manager.**

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

1 **pharmacy.**

2 **“(f) Shall update each list maintained by the pharmacy benefit**  
3 **manager every seven business days and make the updated lists, in-**  
4 **cluding all changes in the price of drugs, available to network phar-**  
5 **macies in a readily accessible and usable format.**

6 **“(g) Shall ensure that dispensing fees are not included in the cal-**  
7 **ulation of maximum allowable cost.**

8 **“(3) A pharmacy benefit manager must establish a process by which**  
9 **a network pharmacy may appeal its reimbursement for a drug subject**  
10 **to maximum allowable cost pricing. A network pharmacy may appeal**  
11 **a maximum allowable cost only if the reimbursement for the drug is**  
12 **less than the net amount that the network pharmacy paid to the**  
13 **supplier of the drug. An appeal requested under this section must be**  
14 **completed within 30 calendar days of the pharmacy making the claim**  
15 **for which appeal has been requested.**

16 **“(4) A pharmacy benefit manager must provide as part of the ap-**  
17 **peals process established under subsection (3) of this section:**

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

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

23 **“(c) If the appeal is denied, the reason for the denial and the na-**  
24 **tional drug code of a drug that may be purchased by similarly situated**  
25 **pharmacies at a price that is equal to or less than the maximum al-**  
26 **lowable cost.**

27 **“(5)(a) If an appeal is upheld under this section, the pharmacy**  
28 **benefit manager shall make an adjustment on the date that the phar-**  
29 **macy benefit manager makes the determination. The pharmacy benefit**  
30 **manager shall make the adjustment effective for all similarly situated**



1 **pharmacies in this state that are within the network.**

2 **“(b) A pharmacy benefit manager may not make an adjustment**  
3 **described in paragraph (a) of this subsection for a critical access**  
4 **pharmacy, as defined by the Oregon Health Authority by rule for**  
5 **purposes related to the Oregon Prescription Drug Program.**

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

8 **“SECTION 12. The amendments to section 11 of this 2013 Act by**  
9 **section 13 of this 2013 Act become operative on January 1, 2015.**

10 **“SECTION 13. Section 11 of this 2013 Act is amended to read:**

11 **“Sec. 11. (1) As used in this section:**

12 **“(a) ‘List’ means the list of drugs for which maximum allowable costs**  
13 **have been established.**

14 **“(b) ‘Maximum allowable cost’ means the maximum amount that a phar-**  
15 **macy benefit manager will reimburse a pharmacy for the cost of a drug.**

16 **“(c) ‘Multiple source drug’ means a therapeutically equivalent drug that**  
17 **is available from at least two manufacturers.**

18 **“(d) ‘Network pharmacy’ means a retail drug outlet registered under ORS**  
19 **689.305 that contracts with a pharmacy benefit manager.**

20 **“(e) ‘Therapeutically equivalent’ has the meaning given that term in ORS**  
21 **689.515.**

22 **“(2) A pharmacy benefit manager:**

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

27 **“(b) Shall ensure that all drugs on a list are generally available for pur-**  
28 **chase by pharmacies in this state from national or regional wholesalers.**

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

30 **“(d) Shall make available to each network pharmacy at the beginning of**

1 the term of a contract, and upon renewal of a contract, the sources utilized  
2 to determine the maximum allowable cost pricing of the pharmacy benefit  
3 manager.

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

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

10 “(g) Shall ensure that dispensing fees are not included in the calculation  
11 of maximum allowable cost.

12 “(3) A pharmacy benefit manager must establish a process by which a  
13 network pharmacy may appeal its reimbursement for a drug subject to max-  
14 imum allowable cost pricing. A network pharmacy may appeal a maximum  
15 allowable cost only if the reimbursement for the drug is less than the net  
16 amount that the network pharmacy paid to the supplier of the drug. An ap-  
17 peal requested under this section must be completed within 30 calendar days  
18 of the pharmacy making the claim for which appeal has been requested.

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

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

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

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

29 “(5)(a) If an appeal is upheld under this section, the pharmacy benefit  
30 manager shall make an adjustment [*on the date that the pharmacy benefit*

1 *manager makes the determination. The pharmacy benefit manager shall make*  
2 *the adjustment effective for all similarly situated pharmacies in this state that*  
3 *are within the network.]* **for the pharmacy that requested the appeal from**  
4 **the date of initial adjudication forward.**

5 “(b) A pharmacy benefit manager may not make an adjustment described  
6 in paragraph (a) of this subsection for a critical access pharmacy, as defined  
7 by the Oregon Health Authority by rule for purposes related to the Oregon  
8 Prescription Drug Program.

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

10 **“SECTION 14. (1) Section 11 of this 2013 Act applies to contracts**  
11 **between pharmacies and pharmacy benefit managers that are entered**  
12 **into, renewed or extended on or after the effective date of this 2013**  
13 **Act.**

14 **“(2) The amendments to section 11 of this 2013 Act by section 13 of**  
15 **this 2013 Act apply to contracts between pharmacies and pharmacy**  
16 **benefit managers that are entered into, renewed or extended on or**  
17 **after the operative date specified in section 12 of this 2013 Act.”.**

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