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# MEMORANDUM

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**To:** Human Services Subcommittee of the Joint Committee on Ways and Means

**From:** Kim To, Legislative Fiscal Office, 503-986-1830

**Date:** June 6, 2013

**Subject:** HB 2123 Relating to prescription drugs  
Work Session Recommendation

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HB 2123 A-Engrossed requires the State Board of Pharmacy to license pharmacy benefit managers (PBMs). The measure imposes limits on audits of pharmacies, and requires that PBMs apply individual pharmacy reimbursement readjustments on a network-wide basis.

The measure previously had hearings in the House Committee on Health Care on 3/15/2013, 4/1/2013, and 4/3/2013. A public hearing was held for the bill in this Subcommittee on 5/16/2013.

Staff measure summaries, the - A10 amendment, and fiscal impact statements are attached to this memo, and available on the Oregon Legislative Information System (OLIS).

## **The - A1- amendment**

The -A10 amendment replaces the bill, modifies the Insurance Code, and:

- Requires a pharmacy benefit manager (PBM) to register with the Department of Consumer and Business Services, and to annually renew the registration. The bill provides that the registration fee and renewal does not exceed \$50, and allows DCBS to adopt fees by rule.
- Establishes limitations and requirements for an audit of a pharmacy by a PBM, an insurer, a third party administrator, a state agency or a person that represents or is employed by one of those entities.
- Imposes requirements on a PBM relating to their list of drugs for which maximum allowable costs have been established. Limits the applicability of an adjustment made in response to a critical access pharmacy when a critical access pharmacy appeal of a reimbursement determination is upheld. Allows a network pharmacy to appeal a maximum allowable cost only if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the drug supplier.

**Fiscal impact of the - A10 amendment**

The fiscal impact of this bill on the Department of Consumer and Business Services is indeterminate, but anticipated to be absorbable. The Other Funds fiscal impact to OEBC is also indeterminate. Based on an extensive review of generic claims across the retail pharmacy network currently supporting OEBC members, MODA Health is projecting that passage of this bill could potentially increase premium costs.

**Recommendation**

LFO recommends moving the - A10 amendment into the bill.

**Motion**

**Motion: Senator/Representative \_\_\_\_\_ move the dash A10 amendment into HB 2123.**

**Recommendation**

LFO recommends the measure, as amended, be moved to the Full Committee.

**Motion**

**Motion: Senator/Representative \_\_\_\_\_ move HB 2123 with the dash A10 amendment to the Full Committee with a "do pass" recommendation as amended.**

**Assignment of Carriers**

Full: \_\_\_\_\_

Senate: \_\_\_\_\_

House: \_\_\_\_\_

**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 250 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 if the reimbursement for the drug is less**  
12 **than the net amount that the network pharmacy paid to the supplier**  
13 **of the drug. An appeal requested under this section must be completed**  
14 **within 30 calendar days of the pharmacy making the claim for which**  
15 **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) If the request for an adjustment has come from a critical ac-**  
3 **cess pharmacy, as defined by the Oregon Health Authority by rule for**  
4 **purposes related to the Oregon Prescription Drug Program, the ad-**  
5 **justment approved under paragraph (a) of this subsection shall apply**  
6 **only to critical access pharmacies.**

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

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

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

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

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

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

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

19 **“(d) ‘Network pharmacy’ means a retail drug outlet registered under ORS**  
20 **689.305 that contracts with a pharmacy benefit manager.**

21 **“(e) ‘Therapeutically equivalent’ has the meaning given that term in ORS**  
22 **689.515.**

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

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

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

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

1 “(d) Shall make available to each network pharmacy at the beginning of  
2 the term of a contract, and upon renewal of a contract, the sources utilized  
3 to determine the maximum allowable cost pricing of the pharmacy benefit  
4 manager.

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

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

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

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

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

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

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

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

30 “(5)(a) If an appeal is upheld under this section, the pharmacy benefit

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

6 “(b) If the request for an adjustment has come from a critical access  
7 pharmacy, as defined by the Oregon Health Authority by rule for purposes  
8 related to the Oregon Prescription Drug Program, the adjustment approved  
9 under paragraph (a) of this subsection shall apply only to critical access  
10 pharmacies.

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

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

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

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## FISCAL IMPACT OF PROPOSED LEGISLATION

Measure: HB 2123 - A10

Seventy-Seventh Oregon Legislative Assembly – 2013 Regular Session  
Legislative Fiscal Office

*Only Impacts on Original or Engrossed  
Versions are Considered Official*

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Prepared by: Kim To  
Reviewed by: Linda Ames, Susie Jordan  
Date: 6/3/2013

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### Measure Description:

Requires Department of Consumer and Business Services to register pharmacy benefit managers.

### Government Unit(s) Affected:

Oregon Health Authority (OHA), Department of Consumer and Business Services (DCBS)

### Local Government Mandate:

This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

### Analysis:

House Bill 2123 with the – A10 amendment modifies the Insurance Code. The measure:

- Defines claim, insurer, pharmacist, pharmacy, third party administrator, and pharmacy benefit manager.
- Requires a pharmacy benefit manager (PBM) to register with the Department of Consumer and Business Services, and to annually renew the registration. The bill provides that the registration fee and renewal does not exceed \$50, and allows DCBS to adopt fees by rule.
- Establishes limitations and requirements for an audit of a pharmacy by a PBM, an insurer, a third party administrator, a state agency or a person that represents or is employed by one of those entities. The audit limitations and requirements in the bill apply to contracts between pharmacies and PBMs that are entered into, renewed or extended on or after the effective date of the bill.
- Imposes requirements on a PBM relating to their list of drugs for which maximum allowable costs have been established. The requirements related to the list of drugs for which maximum allowable costs have been established become operative on January 1, 2015. Limits the applicability of an adjustment made in response to a critical access pharmacy when a critical access pharmacy appeal of a reimbursement determination is upheld. Allows a network pharmacy to appeal a maximum allowable cost only if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the drug supplier.

### Oregon Health Authority (OHA)

The full fiscal impact of this bill on the Oregon Health Authority's Oregon Educators Benefit Board (OEBB) is indeterminate. The bill requires that PBMs apply individual pharmacy reimbursement readjustments on a network-wide basis. OEBB contracts with a PBM. According to OEBB's largest health insurer, Moda Health, this requirement has the potential of inflating costs across the network. Inflated costs would impact OEBB through increased medical prescription drug rates. Although the exact premium increase is indeterminate at this time, Moda Health predicts the fiscal impact could result in a 0.5% increase in rates. Based on January 2013 premium costs and 2012 enrollment over three month period, OEBB calculates that a 0.5% increase in premium rates would result in an estimated fiscal impact of roughly \$542,777 Other Funds Non-Limited in the 2013-2015 biennium.

Note that the Oregon Educators Revolving Fund (ORS 243.884) authorizes the Oregon Health Authority's Oregon Educators Benefit Board to collect employee and employer contributions for pass-through of benefit premiums to insurance carriers for eligible members. Therefore, any proposed legislation resulting in a fiscal impact on revenues or expenditures with regard to insurance premiums

provided by OEGB will impact any educational entity that has mandated or elective coverage under OEGB. This includes school districts, community colleges, education service districts and some charter schools.

Department of Consumer and Business Services (DCBS)

The fiscal impact of this bill on the Department of Consumer and Business Services is indeterminate, but anticipated to be absorbable. The department reports that existing law requires a person who transacts business as a third party administrator (TPA) to be licensed through DCBS. A third party administrator is defined as a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of this state or residents of another state from offices in this state, in connection with life insurance or health insurance coverage. Therefore some TPAs also conduct pharmacy benefit manager activities. Currently DCBS licenses 296 TPAs. It is unknown how many of these existing TPAs will register as PBMs, or how many other PBMs will be subject to registration.

Should this bill become law, DCBS will be required to: (1) conduct rulemaking to develop the registration form and set fees; (2) create and maintain the registration system; (3) assure that all PBMs are registered and that registrations are renewed; and (4) monitor and carry out compliance and enforcement activities. Extrapolating from historical enforcement data on TPAs, DCBS assumes that its Insurance Division can perform these duties using existing staff and resources. However, if the enforcement activities of this bill or if the cumulative impact of legislation affecting the enforcement of the Insurance Code is greater than anticipated, DCBS may need to return to seek additional resources in the event that reprioritization of duties and responsibilities of existing staff is not feasible.

## FISCAL IMPACT OF PROPOSED LEGISLATION

Seventy-Seventh Oregon Legislative Assembly – 2013 Regular Session  
Legislative Fiscal Office

Measure: HB 2123 - A

*Only Impacts on Original or Engrossed  
Versions are Considered Official*

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Prepared by: Kim To  
Reviewed by: Linda Ames, Matt Stayner  
Date: 4/1/2013

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### Measure Description:

Requires State Board of Pharmacy to license pharmacy benefit managers.

### Government Unit(s) Affected:

Oregon Health Authority (OHA), Board of Pharmacy

### Local Government Mandate:

This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

### Analysis:

House Bill 2123 A-Engrossed:

1. Requires individuals to obtain a license from the State Board of Pharmacy in order to act as a Pharmacy Benefit Manager (PBM) in Oregon. This license must be renewed annually.
2. Imposes limits on audits of pharmacies by PBMs, and other entities including insurers, third party administrators, and state agencies.
3. Requires that PBMs apply individual pharmacy reimbursement readjustments on a network-wide basis.

At this time, the fiscal impact of this bill on the State Board of Pharmacy and the Oregon Health Authority is indeterminate due to several factors discussed below.

### State Board of Pharmacy

The full fiscal impact of this bill on the Board of Pharmacy is indeterminate due to the potential costs associated with compliance and enforcement. The bill requires the Board of Pharmacy to license PBMs in Oregon. If the bill passes, the Board of Pharmacy anticipates establishing one Operations Policy Analyst 2 position to oversee the licensing program. The agency estimates the Personal Services, related Services Supplies cost of the licensing program to be roughly \$290,000 Other Funds and 1.00 FTE per biennium. However, note that in addition to licensing, the agency anticipates additional costs associated with modifying existing databases, changes in accounting processes, training of staff and Board members, as well as costs associated with complaints and investigations. Although at this time, these costs are indeterminate, but expected to be significant, the Board of Pharmacy provides the following information as a point of reference:

**Accounting System:** The bill stipulates that all moneys collected from PBM's for registration and renewal must be used only for the purpose of administering the PBM program. This mandated separation of the PBM program funds from other agency funds will require an additional layer of accounting for the agency.

**Complaints and Investigations:** The bill directs the agency to refuse to issue or renew, or suspend or revoke a licensee or applicant if the applicant or licensee engages in conduct likely to mislead, deceive or defraud the general public, or engages in unfair or deceptive business practices. Because these broad conditions may be subject to interpretation, the Board of Pharmacy anticipates an increase in the number of complaints, and investigations. Furthermore, if a case



results in disciplinary action, the licensee has due process rights for any disciplinary action. As a result, additional hearings and Department of Justice costs may be incurred. The Attorney General 2013-2015 proposed hourly rate for 2013-2015 is \$167.00 per hour. A hearing relating to disciplinary action is estimated to require on average six hours of attorney general time. On average it takes an investigator about eight hours to conduct an investigation. If the investigation workload for the PBM program is significant, the Board of Pharmacy may need additional staffing and resources.

Inspections: At this time, it is not known whether or not inspections of PBM's will be necessary and if so, whether or not they will be conducted by the PBM Administrator or the Compliance Investigator. If the Board of Pharmacy is required to conduct inspections, affected staff members as well as Board members will require training. If the inspection workload for the PBM program is significant, the Board of Pharmacy may need additional staffing and resources.

#### Oregon Health Authority

The full fiscal impact of this bill on the Oregon Health Authority's Oregon Educators Benefit Board (OEBB) is indeterminate. The bill requires that PBMs apply individual pharmacy reimbursement readjustments on a network-wide basis which would inflate costs across the network especially if higher reimbursement rates provided to Critical Access Pharmacies are applied network-wide. OEBB contracts with a PBM. Inflated costs would impact OEBB through increased medical prescription drug rates. Although the exact premium increase is indeterminate at this time, according to OEBB's largest health insurer, Moda Health, the fiscal impact could range between two and three percent. A three percent increase in premium rates would result in an estimated fiscal impact of \$27,560,914 Other Funds Non-Limited in the 2013-2015 biennium.

Also, note that the Oregon Educators Revolving Fund (ORS 243.884) authorizes the Oregon Health Authority's Oregon Educators Benefit Board to collect employee and employer contributions for pass-through of benefit premiums to insurance carriers for eligible members. Therefore, any proposed legislation resulting in a fiscal impact on revenues or expenditures with regard to insurance premiums provided by OEBB will impact any educational entity that has mandated or elective coverage under OEBB. This includes school districts, community colleges, education service districts and some charter schools.

REVENUE: No revenue impact  
FISCAL: Fiscal statement issued

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<b>Action:</b>	Do Pass as Amended and Be Printed Engrossed and Be Referred to the Committee on Ways and Means by Prior Reference
<b>Vote:</b>	8 - 1 - 0
<b>Yeas:</b>	Clem, Conger, Harker, Kennemer, Keny-Guyer, Lively, Thompson, Greenlick
<b>Nays:</b>	Weidner
<b>Exc.:</b>	0
<b>Prepared By:</b>	Tyler Larson, Administrator
<b>Meeting Dates:</b>	3/15, 4/1

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**WHAT THE MEASURE DOES:** Requires licensure from State Board of Pharmacy to act as pharmacy benefit manager (PBM). Requires board establish rules for obtaining and renewing license. Allows board to refuse to issue or renew, suspend or revoke PBM license for specified conduct. Imposes limits on audits of pharmacies. Limits drugs be placed on maximum allowable cost (MAC) list. Requires PBMs disclose sources informing MAC list to network pharmacies and establish process for network pharmacy to request adjustment of MAC price.

**ISSUES DISCUSSED:**

- Work group history
- Impact of PBMs on local pharmacies
- PBM regulations in other states
- PBM audit procedures
- State Board of Pharmacy authority to license PBMs
- MAC pricing

**EFFECT OF COMMITTEE AMENDMENT:** Replaces the measure.

**BACKGROUND:** The Oregon State Board of Pharmacy (OSBP) regulates the practice of Pharmacy and enforces laws regarding pharmacists, drug outlets and the sale of drugs in Oregon. OSBP licenses pharmacists, registers and inspects retail and hospital pharmacies and stores that sell over the counter drugs, registers and inspects drug wholesalers and manufacturers and regulates the quality and distribution of drugs in Oregon.

A pharmacy benefit manager (PBM) is a third party administrator of prescription drug programs, and are primarily responsible for processing and paying prescription drug claims. Proponents assert that PBMs are profitable at the expense of pharmacies, and that audit procedures based on technicalities and undisclosed pricing practices endanger small pharmacies in Oregon.

House Bill 2123-A requires PBMs to be licensed by the OSBP, establishes regulations for audits of pharmacies and creates regulations around maximum allowable cost (MAC) pricing lists used by PBMs.

4/2/2013 2:57:00 PM

*This summary has not been adopted or officially endorsed by action of the committee.*

Joint Committee on Ways and Means

Carrier – House: Rep.  
Carrier – Senate: Sen.

**Revenue:** No revenue impact

**Fiscal:** Fiscal statement issued

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**Action:**

**Vote:**

House

Yeas:

Nays:

Exc:

Senate

Yeas:

Nays:

Exc:

**Prepared By:** Kim To, Legislative Fiscal Office

**Meeting Date:** 6/6/2013

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**WHAT THE MEASURE DOES:** Requires licensure from State Board of Pharmacy to act as pharmacy benefit manager (PBM). Requires board establish rules for obtaining and renewing license. Allows board to refuse to issue or renew, suspend or revoke PBM license for specified conduct. Imposes limits on audits of pharmacies. Limits drugs be placed on maximum allowable cost (MAC) list. Requires PBMs disclose sources informing MAC list to network pharmacies and establish process for network pharmacy to request adjustment of MAC price.

**ISSUES DISCUSSED:**

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**EFFECT OF COMMITTEE AMENDMENT:** The –A10 amendment replaces bill. Requires a pharmacy benefit manager (PBM) to register with the Department of Consumer and Business Services, and to annually renew the registration. Establishes limitations and requirements for an audit of a pharmacy by a PBM, an insurer, a third party administrator, a state agency or a person that represents or is employed by one of those entities. Imposes requirements on a PBM relating to their list of drugs for which maximum allowable costs have been established.

**BACKGROUND:** A pharmacy benefit manager (PBM) is a third party administrator of prescription drug programs, and are primarily responsible for processing and paying prescription drug claims. Proponents assert that PBMs are profitable at the expense of pharmacies, and that audit procedures based on technicalities and undisclosed pricing practices endanger small pharmacies in Oregon.

House Bill 2123-A10 requires PBMs to register with DCBS, establishes regulations for audits of pharmacies and creates regulations around maximum allowable cost (MAC) pricing lists used by PBMs.