Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 725 (Senator Klausmeier, *et al.*)

Finance Health and Government Operations

Pharmacy Benefits Managers - Contracts with Pharmacies and Pharmacists

This bill requires specified disclosures by a pharmacy benefits manager to pharmacy providers and establishes provisions governing audits of pharmacies by a PBM.

The bill applies to contracts entered into or renewed between a pharmacist or pharmacy and a PBM and audits conducted by PBMs on or after January 1, 2009.

Fiscal Summary

State Effect: Potential minimal increase in special fund expenditures for the Maryland Insurance Administration beginning in FY 2009 to ensure compliance with the bill.

Local Effect: None.

Small Business Effect: Minimal to none.

Analysis

Bill Summary: The bill applies to HMOs but does not apply to Medicaid managed care organizations or a nonprofit health maintenance organization that operates as a group model and provides pharmacy benefits management services under specified circumstances.

The bill may not be construed to limit the applicability of insurance laws regarding denial of claims made by or on behalf of a carrier.

A PBM must provide a copy of its audit procedures or appeals processes on request of the Insurance Commissioner.

Contract Disclosures: A PBM, at the time of entering into a contract with a pharmacy or pharmacist and at least 30 working days before any contract change, must disclose to the pharmacy or pharmacist: (1) applicable terms, conditions, and reimbursement rates; (2) processes and procedures for verifying pharmacy benefits and beneficiary eligibility; (3) dispute resolution and audit appeals processes; and (4) processes and procedures for verifying the prescription drugs included on the formularies used by the PBM.

Audits: When conducting an audit, a PBM must • for an onsite audit, provide written notice at least two weeks prior to conducting the audit for each audit cycle; • employ the services of a pharmacist if the audit requires the clinical or professional judgment of a pharmacist; • allow the pharmacy or pharmacist to use specified hospital or physician records to validate specified orders or refills; • audit each pharmacy and pharmacist under similar standards and parameters; • only audit claims submitted or adjudicated within the two years immediately preceding the audit unless otherwise provided by law; • deliver a preliminary audit report within 120 calendar days after completion of the audit; • allow a pharmacy or pharmacist to produce documentation to address any discrepancy within a specified timeframe; and • deliver the final audit report within a specified timeframe.

A PBM may not use extrapolation to calculate overpayments or underpayments. A PBM may not schedule an onsite audit to begin during the first five calendar days of a month unless requested by the pharmacy or pharmacist. Recoupment of claims payments must be based on actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist. Any decision of a PBM on an appeal of a disputed claim in a preliminary audit report must be reflected in the final audit report.

A PBM must establish a specified internal appeals process for pharmacies or pharmacists to appeal any disputed claim in a preliminary audit report. A PBM must deliver a final audit report within 30 days after conclusion of the internal appeals process. A PBM may not recoup by setoff any moneys for an overpayment or denial of a claim until 30 working days after the final audit report has been provided to the pharmacy or pharmacist. A PBM must remit any money due to a pharmacy or pharmacist within 30 working days after the final audit report has been provided. A PBM may withhold future payments prior to provision of the final audit report if the identified discrepancy exceeds $25,000.

These requirements do not apply to an audit that involves probable or potential fraud or willful misrepresentation.

Underpayment of Claims: A PBM must establish a reasonable internal review process for a pharmacy to request the review of failure to pay the contractual reimbursement amount (underpayment) of a claim. A pharmacy may request a PBM to review underpayment of a claim within 180 calendar days of the date the claim was paid; however, a pharmacy and PBM can contractually agree that the pharmacy has a longer period to request an internal review. The PBM must provide a written decision within 90 calendar days of the request and pay any money due within 30 working days after completing the internal review process.

Current Law: Chapter 323 of 2000 provides for the regulation of HMO downstream risk arrangements. PBMs that conduct utilization review are required to be registered with MIA as a private review agent.

Background: PBMs are businesses that administer and manage prescription drug benefit plans for a variety of organizations. More than 100 PBMs operate in the United States, but the industry is dominated by three – CVS Caremark; Express Scripts; and Medco. Approximately 95% of all patients with prescription drug coverage receive benefits through a PBM. PBMs manage an estimated 70% of prescription drugs dispensed through retail pharmacies that are covered by private third-party payors.

PBMs earn most of their revenues in three ways: • receiving a fee for administrative tasks; • negotiating discounts and rebates from drug manufacturers by including a company's drugs on a preferred drug list and obtaining a greater market share for the company's drug; and • operating mail-order prescription drug companies.

Regulation of PBMs in Other States: Concerns have been raised by consumer organizations and several states regarding the business practices of PBMs. Specifically, demands for greater transparency in financial relationships between PBMs and drug manufacturers have prompted states to propose regulation of PBM activities.

Since 2003, 36 states and the District of Columbia have introduced legislation to regulate PBMs including transparency and financial disclosure requirements and licensure and certification requirements. Kansas requires registration of PBMs with the state insurance department. North Dakota requires licensure and financial disclosure. Maine, South Dakota, Vermont, and the District of Columbia require disclosure of financial relationships. California passed legislation requiring registration of PBMs and financial disclosure in 2005, but the bill was vetoed by the Governor.

State Expenditures: MIA special fund expenditures could increase beginning in fiscal 2009 to ensure that PBMs are in compliance with the bill's requirements and, to the extent that complaints about PBMs increase, for MIA's Market Conduct Unit to investigate. The amount of any increase cannot be reliably estimated at this time but is expected to be minimal.

Additional Information

Prior Introductions: Many of the provisions in this bill, in addition to other regulatory requirements relating to PBMs, were included in SB 677/HB 734 of 2007. No action was taken on either bill by the Senate Finance or House Health and Government Operations committees.

Cross File: HB 257 (Delegate Kullen, *et al.*) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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