SENATE BILL REPORT
E2SHB 1224

As of March 19, 2019

Title: An act relating to prescription drug cost transparency.

Brief Description: Concerning prescription drug cost transparency.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Robinson, Macri, Ryu, Peterson, Frame, Tharinger, Bergquist, Gregerson, Jinkins, Ortiz-Self, Lovick, Doglio, Stanford, Appleton, Slatter and Wylie).

Brief History: Passed House: 3/08/19, 80-18.
Committee Activity: Health & Long Term Care: 3/18/19.

Brief Summary of Bill

- Requires health carriers and drug manufacturers to report certain prescription drug pricing data to a data organization contracted by the Health Care Authority (HCA).
- Requires the data organization to summarize the prescription drug pricing data and provide reports to the Legislature and the HCA.
- Requires pharmacy benefit managers (PBMs) to submit certain information on discounts, rebates, and reimbursement for drugs in a PBM's formulary.
- Requires the Office of the Insurance Commissioner (OIC) to analyze and report on the data submitted by PBMs and allows OIC to audit a PBM's financial records to ensure the information submitted is accurate.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: Prescription Drug Purchasing Consortium. Pursuant to statute, the HCA established a prescription drug purchasing consortium. State purchased health care programs must purchase prescription drugs through the consortium, and local governments, private entities, labor organizations, uninsured, and underinsured residents may voluntarily participate in the consortium. In 2006, Washington State and Oregon formed the Northwest

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Prescription Drug Consortium (Northwest Consortium) to expand their purchasing power. The Northwest Consortium offers access to retail pharmacy discounts, pharmacy benefit management services, rebate management services, and a prescription discount card for uninsured residents.

All-Payer Health Care Claims Database. Pursuant to statute, the Office of Financial Management (OFM) established the all-payer claims database to support transparent public reporting of health care information. The database collects claims data from the Medicaid program, Public Employees' Benefits Board programs, all health carriers, third-party administrators, and Department of Labor and Industries programs. Claim files submitted to the database include pharmacy claims.

State Agency Work on Prescription Drug Costs. In 2016, the Department of Health (DOH) convened a taskforce to evaluate factors contributing to out-of-pocket costs for patients, including prescription drug cost trends. The same year, HCA and OFM prepared a report on prescription drug costs and potential purchasing strategies at the request of legislators. The report describes increases in state agency spending on prescription drugs in recent years, current cost drivers, strategies to slow the rate of prescription drug spending, and policy options.

Pharmacy Benefit Managers. A pharmacy benefit manager (PBM) acts as an intermediary between the entities with which it contracts and pharmaceutical manufacturers to administer the drug benefit portion of a health plan. A PBM is defined as a person that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium to: process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists; pay pharmacies or pharmacists for prescription drugs or medical supplies; or negotiate rebates with manufacturers for drugs paid for or procured as described in this subsection. A PBM does not include a health care service contractor. A PBM must register with OIC and renew the registration annually.

Summary of Bill: HCA must conduct a competitive procurement process to select a data organization to collect, verify, and summarize prescription drug pricing data provided by drug manufacturers and carriers.

Carrier Reporting. Beginning October 1, 2019, and yearly thereafter, carriers must provide the data organization:

- the 25 most frequently prescribed prescription drugs by health care providers in their network;
- the 25 costliest prescription drugs, and the issuer's total spending on each drug;
- the 25 prescription drugs with the largest year-over-year increase in spending, including the percentage increase; and
- a summary of the impact of prescription drug costs on health plan premiums.

Manufacturer Reporting. Beginning October 1, 2019, manufacturers must provide the data organization with the following data for each new drug costing $10,000 or more for a course of treatment or 30-day supply, and each existing drug costing at least $100 for a course of treatment or 30-day supply that has a price increase of at least 16 percent:

- a description of the factors considered when setting or increasing the price of the drug and an explanation of how the factors justify the increase;
- if the drug was produced by the manufacture during the previous five years, a history of price increases during that time;
- if the drug was acquired by the manufacturer in the previous five years (1) the price of the drug at the time of the acquisition; and (2) the company from which the drug was purchased, and the purchase price;
- the year the drug was introduced to the market and at what price;
- the patent expiration date, if the drug is under patent;
- whether the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug;
- an itemized cost for the production and sale of each drug; and
- the total financial assistance given through programs, rebates, and coupons.

A manufacturer must submit this information at least 60 days in advance of a qualifying price increase of a drug and within 30 days of release of a new covered drug.

Manufacturer Notice to Purchasers. Beginning October 1, 2019, a manufacturer must notify purchasers of a qualifying price increase in writing at least 60 days prior to the planned effective date of the increase for drugs. The notification must include:

- the date of the increase, the current wholesale acquisition cost of the prescription drug, and the dollar amount of the future increase in the wholesale acquisition cost of the prescription drug; and
- a statement regarding whether a change or improvement in the drug necessitates the price increase, and if so, the manufacturer shall describe the change or improvement.

If a PBM receives a notice of an increase in wholesale acquisition cost it must notify its large contracting public and private purchasers, those that provide coverage to more than 500 lives, of the increase.

HCA Enforcement. HCA may assess a fine of up to $1,000 per day if a carrier or manufacturer fails to comply with these requirements. Fines collected must be deposited in the Medicaid Fraud Penalty Account. HCA must report any fines levied against a health carrier to OIC.

HCA Reporting. The data organization must compile the data collected from carriers and manufacturers into a report to HCA. HCA must conduct an independent analysis of the data and produce a report for the public and the Legislature demonstrating the impact of prescription drug costs on health care premiums. Beginning January 1, 2020, and each following January 1st, HCA must publish the report on its website. HCA must also share the information provided by carriers with OIC. Except for reporting purposes, HCA and OIC must keep all information provided pursuant to these requirements confidential and the information is not subject to public disclosure. HCA must also collect data from the all payers claims database on prescription drug claims to include billed and paid charges. By November 1, 2020, HCA must produce a report for the Legislature that includes charts demonstrating the variance in billed and paid charges among the carriers for the 25 drugs with higher than average variances in billed and paid charges based on data from the all payers claims database.

Pharmacy Benefit Managers. By March 1st of each year, a PBM must submit to OIC the following information from the previous calendar year:

- all discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for each drug on the PBM's formularies;
- the total dollar amount of all discounts and rebates that are retained by the PBM for each drug on the PBM's formularies;
- actual total reimbursement amounts for each drug the PBM pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied;
- the negotiated price health plans pay the PBM for each drug on the PBM's formularies;
- the amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan;
- any ownership interest the PBM has in a pharmacy or health plan with which it conducts business;
- the results of any appeal filed by a network pharmacy against a PBM for reimbursement for a drug subject to predetermined reimbursement costs for multisource generic drugs; and
- a report for the preceding calendar year stating that the pharmacy benefit manager is in compliance with the requirements of the act.

A PBM has a fiduciary duty to patients and beneficiaries to perform services in accordance with state and federal law, except for health plans covered by the Employee Retirement Income Security Act of 1974. A PBM may not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

OIC Enforcement. OIC may examine or audit the financial records of a PBM for purposes of ensuring the information submitted is accurate. Information OIC acquires in the examination of records is proprietary and confidential. OIC may assess a fine of up to $1,000 per day for a violation or failure to comply with the requirements of the act.

OIC Reporting. OIC must analyze the data submitted by PBMs and prepare a final report for the public and legislators. Beginning December 1, 2020, and each following December 1st, OIC must publish the report on its website. The data in the report must be aggregated and must not reveal information specific to individual health plans or PBMs. Except for the report, OIC must keep all information submitted by PBMs confidential and the information is not subject to public disclosure.

If specific funding for the purposes of this act is not provided, the act is null and void.

Appropriation: None.

Fiscal Note: Requested on March 14, 2019.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Patients need drugs they can afford and information is necessary to address the issue. PBM transparency is an important part of the bill to help understand consumer prices.

CON: All members of the supply chain should be included in transparency legislation. Focusing on the list price does not help to explain what consumers pay for drugs. It is important to consider how rebates and discounts affect retail prices. The advanced notification requirement does not reflect how the generic drug market operates. PBMs and health carriers collaborate to keep drug prices down for consumers. PBMs are already transparency with their clients. PBMs do not have a direct relationship with patients so there is no fiduciary relationship.

OTHER: The manufacturer reporting requirements in the bill are strong, but the approach to PBMs in SB 5292 is better.

Persons Testifying: PRO: Representative June Robinson, Prime Sponsor; Sybill Hyppolite, SEIU Healthcare 1199NW; Dedi Little, Washington State Pharmacy Association; Rick Hughes, Ray's Pharmacy.

CON: Lee Newgent, Pharmaceutical Industry Labor-Management Association; Christine Brewer, Association of Washington Healthcare Plans; Carrie Tellefson, Pharmaceutical Care Management Association; Eric Lohnes, Pharmaceutical Research and Manufacturers of America; Brett Michelin, Association of Accessible Medicine; Brian Warren, Biotechnology Innovation Organization.

OTHER: Amber Ulvenes, Kaiser Permanente.

Persons Signed In To Testify But Not Testifying: No one.