



FEBRUARY 2009

WEST VIRGINIA INFORMATIONAL LETTER

NO. 166

TO: All Pharmacy Benefits Managers Doing Business in West Virginia

RE: Licensure of PBMs as TPAs

The purpose of this letter is to notify persons providing pharmacy benefits management services, as that term is defined herein, that the Insurance Commissioner has decided that such persons must be licensed as third-party administrators in accordance with West Virginia Code §§33-46-1 *et seq.* This letter will also explain the basis for this decision and will set forth the timeframe in which licensing must occur.

A third-party administrator (TPA) is defined in W. Va. Code §33-46-2(a) as follows:

“Administrator” or “third-party administrator” means a person who directly or indirectly underwrites or collects charges or premiums from, or adjusts or settles claims on residents of this state, in connections with life, annuity or accident and sickness coverage offered or provided by an insurer.¹

As a general matter, a PBM may establish a nationwide network of pharmacies that agree to terms of participation or a network that is specific to a particular client health plan (PBM-network arrangements), or it may simply administer a health plan’s relationship with those pharmacies with which the health plan has already contracted (provider-network arrangement). Although some PBMs contend that their role does not involve the type of

¹ The definition is qualified by several exceptions, none of which is relevant to this general discussion of PBMs.



discretionary authority usually associated with the adjustment or settlement of a claim for benefits under a health insurance policy, some courts have indicated that much of what PBMs do fits quite comfortably within the concept of “adjusts or settles claims.”

The following, which is from the district court’s opinion in a case dealing with the constitutionality of a state statute that mandated that PBMs make certain disclosures to the insurers and self-insured employers for which they operated, contains a good discussion of PBMs’ functions:

The parties are in agreement that it is the business of PBMS to act as transactional intermediaries or “middlemen” in the multi-billion dollar trade in prescription drugs. Among their customers are insurance companies, health maintenance organizations and private and public health plans and programs (collectively, what I will call “benefits providers”), ... Generally speaking, the services that PBMs extend to these benefits providers are designed to facilitate the provision of prescription drug benefits to the benefits providers’ insureds, participants or subscribers. For example, a PBM might provide its benefits provider customers with access to an established network of pharmacies, including mail order pharmacies, or with certain formulary services, all of which permit the benefits provider customers to obtain drugs at established prices. Conceptually, by pooling the prescription drug purchasing power of a number of benefits providers, a PBM can negotiate substantial volume discounts and rebates from drug manufacturers and pharmacies, and thereby not only provide its customers with savings on prescription drugs and other pharmaceutical products, but also ensure a profit for itself and its shareholders or stakeholders. Additional services that a PBM might extend to a benefits provider include “drug utilization review services” and “therapeutic interchange programs.” As intermediaries, PBMs provide services to pharmacies and drug manufacturer (the supply-side of the trade) as well as to benefits providers (the demand side of the trade). In particular, when it comes to drug utilization services and therapeutic interchange programs, PBMs are as apt to be serving pharmacies and manufacturers as health benefits providers. For example, “therapeutic interchange” refers to the practice of substituting a drug for the one actually prescribed by a doctor. This may involve substituting an equally efficacious and cheaper generic drug for a brand name drug, which might benefit a provider. On the other hand, the practice may involve substituting a more expensive brand name drug for the benefit of the manufacturer, a pharmacy and/or the PBM. Thus, for instance, a brand name drug might be substituted so that a pharmacy or PBM can obtain a “reward” or “incentive” from the manufacturer for helping increase the manufacturer’s market share within a

certain drug category. Similarly, a PBM might be paid a rebate or fee by a drug manufacturer in exchange for including a drug on the PBM's formulary or for "featuring" or "preferring" that drug, sometimes to the exclusion of others.

Pharm. Care Mgmt. Ass'n v. Rowe, 2005 U.S. Dist. LEXIS 2339, 3-6 (D. Me. Feb. 2, 2005) (footnote and citations to record omitted), *affirmed* 2005 U.S. App. LEXIS 24032 (1st Cir. Nov 8, 2005).

Some PBMs argue, however, that they lack discretionary authority to decide substantive questions and that they perform merely ministerial tasks within the parameters of the plans under which they operate. For instance, a letter from a PBM to this office described their role as follows:

The PBM's role is typically to receive reimbursement claims under prescription drug benefit plans from pharmacies and will then communicate back to the pharmacies information relative to payment of the claim, such as member eligibility, drug coverage, drug exclusions, co-payments amounts, deductibles, dispensing limitations. If the claim information provided by the pharmacies to the PBM does not fall within the parameters set by the health plan, then the claim is approved and the pharmacy is reimbursed for the pharmacy benefit provided at the pharmacy's contracted rates and terms. If the claim information provided by the pharmacies to the PBM does not fall within the parameters set by the health plan, then the claim is denied. If a pharmacy disputes the denial, the PBM reviews the matter to determine if there has been a computer processing error, If a processing error has not occurred, the denial of the claim remains, and the pharmacy must collect the cost of the prescription benefit from the plan member, who is then referred to the health plan for resolution of any dispute about whether and/or to what extent a prescription drug claim is covered.

This description rests on a characterization of the PBM's duties as essentially nondiscretionary in nature, the implicit assumption being that a TPA necessarily has the ability to act in a fiduciary capacity. Designation as a TPA, however, does not necessarily hinge on possession of such "ultimate decisional authority." *See, e.g., Lampen v. Albert Trostel & Sons Co. Employee Welfare Plan*, 832 F. Supp. 1287, 1291 (E.D. Wis. 1993).

("[T]he bulk of authority in this area indicates that when ... the claims administrator's decision-making authority falls only within the ambit of implementing rules established by another entity and is subject to the 'ultimate decisional authority' of that entity, the claims administrator is not a fiduciary"). However, it is clear from the caselaw discussing various aspects of the recent growth in the use of PBMs that they are essentially specialized TPAs:

PBMs, however, administer prescription plans in the same manner and with the same general type of authority that other TPAs manage health insurance plans. Many health benefit plan sponsors offer their plan members, or beneficiaries, prescription drug insurance coverage along with the more traditional medical insurance coverage. Similar to how they often engage third party administrators (TPAs) to administer plans' medical insurance claims, the plan sponsors also engage PBMS to manage their pharmacy insurance claims. Plan sponsors typically contract with PBMS to provide prescription drug benefit administration and management services.

Moeckel v. Caremark, Inc., 2007 U.S. Dist. LEXIS 83908 n.1 (M.D. Tenn. Nov. 13, 2007) (quotation omitted). The Commissioner has determined that the TPA Act mandates the inclusion of PBMs.

For the purposes of this informational letter, a PBM is any entity that meets the following definition:

A "pharmacy benefit manager" means an entity that performs pharmacy benefit management and includes a person or entity acting for a pharmacy benefit manager in a contractual or employment relationship in the performance of pharmacy benefit management services, including mail service pharmacy. "Pharmacy benefit management" means the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals, the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals or any of the following services provided with regard to the administration of pharmacy benefits: Mail service pharmacy; claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals; clinical formulary development and management services; rebate contracting and administration; certain patient compliance, therapeutic intervention and generic substitution programs; and disease management programs.

After June 30, 2009, an entity meeting this definition of a PBM may not operate in West Virginia unless it is licensed or registered as a TPA in accordance with the provisions of West Virginia Code §33-46-1 *et. seq.* The Commissioner may grant extensions for good cause shown.

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Insurance Commissioner