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No. 50348-4-II

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

EXPRESS SCRIPTS, INC.,

Appellant,

v.

STATE OF WASHINGTON,
DEPARTMENT OF REVENUE,

Respondent.

AMICUS BRIEF OF OPTUMRX, INC.

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I. INTRODUCTION

This case involves the fundamental question of what constitutes “gross income” for purposes of Washington’s Business and Occupation (B&O) tax, Ch. 82.04 RCW. “Gross income” is “the value proceeding and accruing by reason of the transaction of the business engaged in.” RCW 82.04.080. The term “value proceeding and accruing” means “the consideration...actually received or accrued.” RCW 82.04.090. Thus, it is critical to understand both the scope of the taxpayer’s business activities and the reason it is receiving money. For example, an outside bookkeeper paying bills for a company is not engaged in performing the underlying business activities represented by those bills. The crux of the gross income analysis comes down to whether the amount is received for performing an activity within the scope of the taxpayer’s business, or whether it is instead received to satisfy a client’s obligation to a third party.

In WAC 458-20-111 (“Rule 111”), the Department of Revenue (the “Department”) recognizes that amounts can be excluded from gross income “wherein the taxpayer, as an incident to the business, undertakes, on behalf of the ...client, the payment of money, ... upon an obligation owing by the ... client to a third person.”

The parties in this case talk a great deal about the statements in Express Script’s financial filings and how it’s actions are or are not similar to credit card processors. However, neither party addresses the regulatory and industry environment in which pharmacy benefit managers (“PBMs”)

operate. When the broader industry and regulatory context is considered, it is clear that PBMs are making payments on behalf of health plan clients to satisfy the client's obligation to pay for members' pharmacy costs and that PBMs are not in the business of assuming the clients' insurance obligations or selling prescription drugs to the plan members.

The Department's position that PBMs are liable for B&O tax on the full amount of reimbursements at the Service and Other rate fails to analyze the pertinent regulatory and contractual provisions or explain how processing a customer's obligation to pay a third party is taxable as gross income. *See* Brief of Respondent ("Resp. Br.") at 29. There are two business activities that drive the payments for ingredient (prescription drug) costs: the insurance obligations of the health insurers, (the PBMs' clients), and the sale of prescription drugs performed by the network pharmacies to the members. PBMs cannot assume the health insurer's obligation to pay for pharmacy benefits as that would be the unauthorized offering of insurance. Thus, the PBMs are either acting as agents to pay the obligations of insurance company clients or they are making sales of prescription drugs. As both parties acknowledge that PBMs are not selling prescription drugs, that means they are acting only as agents to pay the obligations of their insurance company clients.

II. IDENTITY AND INTEREST OF AMICUS CURIAE

OptumRx, Inc. performs PBM services for a number of health insurance plans, including health insurance plans in Washington. Because

this case involves the taxation of PBM services in Washington, OptumRx's tax liability may be affected by the Court's decision in this case.

III. STATEMENT OF THE CASE

The PBM industry came into existence in the late 1960's. A PBM company is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, unions, trusts, managed care organizations and government entities (for purposes of this brief they will be collectively referred to as "health plans").

The PBM industry arose as a result of the increase in prescription drug coverage by health plans and the insurance challenge to efficiently and economically manage a high volume of relatively small claims. National Health Policy Forum, *The ABCs of PBMs*, Issue Brief No. 749 (October 27, 1999). The first PBM was Pharmaceutical Card Systems Inc. in Scottsdale, Arizona which introduced the plastic pharmacy benefit card for pharmacy transactions.¹ Still in use today, the benefit card acts like a credit card for the purchase of prescription drugs. Someone insured by a health plan could purchase prescription drugs at an approved pharmacy by presenting the benefit card and also make a small co-payment. The health plan would pay the pharmacy the balance due for the purchased prescription.

¹ See, e.g. https://en.wikipedia.org/wiki/Pharmacy_benefit_management.

PBM companies specialized in electronic claims processing utilizing data standardization and advanced information systems. Thomas Reinke, *Large PBMs Transform Old Business Models*, Managed Care magazine, October 1, 2009. This allowed health plans to remain focused on their core business of providing medical benefits, and outsourcing the insurance function of processing prescription drug claims to PBMs. “Historically, PBMs were ‘middlemen’ entities designed to process prescription medication claims (for a small fee per claim) for insurance companies and plan sponsors (ex. Private employers).” Brittany Hoffman-Eubanks, *The Role of Pharmacy Benefit Managers in American Health Care: Pharmacy Concerns and Perspectives: Part 1*, Pharmacy Times, November 14, 2017.

Over the years, PBMs expanded their services in an effort to help reduce prescription drug costs. For example, in addition to claims processing, PBMs often establish and maintain a “preferred” network of retail pharmacies willing to provide prescription services to the health plans’ insureds at negotiated rates. PBMs also negotiate with pharmaceutical manufacturers and wholesalers to achieve discounts and rebates for drugs on the health plans’ formulary, help establish the formulary to promote generic drug alternatives, and provide or promote the use of mail-order pharmacy and specialty pharmacy prescription drug services. Hoffman-Eubanks, *Supra*. Nevertheless, as noted above, “[t]he core function of a PBM is to process prescription claims electronically.” Warren K. Williams, *Key PBM Functional Areas Require Radical*

Transformation, Managed Care, August 28, 2012. This capability has not changed over the years and continues to be the most automated process in health care. *Id.*

This core function of processing claims on behalf of health plans explains why PBMs in Washington are today regulated as third-party administrators by the Office of the Insurance Commissioner (“OIC”). See RCW 19.340.010 et. seq.; WAC 284-180-110 et. seq. Although a PBM is performing a core insurance function that is subject to OIC regulation, a PBM is not authorized as an insurer in Washington. See RCW 48.05.030 (1) (“No person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.”) As such, a PBM is unable to contract “to indemnify another or pay a specified amount upon determinable contingencies.” RCW 48.01.040 (insurance defined); RCW 48.01.050 (insurer defined). Only an authorized insurer may do that. The health plans are the parties that indemnify insureds and pay specified amounts upon the determinable contingency of a covered prescription being filled by a pharmacy for an insured. A PBM merely facilitates that process.

Although the core function of all PBMs are to process claims electronically for health plans, different business models have evolved over time. These different business models are reflected in the agreements between PBMs and the various health plans, as well as the agreements

between PBMs and the network of pharmacies that are approved for prescription drug sales within the various health plans. Although PBMs were originally compensated solely through claims processing fees, additional alternative models have developed as the scope of PBM services have expanded. Today, PBMs derive their revenue from one or a combination of mechanisms, consisting of: (1) claim processing fees/management fees, (2) reimbursement “spread” between the amount claimed from the health plans and the amount that pharmacies are paid for prescriptions, and (3) retaining a portion of the rebates obtained from pharmaceutical manufacturers and wholesalers for drugs included on the health plans’ formularies. PBMs also derive revenue by promoting prescription sales through captive or affiliated mail order pharmacies (a separate line of business). Regardless of the mechanism used to calculate a PBM’s revenue, the fact remains that PBMs remain third-party administrators of pharmacy benefit programs for health plans; they are not performing pharmacy services, nor are they acting as an insurer.

IV. ARGUMENT

A. A PBM's Primary Function Is To Facilitate The Payment Of Obligations Owed By Its Health Plan Clients To Pharmacies.

In Washington, health plans offered by health carriers² must cover “prescription drug services.” See WAC 284-43-5640(6). “Prescription drug services” include medically necessary prescribed drugs, medication, and drug therapies. *Id.* A health plan’s formulary, which is a listing of drugs available within a health plan, is part of the prescription drug services the health plan must provide. WAC 284-43-5640(6)(f).

To provide essential health benefits to members, health plans must establish a network of “providers” willing to provide these services to health plan members in a timely manner. WAC 284-170-200.³

“Participating providers” are defined as “providers” who have:

agreed to provide health care services to covered persons with an *expectation of receiving payment . . . from the health carrier* rather than from the covered person.

WAC 284-170-130(23)(emphasis added).

The contracts with each “participating provider” are heavily regulated and must include a number of terms. See WAC 284-170-421 to 480. Every participating provider contract must set forth a schedule for

² A “health carrier” is defined as a “disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes ‘issuers’ as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).” WAC 284-43-160(16).

³ The term “providers” includes persons providing pharmacy services under Ch. 18.64 RCW. See WAC 284-170-130(12) (defining “provider,” in part, as a person regulated under Title 18 RCW); WAC 284-170-130(25)(defining “pharmacy services” as the practice of pharmacy regulated under Ch. 18.64 RCW.)

the prompt payment of amounts “owed by the carrier to the provider.”
WAC 284-170-431. A health plan must pay providers as soon as possible.
Id. While health plans may use subcontractors to establish a provider network,⁴ the insurer’s obligation to comply with these requirements, including the requirement to pay providers, is nondelegable, and an insurer cannot avoid responsibility because it relied on subcontractor to establish a provider network. WAC 284-170-401. The health care network regulations state:

A carrier may not offer as a defense to a violation of any provision of this chapter *that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier,* or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier.

Thus, under the insurance regulations, the insurers are the principals responsible for paying providers to treat members. PBMs are merely third-party administrators that operate as agents to assist the carriers in administering their obligations to establish provider networks and make reimbursement payments to the providers for health care services provided to members. *See* WAC 284-170-431 (requiring “ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier *or agent of the carrier*”).

⁴ WAC 284-170-240.

Under RCW 19.340.010, a “pharmacy benefit manager” is defined as “person that contracts with pharmacies *on behalf of an insurer*” to process claims for prescription drugs. Under this statute a “claim” is defined as “a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug.” *Id.* Again, these provisions show that PBMs are acting as agents for the insurance companies to facilitate the insurance company’s payment for health care services provided to plan members.

This is consistent with Express Script’s sole contract with a health plan in the record. Under this contract with King County, Express Scripts is responsible for processing claims from network pharmacies. CP 683. Importantly, the health plan has “final responsibility for all decisions with respect to coverage of a Prescription Drug Claim and the benefits allowable under the Plan, including determining whether any rejected or disputed claim will be allowed.” *Id.*⁵ Because the King County health plan retains ultimate control over the payment of the pharmacy’s claim, this demonstrates that Express Scripts acts under the control of King County, and thus the payment of the claim is an obligation of the health plan, not the PBM.

⁵ While the statements in Express Script’s 10-K claiming that it acts as a principle in transactions with the pharmacies may reflect how it typically does business across the country, it is hard to see how they accurately reflect its operations in Washington, given the language of the insurance regulations and the only contract in the record.

B. The Payment Of A Client’s Obligation To A Third Party Is Not Part Of A Taxpayer’s Gross Income.

“Gross income” is “the value proceeding and accruing by reason of the transaction of the business engaged in.” RCW 82.04.080. The term “value proceeding and accruing” means “the consideration ... actually received or accrued.” RCW 82.04.090. Where a taxpayer receives money to pay an obligation of the client to a third party, those amounts are not consideration for the services provided by the taxpayer. Rule 111 explicitly recognizes that amounts may be excluded from gross income where “the taxpayer, as an incident to the business, undertakes, on behalf of the ... client, the payment of money, ... upon an obligation owing by the ... client to a third person.”

Similar to the facts in *Walthew, Warner, Keefe, Arron, Costello & Thompson v. State, Dep't of Revenue*, 103 Wn.2d 183, 188, 691 P.2d 559, 562 (1984), health plans remain ultimately liable for the payment of the pharmacy services provided to their members. *See Walthew*, 103 Wn.2d at 188 (holding that “gross income” does not include reimbursements paid to lawyers for litigation costs where the client remains ultimately liable for the costs); WAC 284-170-431 (obligating insurance carriers to promptly pay providers for health care services provided to its members).

The prior decisions dealing with Rule 111 recognize that it is interpreting the scope of the term “gross income” in RCW 82.04.080. Thus, it is important to read Rule 111 in light of the statutory language. The term “reimbursement” as used in Rule 111 means “money or credits

received from a customer or client to repay the taxpayer for money or credits expended by the taxpayer in payment of costs or fees for the client.” However, pass-through treatment does not apply to:

cases where the customer, guest or client makes advances to the taxpayer upon *services to be rendered by the taxpayer* or upon goods to be *purchased by the taxpayer in carrying on the business in which the taxpayer engages*.

Id. (emphasis added).

The distinction between the two scenarios is whether the taxpayer has undertaken the obligation to perform the activity, either by itself or through a subcontractor, or if the transaction is between the client and a third party with payment merely passing through the taxpayer. Where the taxpayer is the party to whom the client looks to perform the service, then the amounts they receive are part of the consideration received for performing the activities. However, if all the parties recognize that the third party is the solely responsible for performing the activity and that the client is responsible for paying the third party, then the amounts are not “consideration” for the taxpayer’s role in passing through the payments.

Here, PBMs are not responsible for providing prescription drugs to plan members; that is solely the responsibility of the pharmacies. Nor are the pharmacies subcontractors that are part of performing the claims processing responsibilities of the PBMs. This is explicitly stated in Express Script’s health plan contract. *See* CP 668 (excluding Participating Pharmacies from definition of Subcontractors that are responsible for helping to perform the PBM activities). Express Scripts, Inc. does not

hold a Pharmacy License in Washington and cannot legally provide pharmacy services within the state. Therefore, the amounts are not consideration paid to the PBMs as part of their business activities, but reimbursements for the payment of amounts owed by the health plans to the pharmacies.

C. The Business Of Processing Claims Does Not Include Providing The Underlying Activities That Generate The Claims.

The Department's arguments in this case fail to address how the reimbursements for payments made to pharmacies constitute consideration for activities performed by the PBMs. It is undisputed that PBMs are not involved in the sale or distribution of the prescription drugs. Yet, that is the basis for the reimbursements paid by the health plans to the pharmacies through the PBMs. While the reimbursement payments are part of the claims processing function PBMs perform on behalf of the health plans, the underlying activities that created the payment obligation are not part of the PBM's business activities. The PBMs do not sell prescription drugs, nor are they insurance companies or health carriers that assume the obligation to pay for those drugs. Therefore, the amounts flowing through the PBMs to satisfy the health plans's obligations and compensate pharmacies are not consideration for services provide by the PBMs.

In most Rule 111 cases, the amounts at issue are typically considered gross income because the court concludes that the taxpayer

undertook to provide the goods or services to its customer through a third party. For example, in *Washington Imaging Services v. Department of Revenue*, 171 Wn.2d 548 (2011), the court concluded that Washington Imaging sold both the image and the interpretation services as part of its business. 171 Wn. 2d at 556. Unlike the Rule 111 cases cited by the Department, the PBM clients are not the recipients of the prescription drugs sold by the pharmacies. The plan members are consuming the drugs and have merely arranged for the insurance companies to make payments on their behalf to the pharmacies. There are no goods or services flowing from the pharmacies to the PBMs or the insurance companies. As such, the pharmacy claim payments flowing through the PBMs are not related to goods or services provided to the health plans. Rather they arise from two activities: (1) the pharmacy's sale of prescription drugs to the plan members, and (2) the health plans' obligation pay for member's prescription drug costs. Neither of which are part of the PBM's business activities. Instead, the very nature of a PBM's activities is to merely act as a conduit for the health plan's payments.

To the extent that the Department argues that PBMs are in the business of assuming the underlying obligation of insurers to pay pharmacy claims, this would be providing "insurance" and exempt from B&O tax.⁶ Under RCW 48.01.040, "insurance" is defined as "a contract

⁶ The "business of insurance" subject to the premiums tax and is exempt from B&O tax under RCW 82.04.320.

whereby one undertakes to indemnify another or to pay a specified amount upon determinable contingencies.” If the PBMs really did assume the underlying obligation to pay pharmacies when they make a claim, then this is an agreement to “indemnify another or pay a specified amount” when the claim is made. However, neither party has argued that PBMs are in the business of providing insurance by assuming the insurer’s obligation to pay prescription drug claims. Therefore, PBMs are responsible for processing the claims, not assuming the underlying obligation. This is directly analogous to the situation in *Walthev* where the attorneys were prohibited from assuming the underlying obligation to pay litigation expenses. See *Washington Imaging*, 171 Wn.2d at 563 (noting that clients in *Walthev* assumed obligation under ethics rules and contracts with attorneys).

While the Department points out that Express Scripts pays the pharmacy claims and cannot reclaim those amounts from the pharmacies if it is not reimbursed by its clients, this does not necessarily mean that it has assumed the underlying obligation to pay pharmacy claims.⁷ The health plans remain ultimately liable for paying claims from providers, just as the clients remained ultimately liable for paying litigation expenses in *Walthev*. See WAC 284-170-431(5)(“Every carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the

⁷ See Resp. Br. at 15 (citing the statement in Express Script’s 10-K that it “assume[s] the credit risk of [its] clients’ ability to pay for the drugs dispensed by [the] network pharmacies.”)(parentheticals in original).

carrier or acting pursuant to carrier standards or requirements complies with these billing and claim payment standards.”). This obligation is expressly set out in the contract between Express Scripts and King County. CP 682 (“County shall be responsible for all Prescription Drug Claims”).

Furthermore, in any situation where an agent is responsible for making a payment to a third party and seeking reimbursement from the principal, there is a risk that the agent will make the payment and not get reimbursed. For example, a lawyer may pay a filing fee on behalf of a client who subsequently goes bankrupt and is unable to pay. This is still excludable from gross income under Rule 111, even though nothing allows the attorney to get a refund of the filing fee from the court because they weren’t reimbursed by the client.

The relevant question is whether the client remains ultimately liable for the payment. *Walthew*, 103 Wn. 2d at 185. Since that is the case here, under both Washington’s insurance regulations and the sole contract in the record, the pharmacy claim reimbursements are properly excluded from the PBMs’ gross income.

V. CONCLUSION

For these reasons, Optum RX urges the court to hold that reimbursements for amounts paid by a PBM as part of processing claims from pharmacies on behalf of insurers are not part of the “gross income” of the PBM.

RESPECTFULLY SUBMITTED this 21st day of May, 2018.

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