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SENATE FILE 2283
BY COMMITTEE ON STATE GOVERNMENT

(SUCCESSOR TO SSB 3039)

Passed Senate, Date ________ Passed House, Date ________
Vote: Ayes ______ Nays ______ Vote: Ayes ______ Nays ______
Approved ______________________

## A BILL FOR

1 An Act relating to the regulation of pharmacy benefit managers
2 and making appropriations.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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SF 2283 STATE GOVERNMENT

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1 Section 1. NEW SECTION. 155B.1 SHORT TITLE.
2 This chapter shall be known and may be cited as the
3 "Pharmacy Benefits Manager Regulation Act".
4 Sec. 2. NEW SECTION. 155B.2 PURPOSE AND INTENT.
5 The purposes of this chapter are:
6 1. To establish standards and criteria for the regulation
7 and licensing of pharmacy benefits managers.
8 2. To promote, preserve, and protect the public health,
9 safety, and welfare by and through effective regulation and
10 licensing of pharmacy benefits managers.
11 Sec. 3. NEW SECTION. 155B.3 DEFINITIONS.
12 For purposes of this chapter, unless the context otherwise
13 requires:
14 1. "Board of pharmacy" or "board" means the board of
15 pharmacy examiners.
16 2. "Cease and desist order" means an order of the board
17 prohibiting a pharmacy benefits manager or other person from
18 continuing a particular course of conduct which violates this
19 chapter or the rules adopted under this chapter.
20 3. "Commissioner" means the commissioner of insurance.
21 4. "Enrollee" means an individual who is enrolled in a
22 pharmacy benefits management plan.
23 5. "Health insurance plan or contract" means a third-party
24 payment provider contract or policy that is an individual or
25 group policy of accident or health insurance or individual or
26 group hospital or health care services contract issued
27 pursuant to chapter 509, 509A, 514, or 514A, or an individual
28 or group health maintenance organization contract issued and
29 regulated under chapter 514B.
30 6. "Insolvent" or "insolvency" means a financial situation
31 in which, based upon the financial information required by
32 this chapter for the preparation of a pharmacy benefits
33 manager's annual statement, the assets of the pharmacy
34 benefits manager are less than the sum of all the company's
35 liabilities and required reserves.

1 7. "Maintenance drug" means a drug prescribed by a
2 practitioner who is licensed to prescribe drugs and used to
3 treat a medical condition for a period of more than thirty
4 days.
5 8. "Multisource drug" means a drug that is stocked and is
6 available from three or more suppliers.
7 9. "Pharmacist" means pharmacist as defined in section
8 155A.3.
9 10. "Pharmacists' services" include drug therapy and other
10 patient care services provided by a licensed pharmacist
11 intended to achieve outcomes related to the cure or prevention
12 of a disease, elimination or reduction of a patient's
13 symptoms, or arresting or slowing of a disease process as
14 defined by rule of the board.
15 11. "Pharmacy" means pharmacy as defined in section
16 155A.3.
17 12. "Pharmacy benefits management plan" means an
18 arrangement for the delivery of prescription services in which
19 a pharmacy benefits manager provides, arranges for, pays for,
20 or reimburses any of the costs of prescription services for an
21 enrollee on a prepaid or insured basis which provides all of
22 the following:
23 a. Contains one or more incentive arrangements intended to
24 influence the cost or level of prescription services between
25 the plan sponsor and one or more pharmacies with respect to
26 the delivery of prescription services.
27 b. Requires or creates benefit payment differential
28 incentives for enrollees to use under contract with the
29 pharmacy benefits manager.
30 "Pharmacy benefits management plan" does not mean an
31 employee welfare benefit plan as defined in the federal
32 Employee Retirement Income Security Act of 1974, 29 U.S.C. §
33 1002(1), which is self-insured or self-funded.
34 13. "Pharmacy benefits manager" or "company" means an
35 entity that administers the prescription drug or device

1 portion of a health insurance plan or contract on behalf of
2 the sponsors of the health insurance plan or contract.
3 14. "Plan sponsor" means an employer, insurance company,
4 union, or health maintenance organization that contracts with
5 a pharmacy benefits manager for delivery of prescription
6 services.
7 15. "Usual and customary price" means the price the
8 pharmacist would have charged a cash-paying patient for the
9 same services on the same date inclusive of any discounts
10 applicable.
11 Sec. 4. NEW SECTION. 155B.4 CERTIFICATE OF AUTHORITY.
12 1. A person shall not establish or operate as a pharmacy
13 benefits manager in this state to provide pharmacy benefits
14 management plans without first obtaining a certificate of
15 authority from the board of pharmacy examiners. A pharmacy
16 benefits manager providing pharmacy benefits management plans
17 in this state shall obtain a certificate of authority from the
18 board every four years.
19 2. A person may apply to the board to obtain a certificate
20 of authority to establish and operate as a pharmacy benefits
21 manager in compliance with this chapter if the person obtains
22 an annual license to do business in this state from the
23 commissioner under section 155B.5.
24 3. The board may suspend or revoke a certificate of
25 authority issued to a pharmacy benefits manager under this
26 chapter or may deny an application for a certificate of
27 authority if the board finds any of the following:
28 a. The pharmacy benefits manager is operating
29 significantly in contravention of its basic organizational
30 document.
31 b. The pharmacy benefits manager does not arrange for
32 pharmacists' services.
33 c. The pharmacy benefits manager has failed to meet the
34 requirements for issuance of a certificate of authority
35 established in this chapter.

1 d. The pharmacy benefits manager is unable to fulfill its
2 obligation to furnish pharmacists' services as required under
3 its pharmacy benefits management plan.
4 e. The pharmacy benefits manager is no longer financially
5 responsible and may reasonably be expected to be unable to
6 meet its obligations to enrollees or prospective enrollees.
7 f. The pharmacy benefits manager, or any person on the
8 company's behalf, has advertised or merchandised its services
9 in an untrue, misrepresentative, misleading, deceptive, or
10 unfair manner.
11 g. The continued operation of the pharmacy benefits
12 manager would be hazardous to its enrollees.
13 h. The pharmacy benefits manager has failed to file an
14 annual statement with the commissioner in a timely manner.
15 i. The pharmacy benefits manager has otherwise failed to
16 substantially comply with this chapter.
17 4. When the certificate of authority of a pharmacy
18 benefits manager is revoked, the company shall proceed,
19 immediately following the effective date of the order of
20 revocation, to conclude the company's affairs and shall
21 conduct no further business except as may be essential to the
22 orderly conclusion of the affairs of the company. The board
23 may permit further operation of the company as the board may
24 find to be in the best interest of enrollees so that the
25 enrollees will be afforded the greatest practical opportunity
26 to obtain pharmacists' services.
27 Sec. 5. <u>NEW SECTION</u>. 155B.5 LICENSE TO DO BUSINESS.
28 1. The commissioner shall not issue an annual license to
29 do business in this state to any pharmacy benefits manager
30 providing pharmacy benefits management plans until the
31 commissioner is satisfied that the pharmacy benefits manager
32 has complied with all of the following:
33 a. Paid all fees, taxes, and charges required by law.
34 b. Has made any deposit required by this chapter.
35 c. Has met the minimum capital and surplus requirements

1 specified by the commissioner.
2 d. Has filed any necessary financial statement and any
3 reports, certificates, or other documents the commissioner
4 considers necessary to secure a full and accurate knowledge of
5 the company's affairs and financial condition.
6 e. Is solvent, and the company's financial condition,
7 method of operation, and manner of doing business satisfy the
8 commissioner that the company can meet the company's
9 obligations to all enrollees.
10 f. Has otherwise complied with all the requirements of
11 law.
12 2. The license shall be in addition to the certificate of
13 authority required by the board. A nonrefundable license
14 application fee of five hundred dollars shall accompany each
15 application for a license to transact business in this state.
16 The fee shall be collected by the commissioner and shall be
17 deposited in the pharmacy benefits manager fund created in
18 section 155B.16.
19 3. The license shall be signed by the commissioner or the
20 commissioner's agent and shall expire on the next June 30
21 after the date on which the license becomes effective.
22 4. A pharmacy benefits manager providing pharmacy benefits
23 management plans shall obtain an annual renewal of the
24 company's license from the commissioner. The commissioner may
25 refuse to renew the license of any pharmacy benefits manager
26 or may renew the license, subject to any restrictions
27 considered appropriate by the commissioner, if the
28 commissioner finds an impairment of required capital and
29 surplus, or if the commissioner finds that the pharmacy
30 benefits manager has not satisfied all the conditions
31 specified in this chapter. The commissioner shall not fail to
32 renew the license of any pharmacy benefits manager to transact
33 business in this state without providing the pharmacy benefits
34 manager ten days' notice and providing the company an
35 opportunity to be heard. The hearing may be informal, and the

1 commissioner and the pharmacy benefits manager may waive the
2 required notice.
3 Sec. 6. NEW SECTION. 155B.6 ANNUAL STATEMENT.
4 1. A pharmacy benefits manager providing pharmacy
5 management benefits plans in this state shall file a statement
6 with the commissioner annually by March 1. The statement
7 shall be verified by at least two principal officers of the
8 pharmacy benefits manager and shall cover the preceding
9 calendar year. The pharmacy benefits manager shall also
10 submit a copy of the statement to the board.
11 2. The statement shall be on forms prescribed by the
12 commissioner and shall include all of the following:
13 a. A financial statement of the company, including its
14 balance sheet and income statement for the preceding year.
15 b. The number of persons enrolled during the year, the
16 number of enrollees as of the end of the year, and the number
17 of enrollments terminated during the year.
18 c. Any other information relating to the operations of the
19 pharmacy benefits manager required by the commissioner
20 pursuant to this chapter.
21 3. If the pharmacy benefits manager is audited annually by
22 an independent certified public accountant, a copy of the
23 certified audit report shall be filed annually with the
24 commissioner by June 30.
25 4. The commissioner may extend the time prescribed for any
26 pharmacy benefits manager for filing an annual statement or
27 other reports, or exhibits of the statement or report for good
28 cause shown. However, the commissioner shall not extend the
29 time for filing annual statements beyond sixty days after the
30 time prescribed by subsection 1. A pharmacy benefits manager
31 which fails to file its annual statement within the time
32 prescribed by this section may have its licensed revoked by
33 the commissioner or its certificate of authority revoked or
34 suspended by the board until the annual statement is filed.
35 The commission may waive the requirements for a pharmacy

1 benefits manager to file financial information if an affiliate
2 of the pharmacy benefits manager is also required to file the
3 same information.
4 Sec. 7. NEW SECTION. 155B.7 FINANCIAL EXAMINATION.
5 1. In lieu of or in addition to performing a financial
6 examination of a pharmacy benefits manager, the commissioner
7 may accept the report of a financial examination by another
8 person responsible for pharmacy benefits managers under the
9 laws of another state who is certified by the insurance
10 supervisory official, similar regulatory agency, or the state
11 health commissioner of the other state.
12 2. The commissioner shall coordinate financial
13 examinations of pharmacy benefits managers that provide
14 pharmacy benefits management plans in this state to ensure an
15 appropriate level of regulatory oversight and to avoid any
16 undue duplication of effort or regulation. The pharmacy
17 benefits manager being examined shall pay the cost of the
18 examination. Payments of the cost of the examination shall be
19 collected by the commissioner and shall be deposited in the
20 pharmacy benefits manager fund created in section 155B.16.
21 Sec. 8. NEW SECTION. 155B.8 ASSESSMENT.
22 1. The expense of administering this chapter, including
23 the costs incurred by the commissioner and the board, shall be
24 assessed annually by the board against all pharmacy benefits
25 managers operating in this state. Before determining the
26 assessment, the board shall request from the commissioner an
27 estimate of all expenses for the regulation, supervision, and
28 examination of all companies subject to regulation under this
29 chapter. The assessment shall be in proportion to the
30 business done in this state.
31 2. Assessments shall be collected by the commissioner and
32 shall be deposited in the pharmacy benefits manager fund
33 created in section 155B.16.
34 3. The board shall provide each pharmacy benefits manager
35 notice of the assessment, which shall be paid to the board on

1 or before March 1 of each year. A pharmacy benefits manager
2 that fails to pay the assessment on or before the date
3 prescribed shall be subject to a penalty imposed by the board
4 which is ten percent of the assessment and interest for the
5 period between the due date and the date of full payment. If
6 a payment is made in an amount later found to be in error, the
7 following shall apply:
8 a. If the error found is an underpayment and an additional
9 amount is due, the commission shall notify the company of the
10 additional amount and the company shall pay the additional
11 amount within fourteen days of the date of the notice.
12 b. If the error found is an overpayment, a refund shall be
13 ordered.
14 4. If an assessment made under this chapter is not paid to
15 the board by the prescribed date, the amount of the
16 assessment, penalty, and interest may be recovered from the
17 defaulting company on motion of the board made in the name and
18 for the use of the state in the appropriate court after ten
19 days' notice to the company. The certificate of authority of
20 a defaulting company to transact business in this state may be
21 revoked or suspended by the board until the company has paid
22 the assessment.
23 Sec. 9. NEW SECTION. 155B.9 PHARMACY BENEFITS MANAGER
24 CONTRACTS.
25 1. A pharmacy benefits manager that contracts with a
26 pharmacy or pharmacist to provide pharmacists' services
27 through a pharmacy management plan for enrollees in this state
28 shall file the contract with the board thirty days before the
29 execution of the contract. The contract shall be deemed
30 approved unless the board disapproves the contract within
31 thirty days after the contract is filed with the board.
32 2. Disapproval of the contract shall be in writing,
33 stating the reasons for the disapproval, and a copy of the
34 written disapproval shall be delivered to the pharmacy
35 benefits manager.

1 3. The board, consistent with the board's responsibility
2 for protecting the public interest, shall develop formal
3 criteria for the approval and disapproval of pharmacy benefits
4 manager contracts.
5 4. The pharmacy benefits manager shall provide a contract
6 to the pharmacy or pharmacist that is written in plain
7 language that is generally understood by pharmacists.
8 5. A pharmacy benefits manager that contracts with a
9 pharmacy or pharmacist to provide pharmacist services through
10 a pharmacy benefits management plan for enrollees in this
11 state on behalf of any health plan sponsors shall be
12 identified as the agent of the health plan sponsor. The
13 health plan fiduciary responsibilities shall transfer to the
14 contracting pharmacy benefits manager.
15 6. A contract shall apply the same coinsurance, copayment,
16 and deductible to covered drug prescriptions filled by any
17 pharmacy or pharmacist who participates in the network.
18 7. This section shall not be construed to prohibit a
19 contract from applying different coinsurance, copayment, and
20 deductible factors between generic and brand-name drugs that
21 an enrollee may obtain with a prescription if the limits are
22 applied uniformly to all pharmacies or pharmacists in the
23 health insurance plan or contract network.
24 8. A pharmacy benefits management plan shall not require a
25 pharmacy or pharmacist to change an enrollee's maintenance
26 drug unless the prescribing physician and the enrollee agree
27 to the change.
28 9. A pharmacy's or pharmacist's participation in any plan
29 or network offered by a pharmacy benefits manager is optional
30 and at the discretion of the pharmacy or pharmacist. The
31 pharmacy's or pharmacist's participation or lack of
32 participation in one plan shall not affect the pharmacy's or
33 pharmacist's participation in any other plan or network
34 ordered by the pharmacy benefits manager.
35 10. A pharmacy benefits manager that initiates an audit of

1 a pharmacy or pharmacist under the provisions of the contract
2 shall limit the methods and procedures that are recognized as
3 fair and equitable for both the pharmacy benefits manager and
4 the pharmacy or pharmacist. An audit shall not allow for
5 extrapolation calculations. A pharmacy benefits manager shall
6 not recoup any moneys due from an audit by setoff from future
7 remittances until the results of the audit are resolved and
8 finalized by both the pharmacy benefits manager and the
9 pharmacy or pharmacist. If the findings of an audit cannot be
10 finalized and agreed to by both parties, the commissioner
11 shall establish an independent review board to adjudicate
12 unresolved grievances.
13 11. a. Prior to terminating a pharmacy or pharmacist from
14 the network, a pharmacy benefits manager shall provide the
15 pharmacy or pharmacist with a written explanation of the
16 reason for the termination at least thirty days before the
17 actual termination unless the contract termination action is
18 taken as the result of any of the following:
19 (1) Loss of the pharmacy's or pharmacist's license to
20 practice pharmacy or loss of professional liability insurance.
21 (2) Conviction of fraud or misrepresentation in regard to
22 the contract.
23 b. A pharmacy or pharmacist may request and receive,
24 within thirty days, a review of the proposed termination by
25 the board prior to the termination.
26 12. The pharmacy or pharmacist shall not be held
27 responsible for actions of the pharmacy benefits manager or
28 plan sponsors and the pharmacy benefits manager or plan
29 sponsors shall not be held responsible for the actions of the
30 pharmacy or pharmacist.
31 Sec. 10. NEW SECTION. 155B.10 ENFORCEMENT.
32 1. The board shall develop formal investigation and
33 compliance procedures for responding to complaints by health
34 insurance plans or contract sponsors, pharmacists, or
35 enrollees concerning the failure of a pharmacy benefits

1 manager to comply with this chapter. If, based upon an
2 investigation or complaint, the board has reason to believe
3 that there is a violation of this chapter, the board shall
4 issue and serve upon the pharmacy benefits manager concerned a
5 statement of the charges and a notice of a hearing to be held
6 at a time and place fixed in the notice, which shall not be
7 less than thirty days after notice is served. The notice
8 shall require the pharmacy benefits manager to show cause why
9 an order should not be issued directing the company to cease
10 and desist from the violation. At the hearing, the pharmacy
11 benefits manager shall have an opportunity to be heard and to
12 show cause why an order should not be issued requiring the
13 pharmacy benefits manager to cease and desist from the
14 violation.
15 2. The board may perform an examination concerning the
16 quality of services of any pharmacy benefits manager and
17 providers with whom the pharmacy benefits manager has
18 contracts, agreements, or other arrangements pursuant to its
19 pharmacy benefits management plan as often as the board deems
20 necessary for the protection of the interests of the people of
21 this state. The pharmacy benefits manager being examined
22 shall pay the cost of the examination.
23 Sec. 11. NEW SECTION. 155B.11 PRESCRIPTION DRUG
24 REIMBURSEMENT COSTS.
25 Pharmacy benefits managers shall use a current and
26 nationally recognized benchmark on which to base
27 reimbursements for prescription drugs and products dispensed
28 by pharmacies and pharmacists as follows:
29 1. For brand-name, single-source products, the average
30 wholesale price as listed in first data bank or facts and
31 comparisons correct and current on the date the service was
32 provided shall be used as the index.
33 2. For generic drug, multisource products, maximum
34 allowable cost shall be established by referencing first data
35 bank facts and comparisons baseline prices. Only products

1 that are compliant with pharmacy laws as equivalent and
2 generically interchangeable with a federal food and drug
3 administration orange book rating of "A-B" shall be reimbursed
4 from a maximum allowable cost price methodology. In the event
5 a multisource product has no baseline price, the product shall
6 be treated as a single-source branded drug for the purpose of
7 valuing reimbursement.
8 Sec. 12. NEW SECTION. 155B.12 PROHIBITED PRACTICES.
9 1. A pharmacy benefits manager or its representative shall
10 not cause or knowingly permit any of the following:
11 a. The use of advertising that is untrue or misleading.
12 b. Solicitation that is untrue or misleading.
13 c. Any form of evidence of coverage that is deceptive.
14 2. A pharmacy benefits manager, unless licensed as an
15 insurer, shall not use in its name, contracts, or literature
16 any of the following:
17 a. Any form of the word "insurance", "casualty", "surety",
18 or "mutual".
19 b. Any other words descriptive of the insurance, casualty,
20 or surety business, or deceptively similar to the name or
21 description of any insurer or fidelity and surety insurer,
22 doing business in this state.
23 3. A pharmacy benefits manager shall not discriminate on
24 the basis of race, creed, color, sex, or religion in the
25 selection of pharmacies or pharmacists with whom the company
26 does business.
27 4. A pharmacy benefits manager shall not unfairly
28 discriminate against pharmacists when contracting for
29 pharmacists' services.
30 5. A pharmacy benefits manager shall be entitled to access
31 to usual and customary pricing only for comparison to the
32 reimbursement of a specific claims payment made by the
33 pharmacy benefits manager. Usual and customary pricing is
34 confidential and a pharmacy benefits manager is prohibited
35 from any other use or disclosure of usual and customary

1 pricing.
2 6. A pharmacy benefits manager shall not move a plan to
3 another payment network unless the pharmacy benefits manager
4 receives written consent from the plan sponsor.
5 7. A pharmacy benefits manager shall not receive or accept
6 any rebate, kickback, or any special payment or favor or
7 advantage of any valuable consideration or inducement for
8 changing a patient's drug product unless the change is
9 specified in a written contract that has been filed with the
10 commissioner at least thirty days prior to the execution of
11 the contract.
12 8. A claim paid by a pharmacy benefits manager shall not
13 be retroactively denied or adjusted after seven days from
14 adjudication of the claim. Acknowledgement of eligibility
15 shall not be retroactively reversed. A pharmacy benefits
16 manager may retroactively deny or adjust a claim only if the
17 original claim was submitted fraudulently, the original claim
18 payment was incorrect because the provider was previously paid
19 for services rendered, or the services were not rendered by
20 the pharmacist.
21 9. A pharmacy benefits manager shall not terminate a
22 pharmacy from a network based on any of the following:
23 a. The pharmacy expresses disagreement with the pharmacy
24 benefits manager's decision to deny or limit benefits to an
25 enrollee.
26 b. A pharmacist employed by the pharmacy discusses with a
27 current, former, or prospective enrollee any aspect of the
28 person's medical condition or treatment alternatives whether
29 or not the service is a covered service.
30 c. A pharmacist employed by the pharmacy makes a personal
31 recommendation regarding selecting a pharmacy benefits manager
32 based on the pharmacist's personal knowledge of the health
33 needs of the individual.
34 d. The pharmacy protests or expresses disagreement with a
35 medical decision, medical policy, or medical practice of a

1 pharmacy benefits manager.
2 e. The pharmacy has in good faith communicated with or
3 advocated on behalf of one or more of the pharmacy's current,
4 former, or prospective enrollees regarding the provisions,
5 terms, or requirements of the pharmacy benefits manager's
6 health benefit plans as they relate to the needs of the
7 individual regarding the method by which the pharmacy is
8 compensated for services provided under the agreement with the
9 pharmacy benefits manager.
10 10. A pharmacy benefits manager shall not terminate a
11 pharmacy from a network or otherwise penalize a pharmacy
12 solely because of the pharmacy's invoking of the pharmacy's
13 right under the contract or applicable law or regulation.
14 11. A pharmacy benefits manager's termination due to
15 incompetence or unprofessional behavior shall not release the
16 pharmacy benefits manager from the obligation to make any
17 payment due to the pharmacy for services provided in special
18 circumstances post-termination to the enrollees at less than
19 agreed-upon rates.
20 12. Participation or lack of participation by a pharmacy
21 in a plan or network shall not affect participation in any
22 other plan or network offered by a pharmacy benefits manager.
23 Sec. 13. NEW SECTION. 155B.13 DISCLOSURES.
24 1. The following shall be provided to the pharmacy
25 benefits manager enrollees at the time of enrollment or at the
26 time the contract is issued and shall be made available upon
27 request or at least annually:
28 a. A list of the names and locations of all affiliated
29 pharmacists' services providers.
30 b. A description of the service area or areas within which
31 the pharmacy benefits manager provides prescription services.
32 c. A description of the method of resolving complaints of
33 enrollees, including a description of any arbitration
34 procedure if complaints may be resolved through a specified
35 arbitration agreement.

1 d. Notice that the pharmacy benefits manager is subject to
2 regulation in this state by both the board of pharmacy
3 examiners and the commissioner of insurance.
4 e. A prominent notice included within the evidence of
5 coverage, providing substantially the following: "If you have
6 any questions regarding an appeal or grievance concerning the
7 pharmacists' services that you have been provided, which have
8 not been satisfactorily addressed by your plan, you may
9 contact the board of pharmacy examiners." The notice shall
10 also provide the toll-free telephone number, mailing address,
11 and electronic mail address of the board of pharmacy
12 examiners.
13 2. Any disclosure from a pharmacy benefits manager to
14 enrollees shall be written plainly, using terms generally
15 understood by the general public and a copy of the disclosure
16 shall be provided to all pharmacies that are members of the
17 network.
18 Sec. 14. NEW SECTION. 155B.14 PRIVACY.
19 An enrollee has the right to privacy and confidentiality in
20 the provision of pharmacists' services. This right may be
21 expressly waived in writing by the enrollee or the enrollee's
22 guardian.
23 Sec. 15. NEW SECTION. 155B.15 INSOLVENCY.
24 1. If a pharmacy benefits manager becomes insolvent or
25 ceases to be a company in this state in any assessable or
26 license year, the company shall remain liable for the payment
27 of the assessment for the period in which the company operated
28 as a pharmacy benefits manager in this state.
29 2. If a pharmacy benefits manager becomes insolvent, the
30 commissioner may, after notice and hearing, levy an
31 assessment, in addition to an assessment pursuant to section
32 155B.8, on pharmacy benefits managers licensed to do business
33 in this state. The assessments shall be paid quarterly to the
34 commissioner, and upon receipt by the commissioner shall be
35 paid over into an escrow account in the pharmacy benefits

1 manager fund. The escrow account shall be used solely for the
2 benefit of enrollees of the insolvent pharmacy benefits
3 manager.
4 Sec. 16. NEW SECTION. 155B.16 PHARMACY BENEFITS MANAGER
5 FUND -- USES -- ESCROW ACCOUNT.
6 1. A pharmacy benefits manager fund is created in the
7 state treasury under the authority of the commissioner of
8 insurance. Moneys received from licensure of pharmacy
9 benefits managers pursuant to section 155B.5, from
10 examinations collected pursuant to section 155B.7, and from
11 assessments collected pursuant to section 155B.8 shall be
12 deposited in the fund. Moneys in the fund shall be used and
13 an amount necessary is appropriated, annually, to the division
14 of insurance of the department of commerce for the purposes of
15 enforcing this chapter.
16 2. An escrow account is created in the pharmacy benefits
17 manager fund. Assessments collected pursuant to section
18 155B.15 shall be deposited in the account and are appropriated
19 to the division of insurance of the department of commerce to
20 be used solely for the benefit of the enrollees of an
21 insolvent pharmacy benefits manager.
22 EXPLANATION
23 This bill establishes regulation of pharmacy benefits
24 managers. The bill defines terms used in the bill, including
25 "pharmacy benefits manager" (PBM), which is an entity that
26 administers the prescription drug or device portion of a
27 health insurance plan or contract on behalf of the sponsors of
28 the health insurance plan or contract. The bill requires a
29 PBM to obtain a certificate of authority from the board of
30 pharmacy examiners every four years. A prerequisite for
31 obtaining a certificate of authority is the obtaining of a
32 license to do business in the state from the commissioner of
33 insurance. The bill provides criteria that the board may use
34 to suspend or revoke a PBM's certificate of authority.
35 The bill requires a PBM to obtain a license to do business

1 from the commissioner of insurance. Issuance of the license
2 is based on a determination by the commissioner that the PBM
3 is financially sound. A PBM is required to pay a license
4 application fee of $500. The license expires every June 30
5 following the date of issuance.
6 The bill requires a PBM to file an annual statement with
7 the commissioner of insurance by March 1, and also provide a
8 copy of the statement to the board of pharmacy examiners. The
9 annual statement is to be verified by at least two principal
10 officers of the PBM, cover the preceding calendar year, and
11 include: a financial statement of the company, including its
12 balance sheet and income statement for the preceding year; the
13 number of persons enrolled during the year, the number of
14 enrollees as of the end of the year, and the number of
15 enrollments terminated during the year; and any other
16 information relating to the operations of the PBM required by
17 the commissioner pursuant to the bill. If the PBM is audited
18 annually by an independent certified public accountant, a copy
19 of the certified audit report is to be filed annually with the
20 commissioner by June 30. The bill provides for an extension
21 in the time prescribed for submission of the annual statement
22 or other reports by the insurance commissioner for good cause
23 shown. If a PBM fails to file the annual statement in the
24 prescribed time, the commissioner may revoke its license and
25 the board may suspend or revoke the certificate of authority.
26 The bill provides for waiver of the required filing of a
27 financial statement if an affiliate of the PBM is also
28 required to file the same information.
29 The bill provides for the coordination of financial
30 examinations of PBMs, provides that the PBM is to pay the cost
31 of the examination, and provides that the payments collected
32 are to be deposited in the pharmacy benefits manager fund
33 created in the bill.
34 The bill provides that the expenses of administering the
35 regulation of PBMs, including the costs incurred by the

1 commissioner and the board, shall be assessed annually by the
2 board against all pharmacy benefits managers operating in the
3 state. The assessment is to be based upon the commissioner's
4 estimate, provided to the board, of all expenses for the
5 regulation, supervision, and examination of all entities
6 subject to regulation. Assessments are to be collected by the
7 commissioner by March 1, annually, and are to be deposited in
8 the pharmacy benefits manager fund created in the bill. The
9 bill directs the board to provide each pharmacy benefits
10 manager notice of the assessment. A pharmacy benefits manager
11 that fails to pay the assessment on or before the date
12 prescribed is subject to a penalty imposed by the board which
13 is 10 percent of the assessment and interest for the period
14 between the due date and the date of full payment. The bill
15 provides for payment of additional amounts or refunds if a
16 payment is made in an amount later found to be in error. If
17 an assessment is not paid to the board by the prescribed date,
18 the amount of the assessment, penalty, and interest may be
19 recovered and the certificate of authority of any defaulting
20 company to transact business in this state may be revoked or
21 suspended by the board until the company has paid the
22 assessment.
23 The bill requires a PBM that contracts with a pharmacy or
24 pharmacist to provide pharmacists' services to file the
25 contract with the board 30 days before the execution of the
26 contract. The contract is deemed approved unless the board
27 disapproves the contract within 30 days after the contract is
28 filed with the board. Disapproval of the contract is to be in
29 writing and a copy is to be delivered to the PBM. The bill
30 directs the board to develop formal criteria for the approval
31 and disapproval of PBM contracts.
32 The bill also requires the PBM to provide a contract to the
33 pharmacy or pharmacist that is written in plain language that
34 is generally understood by pharmacists; requires that the PBM
35 is to be identified as the agent of the health plan sponsor

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1 under the contract thereby transferring the health plan's
2 fiduciary responsibilities to the PBM; requires that the
3 contract applies the same coinsurance, copayment, and
4 deductible to covered drug prescriptions filled by any
5 pharmacy or pharmacist who participates in the network;
6 provides that the provisions relating to the PBM contract are
7 not to be construed to prohibit a contract from applying
8 different coinsurance, copayment, and deductible factors
9 between generic and brand-name drugs that an enrollee may
10 obtain with a prescription if the limits are applied uniformly
11 to all pharmacies or pharmacists in the health insurance plan
12 or contract network; prohibits a pharmacy benefits management
13 plan from requiring a pharmacy or pharmacist to change an
14 enrollee's maintenance drug unless the prescribing physician
15 and the enrollee agree to the change; provides that a
16 pharmacy's or pharmacist's participation in any plan or
17 network offered by a PBM is optional and at the discretion of
18 the pharmacy or pharmacist and is not to affect the pharmacy's
19 or pharmacist's participation in any other plan or network
20 ordered by the pharmacy benefits manager; requires a PBM that
21 initiates an audit of a pharmacy or pharmacist to limit the
22 methods and procedures that are recognized as fair and
23 equitable for both the PBM and the pharmacy or pharmacist;
24 specifies measures to be taken by a PBM for terminating a
25 pharmacy or pharmacist from the network; and provides that the
26 pharmacy or pharmacist is not to be held responsible for
27 actions of the PBM or plan sponsors and the PBM or plan
28 sponsors are not to be held responsible for the actions of the
29 pharmacy or pharmacist.
30 The bill provides for enforcement of the new Code chapter,
31 specifies medication reimbursement costs, specifies prohibited
32 practices by PBMs, requires PBMs to make certain disclosures
33 to enrollees, and provides that enrollees have the right to
34 privacy and confidentiality in the provision of pharmacists'
35 services which right may be expressly waived in writing by the

1 enrollee or the enrollee's guardian. The bill provides that
2 if a PBM becomes insolvent or ceases to be a company in this
3 state in any assessable or license year, the company remains
4 liable for the payment of the assessment for the period in
5 which the company operated as a PBM in the state. The bill
6 also provides that if a PBM becomes insolvent, the
7 commissioner may, after notice and hearing, levy an additional
8 assessment on PBMs licensed to do business in the state. The
9 assessments are to be paid quarterly to the commissioner,
10 deposited in an escrow account in the pharmacy benefits
11 manager fund, and are to be used solely for the benefit of
12 enrollees of the insolvent PBM.
13 The bill creates the pharmacy benefits manager fund in the
14 state treasury under the authority of the commissioner of
15 insurance. Moneys received from licensure of PBMs from
16 examination fees collected and from assessments collected are
17 deposited in the fund. Moneys in the fund are to be used and
18 an amount necessary is appropriated, annually, to the division
19 of insurance of the department of commerce for the purposes of
20 enforcing the provisions of the bill. The bill also creates
21 an escrow account within the fund. Assessments collected
22 relative to an insolvent PBM are to be deposited in the
23 account and are to be used solely for the benefit of the
24 enrollees of the insolvent PBM.
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**SENATE FILE 2283**

**S-5076**

1 Amend Senate File 2283 as follows:
2 1. By striking everything after the enacting
3 clause and inserting the following:
4 "Section 1. NEW SECTION. 155B.1 DEFINITIONS.
5 As used in this chapter, unless the context
6 otherwise requires:
7 1. "Administrator" means an administrator as
8 defined in section 510.11.
9 2. "Commissioner" means the commissioner of
10 insurance.
11 3. "Contract" means a pharmacy benefits management
12 services contract entered into between a pharmacy
13 benefits manager and a covered entity.
14 4. "Covered entity" means a nonprofit hospital or
15 medical service corporation, health insurer, health
16 benefit plan, or health maintenance organization; a
17 health program administered by this state in the
18 capacity of provider of health coverage; or an
19 employer, labor union, or other group of persons
20 organized in the state that provides health coverage
21 to covered individuals who are employed or reside in
22 this state. "Covered entity" does not include a self-
23 funded plan that is exempt from state regulation
24 pursuant to the Employer Retirement Income Security
25 Act of 1974, as codified at 29 U.S.C. § 1001 et seq.,
26 a plan issued for coverage for federal employees, or a
27 health plan that provides coverage only for accidental
28 injury, specified disease, hospital indemnity,
29 Medicare supplement, disability income, long-term
30 care, or other limited benefit health insurance
31 policies and contracts.
32 5. "Covered individual" means a member,
33 participant, enrollee, contract holder, policy holder,
34 or beneficiary of a covered entity who is provided
35 health coverage by the covered entity. "Covered
36 individual" does not include a dependent or other
37 person provided health coverage through a policy,
38 contract, or plan for a covered individual.
39 6. "Generic drug" means a chemically equivalent
40 copy of a brand-name drug with an expired patent.
41 7. "Labeler" means a person that receives
42 prescription drugs from a manufacturer or wholesaler
43 and repackages those drugs for later retail sale and
44 that has a labeler code from the United States food
45 and drug administration under 21 C.F.R. § 207.20.
46 8. "Parties" means the pharmacy benefits manager
47 and the covered entity that enter into a contract
48 regulated under this chapter.
49 9. "Pharmacy benefits management" means the
50 procurement of prescription drugs at a negotiated rate

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Page 2
1 for dispensing within this state to covered
2 individuals, the administration or management of
3 prescription drug benefits provided by a covered
4 entity for the benefit of covered individuals, or any
5 of the following services provided with regard to the
6 administration of the following pharmacy benefits:
7 a. Mail service pharmacy.
8 b. Claims processing, retail network management,
9 and payment of claims to pharmacies for prescription
10 drugs dispensed to covered individuals.
11 c. Clinical formulary development and management
12 services.
13 d. Rebate contracting and administration.
14 e. Certain patient compliance, therapeutic
15 intervention, and generic substitution programs.
16 f. Disease management programs involving
17 prescription drug utilization.
18 10. "Pharmacy benefits manager" means an entity
19 that performs pharmacy benefits management. "Pharmacy
20 benefits manager" includes a person acting for a
21 pharmacy benefits manager in a contractual or
22 employment relationship in the performance of pharmacy
23 benefits management for a covered entity including
24 mail service pharmacy. "Pharmacy benefits manager"
25 does not include a health insurance carrier when the
26 health insurance carrier or its subsidiary is
27 providing pharmacy benefits management to its own
28 insureds or a public self-funded pool or a private
29 single employer self-funded plan that provides such
30 benefits or services directly to its beneficiaries.
31 11. "Proprietary information" means information on
32 pricing, costs, revenue, taxes, market share,
33 negotiating strategies, customers, and personnel held
34 by a private entity and used for that private entity's
35 business purposes.
36 12. "Trade secret" means information including a
37 formula, pattern, compilation, program, device,
38 method, technique, or process that does both of the
39 following:
40 a. Derives independent economic value, actual or
41 potential, from not being generally known to and not
42 being readily ascertainable by proper means by other
43 persons who can obtain economic value from its
44 disclosure or use.
45 b. Is the subject of efforts that are reasonable
46 under the circumstances to maintain its secrecy.
47 Sec. 2. NEW SECTION. 155B.2 PHARMACY BENEFITS
48 MANAGER -- LICENSE REQUIRED -- PERFORMANCE OF DUTIES
49 -- PROHIBITION.
50 1. A person shall not operate or act as a pharmacy

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1 benefits manager in this state without a valid
2 certificate of registration as an administrator
3 pursuant to section 510.21.
4 2. A pharmacy benefits manager shall perform its
5 duties exercising good faith and fair dealing toward
6 the covered entity.
7 3. Unless otherwise authorized pursuant to the
8 contract entered into between the parties, a pharmacy
9 benefits manager shall not contact a covered
10 individual without the express written permission of
11 the covered entity.
12 Sec. 3. NEW SECTION. 155B.3 DISCLOSURE OF
13 INFORMATION.
14 1. a. A covered entity may request that a
15 pharmacy benefits manager with which the covered
16 entity has entered into a contract disclose to the
17 covered entity the amount of all rebate revenues and
18 the nature, type, and amounts of all other revenues
19 that the pharmacy benefits manager receives from each
20 pharmaceutical manufacturer or labeler with whom the
21 pharmacy benefits manager has a contract. If such a
22 request is received, the pharmacy benefits manager
23 shall disclose all of the following in writing:
24 (1) The aggregate amount, and for a list of drugs
25 to be specified in the contract, the specific amount
26 of all rebates and other retrospective utilization
27 discounts received by the pharmacy benefits manager
28 directly or indirectly from each pharmaceutical
29 manufacturer or labeler that are earned in connection
30 with the dispensing of prescription drugs to covered
31 individuals of the health benefit plans issued by the
32 covered entity or for which the covered entity is the
33 designated administrator.
34 (2) The nature, type, and amount of all other
35 revenue received by the pharmacy benefits manager
36 directly or indirectly from each pharmaceutical
37 manufacturer or labeler for any other products or
38 services provided to the pharmaceutical manufacturer
39 or labeler by the pharmacy benefits manager with
40 respect to programs that the covered entity offers or
41 provides to its enrollees.
42 (3) Any prescription drug utilization information
43 requested by the covered entity relating to covered
44 individuals.
45 b. A pharmacy benefits manager shall provide the
46 information requested by a covered entity within
47 thirty days of receipt of the request. If requested,
48 the information shall be provided at least once,
49 annually. The contract entered into between the
50 parties shall specify any fees to be charged for drug

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1 utilization reports requested by the covered entity.
2 2. a. With the exception of utilization
3 information, a covered entity shall maintain any
4 information disclosed in response to a request
5 pursuant to subsection 1 as confidential and
6 proprietary information, and shall not use such
7 information for any other purpose or disclose such
8 information to any other person except as otherwise
9 provided in this chapter or in the contract entered
10 into between the parties.
11 b. A covered entity that discloses information in
12 violation of this subsection is subject to an action
13 for injunctive relief and is liable for any damages
14 that are the direct and proximate result of such
15 disclosure.
16 c. This subsection does not prohibit a covered
17 entity from disclosing confidential and proprietary
18 information to the commissioner, upon request of the
19 commissioner. Any information disclosed to the
20 commissioner under this subsection is confidential and
21 privileged and is not open to public inspection or
22 disclosure.
23 3. A covered entity may require, in accordance
24 with the terms of the contract entered into between
25 the parties, the audit of the pharmacy benefits
26 manager's books and records related to the information
27 provided to the covered entity under subsection 1 to
28 the extent the information relates either directly or
29 indirectly to the contract. If the contract entered
30 into between the parties does not provide for such
31 audit, such an audit may be conducted if the audit
32 complies with all of the following:
33 a. The covered entity provides the pharmacy
34 benefits manager with thirty-business-days prior
35 written notice regarding the audit.
36 b. The covered entity requests an audit no more
37 than once in a twelve-month period.
38 c. If the covered entity selects an independent
39 person to conduct such audit, the independent person
40 enters into a confidentiality agreement with the
41 covered entity and the pharmacy benefits manager
42 ensuring that all information obtained during the
43 audit remains confidential. The independent person
44 shall not use, disclose, or otherwise reveal any such
45 information in any manner or form to any other person
46 except as otherwise permitted under the
47 confidentiality agreement. The covered entity shall
48 treat all information obtained as a result of the
49 audit as confidential, and shall not use or disclose
50 such information except as may be otherwise permitted

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Page 5
1 under the terms of the contract between the parties or
2 if ordered by a court of competent jurisdiction for
3 good cause shown.
4 d. The audit is conducted at the location of the
5 pharmacy benefits manager where the necessary records
6 are located, during normal business hours, without
7 undue interference with the pharmacy benefits
8 manager's business activities and in accordance with
9 recognized fair and equitable audit procedures.
10 Sec. 4. NEW SECTION. 155B.4 PRESCRIPTION DRUG
11 SUBSTITUTION.
12 1. With regard to the dispensing of a substitute
13 prescription drug for a prescribed drug to a covered
14 individual, if the pharmacy benefits manager requests
15 a substitution, all of the following conditions shall
16 be met:
17 a. The pharmacy benefits manager may request the
18 substitution of a lower-priced generic and
19 therapeutically equivalent drug for a higher-priced
20 prescribed drug.
21 b. With regard to a substitution in which the net
22 cost of the substitute drug is more for the covered
23 individual or the covered entity than the prescribed
24 drug, the substitution may be made only for medical
25 reasons that benefit the covered individual and with
26 the approval of the prescribing health professional.
27 2. This section shall not be interpreted to permit
28 the substitution of an equivalent drug product
29 contrary to the instructions of the prescribing health
30 professional.
31 Sec. 5. NEW SECTION. 155B.5 GENERAL PROVISIONS.
32 1. The commission shall adopt rules pursuant to
33 chapter 17A to administer this chapter.
34 2. A covered entity may bring a civil action to
35 enforce the provisions of this chapter or to seek
36 civil damages for violation of this chapter.
37 3. This chapter shall apply to pharmacy benefits
38 management services contracts entered into or renewed
39 on or after July 1, 2004."
40 2. Title page, line 2, by striking the words "and
41 making appropriations".

**By** MARK ZIEMAN

**S-5076** FILED MARCH 10, 2004

# Fiscal Services Division
# Legislative Services Agency
# Fiscal Note

SF 2283 - Regulation of Pharmacy Benefit Managers (LSB 6169 SV.1)
Analyst: Sue Lerdal (Phone: (515) 281-7794) (sue.lerdal@legis.state.ia.us)
Fiscal Note Version – Amendment S-5076 to SF 2283

## Description

Senate Amendment S-5076 to SF 2283 strikes everything after the enacting clause and requires a registration process within the Division of Insurance of the Department of Commerce for pharmacy benefit management. The Bill requires the regulation of pharmacy benefit managers.

## Assumptions

1. The Insurance Division of the Department of Commerce would have responsibility for the registration process for pharmacy benefits managers.
2. The Board of Pharmacy Examiners would have no role in the regulation process.
3. Requirements of a pharmacy benefits manager to comply with requests from covered entities would be governed by administrative rules adopted by the Insurance Division.
4. Any costs incurred by the pharmacy benefit manager entities would impact the cost of third-party coverage for State employees.

## Fiscal Impact

The fiscal impact of Amendment S-5076 to SF 2283 is as follows:

- The impact to the Division of Insurance would be minimal based upon the limited cost of a registration process and adoption of administrative rules.
- There would be no fiscal impact to the Board of Pharmacy Examiners.
- State employee insurance costs and insurance coverage for other public employees may increase based upon possible additional expenditures of pharmacy benefit managers, which may be reflected in the cost of insurance. Negotiations between the insurer and the insured would determine who would be responsible for the increased cost.

## Sources

Division of Insurance, Department of Commerce
Board of Pharmacy Examiners, Department of Public Health
Wellmark of Iowa

Dennis C Prouty

March 16, 2004

The fiscal note and correctional impact statement for this bill was prepared pursuant to Joint Rule 17 and pursuant to Section 2.56, Code of Iowa. Data used in developing this fiscal note and correctional impact statement are available from the Fiscal Services Division, Legislative Services Agency to members of the Legislature upon request.

Zieman
Veenstra
Connolly

Succeeded By
SF / HF 2283 SSB#3039

SENATE FILE State Government
BY (PROPOSED COMMITTEE ON
STATE GOVERNMENT BILL BY
CHAIRPERSON ZIEMAN)

Passed Senate, Date ________ Passed House, Date ________
Vote: Ayes ______ Nays ______ Vote: Ayes ______ Nays ______
Approved ____________________

A BILL FOR

1 An Act relating to the regulation of pharmacy benefit managers
2 and making appropriations.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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1 Section 1. NEW SECTION. 155B.1 SHORT TITLE.
2 This chapter shall be known and may be cited as the
3 "Pharmacy Benefits Manager Regulation Act".
4 Sec. 2. NEW SECTION. 155B.2 PURPOSE AND INTENT.
5 The purposes of this chapter are:
6 1. To establish standards and criteria for the regulation
7 and licensing of pharmacy benefits managers.
8 2. To promote, preserve, and protect the public health,
9 safety, and welfare by and through effective regulation and
10 licensing of pharmacy benefits managers.
11 Sec. 3. NEW SECTION. 155B.3 DEFINITIONS.
12 For purposes of this chapter, unless the context otherwise
13 requires:
14 1. "Board of pharmacy" or "board" means the board of
15 pharmacy examiners.
16 2. "Cease and desist order" means an order of the board
17 prohibiting a pharmacy benefits manager or other person from
18 continuing a particular course of conduct which violates this
19 chapter or the rules adopted under this chapter.
20 3. "Commissioner" means the commissioner of insurance.
21 4. "Enrollee" means an individual who is enrolled in a
22 pharmacy benefits management plan.
23 5. "Health insurance plan or contract" means a third-party
24 payment provider contract or policy that is an individual or
25 group policy of accident or health insurance or individual or
26 group hospital or health care services contract issued
27 pursuant to chapter 509, 509A, 514, or 514A, or an individual
28 or group health maintenance organization contract issued and
29 regulated under chapter 514B.
30 6. "Insolvent" or "insolvency" means a financial situation
31 in which, based upon the financial information required by
32 this chapter for the preparation of a pharmacy benefits
33 manager's annual statement, the assets of the pharmacy
34 benefits manager are less than the sum of all the company's
35 liabilities and required reserves.

1 7. "Maintenance drug" means a drug prescribed by a
2 practitioner who is licensed to prescribe drugs and used to
3 treat a medical condition for a period of more than thirty
4 days.
5 8. "Multisource drug" means a drug that is stocked and is
6 available from three or more suppliers.
7 9. "Pharmacist" means pharmacist as defined in section
8 155A.3.
9 10. "Pharmacists' services" include drug therapy and other
10 patient care services provided by a licensed pharmacist
11 intended to achieve outcomes related to the cure or prevention
12 of a disease, elimination or reduction of a patient's
13 symptoms, or arresting or slowing of a disease process as
14 defined by rule of the board.
15 11. "Pharmacy" means pharmacy as defined in section
16 155A.3.
17 12. "Pharmacy benefits management plan" means an
18 arrangement for the delivery of prescription services in which
19 a pharmacy benefits manager provides, arranges for, pays for,
20 or reimburses any of the costs of prescription services for an
21 enrollee on a prepaid or insured basis which provides all of
22 the following:
23 a. Contains one or more incentive arrangements intended to
24 influence the cost or level of prescription services between
25 the plan sponsor and one or more pharmacies with respect to
26 the delivery of prescription services.
27 b. Requires or creates benefit payment differential
28 incentives for enrollees to use under contract with the
29 pharmacy benefits manager.
30 "Pharmacy benefits management plan" does not mean an
31 employee welfare benefit plan as defined in the federal
32 Employee Retirement Income Security Act of 1974, 29 U.S.C. §
33 1002(1), which is self-insured or self-funded.
34 13. "Pharmacy benefits manager" or "company" means an
35 entity that administers the prescription drug or device

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1 portion of a health insurance plan or contract on behalf of
2 the sponsors of the health insurance plan or contract.
3 14. "Plan sponsor" means an employer, insurance company,
4 union, or health maintenance organization that contracts with
5 a pharmacy benefits manager for delivery of prescription
6 services.
7 15. "Usual and customary price" means the price the
8 pharmacist would have charged a cash-paying patient for the
9 same services on the same date inclusive of any discounts
10 applicable.
11 Sec. 4. NEW SECTION. 155B.4 CERTIFICATE OF AUTHORITY.
12 1. A person shall not establish or operate as a pharmacy
13 benefits manager in this state to provide pharmacy benefits
14 management plans without first obtaining a certificate of
15 authority from the board of pharmacy examiners. A pharmacy
16 benefits manager providing pharmacy benefits management plans
17 in this state shall obtain a certificate of authority from the
18 board every four years.
19 2. A person may apply to the board to obtain a certificate
20 of authority to establish and operate as a pharmacy benefits
21 manager in compliance with this chapter if the person obtains
22 an annual license to do business in this state from the
23 commissioner under section 155B.5.
24 3. The board may suspend or revoke a certificate of
25 authority issued to a pharmacy benefits manager under this
26 chapter or may deny an application for a certificate of
27 authority if the board finds any of the following:
28 a. The pharmacy benefits manager is operating
29 significantly in contravention of its basic organizational
30 document.
31 b. The pharmacy benefits manager does not arrange for
32 pharmacists' services.
33 c. The pharmacy benefits manager has failed to meet the
34 requirements for issuance of a certificate of authority
35 established in this chapter.

1 d. The pharmacy benefits manager is unable to fulfill its
2 obligation to furnish pharmacists' services as required under
3 its pharmacy benefits management plan.
4 e. The pharmacy benefits manager is no longer financially
5 responsible and may reasonably be expected to be unable to
6 meet its obligations to enrollees or prospective enrollees.
7 f. The pharmacy benefits manager, or any person on the
8 company's behalf, has advertised or merchandised its services
9 in an untrue, misrepresentative, misleading, deceptive, or
10 unfair manner.
11 g. The continued operation of the pharmacy benefits
12 manager would be hazardous to its enrollees.
13 h. The pharmacy benefits manager has failed to file an
14 annual statement with the commissioner in a timely manner.
15 i. The pharmacy benefits manager has otherwise failed to
16 substantially comply with this chapter.
17 4. When the certificate of authority of a pharmacy
18 benefits manager is revoked, the company shall proceed,
19 immediately following the effective date of the order of
20 revocation, to conclude the company's affairs and shall
21 conduct no further business except as may be essential to the
22 orderly conclusion of the affairs of the company. The board
23 may permit further operation of the company as the board may
24 find to be in the best interest of enrollees so that the
25 enrollees will be afforded the greatest practical opportunity
26 to obtain pharmacists' services.
27 Sec. 5. NEW SECTION. 155B.5 LICENSE TO DO BUSINESS.
28 1. The commissioner shall not issue an annual license to
29 do business in this state to any pharmacy benefits manager
30 providing pharmacy benefits management plans until the
31 commissioner is satisfied that the pharmacy benefits manager
32 has complied with all of the following:
33 a. Paid all fees, taxes, and charges required by law.
34 b. Has made any deposit required by this chapter.
35 c. Has met the minimum capital and surplus requirements

1 specified by the commissioner.
2 d. Has filed any necessary financial statement and any
3 reports, certificates, or other documents the commissioner
4 considers necessary to secure a full and accurate knowledge of
5 the company's affairs and financial condition.
6 e. Is solvent, and the company's financial condition,
7 method of operation, and manner of doing business satisfy the
8 commissioner that the company can meet the company's
9 obligations to all enrollees.
10 f. Has otherwise complied with all the requirements of
11 law.
12 2. The license shall be in addition to the certificate of
13 authority required by the board. A nonrefundable license
14 application fee of five hundred dollars shall accompany each
15 application for a license to transact business in this state.
16 The fee shall be collected by the commissioner and shall be
17 deposited in the pharmacy benefits manager fund created in
18 section 155B.16.
19 3. The license shall be signed by the commissioner or the
20 commissioner's agent and shall expire on the next June 30
21 after the date on which the license becomes effective.
22 4. A pharmacy benefits manager providing pharmacy benefits
23 management plans shall obtain an annual renewal of the
24 company's license from the commissioner. The commissioner may
25 refuse to renew the license of any pharmacy benefits manager
26 or may renew the license, subject to any restrictions
27 considered appropriate by the commissioner, if the
28 commissioner finds an impairment of required capital and
29 surplus, or if the commissioner finds that the pharmacy
30 benefits manager has not satisfied all the conditions
31 specified in this chapter. The commissioner shall not fail to
32 renew the license of any pharmacy benefits manager to transact
33 business in this state without providing the pharmacy benefits
34 manager ten days' notice and providing the company an
35 opportunity to be heard. The hearing may be informal, and the

1 commissioner and the pharmacy benefits manager may waive the
2 required notice.
3 Sec. 6. NEW SECTION. 155B.6 ANNUAL STATEMENT.
4 1. A pharmacy benefits manager providing pharmacy
5 management benefits plans in this state shall file a statement
6 with the commissioner annually by March 1. The statement
7 shall be verified by at least two principal officers of the
8 pharmacy benefits manager and shall cover the preceding
9 calendar year. The pharmacy benefits manager shall also
10 submit a copy of the statement to the board.
11 2. The statement shall be on forms prescribed by the
12 commissioner and shall include all of the following:
13 a. A financial statement of the company, including its
14 balance sheet and income statement for the preceding year.
15 b. The number of persons enrolled during the year, the
16 number of enrollees as of the end of the year, and the number
17 of enrollments terminated during the year.
18 c. Any other information relating to the operations of the
19 pharmacy benefits manager required by the commissioner
20 pursuant to this chapter.
21 3. If the pharmacy benefits manager is audited annually by
22 an independent certified public accountant, a copy of the
23 certified audit report shall be filed annually with the
24 commissioner by June 30.
25 4. The commissioner may extend the time prescribed for any
26 pharmacy benefits manager for filing an annual statement or
27 other reports, or exhibits of the statement or report for good
28 cause shown. However, the commissioner shall not extend the
29 time for filing annual statements beyond sixty days after the
30 time prescribed by subsection 1. A pharmacy benefits manager
31 which fails to file its annual statement within the time
32 prescribed by this section may have its licensed revoked by
33 the commissioner or its certificate of authority revoked or
34 suspended by the board until the annual statement is filed.
35 The commission may waive the requirements for a pharmacy

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1 benefits manager to file financial information if an affiliate
2 of the pharmacy benefits manager is also required to file the
3 same information.
4 Sec. 7. NEW SECTION. 155B.7 FINANCIAL EXAMINATION.
5 1. In lieu of or in addition to performing a financial
6 examination of a pharmacy benefits manager, the commissioner
7 may accept the report of a financial examination by another
8 person responsible for pharmacy benefits managers under the
9 laws of another state who is certified by the insurance
10 supervisory official, similar regulatory agency, or the state
11 health commissioner of the other state.
12 2. The commissioner shall coordinate financial
13 examinations of pharmacy benefits managers that provide
14 pharmacy management benefits plans in this state to ensure an
15 appropriate level of regulatory oversight and to avoid any
16 undue duplication of effort or regulation. The pharmacy
17 benefits manager being examined shall pay the cost of the
18 examination. Payments of the cost of the examination shall be
19 collected by the commissioner and shall be deposited in the
20 pharmacy benefits manager fund created in section 155B.16.
21 Sec. 8. NEW SECTION. 155B.8 ASSESSMENT.
22 1. The expense of administering this chapter, including
23 the costs incurred by the commissioner and the board, shall be
24 assessed annually by the board against all pharmacy benefits
25 managers operating in this state. Before determining the
26 assessment, the board shall request from the commissioner an
27 estimate of all expenses for the regulation, supervision, and
28 examination of all companies subject to regulation under this
29 chapter. The assessment shall be in proportion to the
30 business done in this state.
31 2. Assessments shall be collected by the commissioner and
32 shall be deposited in the pharmacy benefits manager fund
33 created in section 155B.16.
34 3. The board shall provide each pharmacy benefits manager
35 notice of the assessment, which shall be paid to the board on

1 or before March 1 of each year. A pharmacy benefits manager
2 that fails to pay the assessment on or before the date
3 prescribed shall be subject to a penalty imposed by the board
4 which is ten percent of the assessment and interest for the
5 period between the due date and the date of full payment. If
6 a payment is made in an amount later found to be in error, the
7 following shall apply:
8 a. If the error found is an underpayment and an additional
9 amount is due, the commission shall notify the company of the
10 additional amount and the company shall pay the additional
11 amount within fourteen days of the date of the notice.
12 b. If the error found is an overpayment, a refund shall be
13 ordered.
14 4. If an assessment made under this chapter is not paid to
15 the board by the prescribed date, the amount of the
16 assessment, penalty, and interest may be recovered from the
17 defaulting company on motion of the board made in the name and
18 for the use of the state in the appropriate court after ten
19 days' notice to the company. The certificate of authority of
20 a defaulting company to transact business in this state may be
21 revoked or suspended by the board until the company has paid
22 the assessment.
23 Sec. 9. NEW SECTION. 155B.9 PHARMACY BENEFITS MANAGER
24 CONTRACTS.
25 1. A pharmacy benefits manager that contracts with a
26 pharmacy or pharmacist to provide pharmacists' services
27 through a pharmacy management plan for enrollees in this state
28 shall file the contract with the board thirty days before the
29 execution of the contract. The contract shall be deemed
30 approved unless the board disapproves the contract within
31 thirty days after the contract is filed with the board.
32 2. Disapproval of the contract shall be in writing,
33 stating the reasons for the disapproval, and a copy of the
34 written disapproval shall be delivered to the pharmacy
35 benefits manager.

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1 3. The board, consistent with the board's responsibility
2 for protecting the public interest, shall develop formal
3 criteria for the approval and disapproval of pharmacy benefits
4 manager contracts.
5 4. The pharmacy benefits manager shall provide a contract
6 to the pharmacy or pharmacist that is written in plain
7 language that is generally understood by pharmacists.
8 5. A pharmacy benefits manager that contracts with a
9 pharmacy or pharmacist to provide pharmacist services through
10 a pharmacy benefits management plan for enrollees in this
11 state on behalf of any health plan sponsors shall be
12 identified as the agent of the health plan sponsor. The
13 health plan fiduciary responsibilities shall transfer to the
14 contracting pharmacy benefits manager.
15 6. A contract shall apply the same coinsurance, copayment,
16 and deductible to covered drug prescriptions filled by any
17 pharmacy or pharmacist who participates in the network.
18 7. This section shall not be construed to prohibit a
19 contract from applying different coinsurance, copayment, and
20 deductible factors between generic and brand-name drugs that
21 an enrollee may obtain with a prescription if the limits are
22 applied uniformly to all pharmacies or pharmacists in the
23 health insurance plan or contract network.
24 8. A pharmacy benefits management plan shall not require a
25 pharmacy or pharmacist to change an enrollee's maintenance
26 drug unless the prescribing physician and the enrollee agree
27 to the change.
28 9. A pharmacy's or pharmacist's participation in any plan
29 or network offered by a pharmacy benefits manager is optional
30 and at the discretion of the pharmacy or pharmacist. The
31 pharmacy's or pharmacist's participation or lack of
32 participation in one plan shall not affect the pharmacy's or
33 pharmacist's participation in any other plan or network
34 ordered by the pharmacy benefits manager.
35 10. A pharmacy benefits manager that initiates an audit of

1 a pharmacy or pharmacist under the provisions of the contract
2 shall limit the methods and procedures that are recognized as
3 fair and equitable for both the pharmacy benefits manager and
4 the pharmacy or pharmacist. An audit shall not allow for
5 extrapolation calculations. A pharmacy benefits manager shall
6 not recoup any moneys due from an audit by setoff from future
7 remittances until the results of the audit are resolved and
8 finalized by both the pharmacy benefits manager and the
9 pharmacy or pharmacist. If the findings of an audit cannot be
10 finalized and agreed to by both parties, the commissioner
11 shall establish an independent review board to adjudicate
12 unresolved grievances.
13 11. a. Prior to terminating a pharmacy or pharmacist from
14 the network, a pharmacy benefits manager shall provide the
15 pharmacy or pharmacist with a written explanation of the
16 reason for the termination at least thirty days before the
17 actual termination unless the contract termination action is
18 taken as the result of any of the following:
19 (1) Loss of the pharmacy's or pharmacist's license to
20 practice pharmacy or loss of professional liability insurance.
21 (2) Conviction of fraud or misrepresentation in regard to
22 the contract.
23 b. A pharmacy or pharmacist may request and receive,
24 within thirty days, a review of the proposed termination by
25 the board prior to the termination.
26 12. The pharmacy or pharmacist shall not be held
27 responsible for actions of the pharmacy benefits manager or
28 plan sponsors and the pharmacy benefits manager or plan
29 sponsors shall not be held responsible for the actions of the
30 pharmacy or pharmacist.
31 Sec. 10. <u>NEW SECTION</u>. 155B.10 ENFORCEMENT.
32 1. The board shall develop formal investigation and
33 compliance procedures for responding to complaints by health
34 insurance plans or contract sponsors, pharmacists, or
35 enrollees concerning the failure of a pharmacy benefits

1 manager to comply with this chapter. If, based upon an
2 investigation or complaint, the board has reason to believe
3 that there is a violation of this chapter, the board shall
4 issue and serve upon the pharmacy benefits manager concerned a
5 statement of the charges and a notice of a hearing to be held
6 at a time and place fixed in the notice, which shall not be
7 less than thirty days after notice is served. The notice
8 shall require the pharmacy benefits manager to show cause why
9 an order should not be issued directing the company to cease
10 and desist from the violation. At the hearing, the pharmacy
11 benefits manager shall have an opportunity to be heard and to
12 show cause why an order should not be issued requiring the
13 pharmacy benefits manager to cease and desist from the
14 violation.
15 2. The board may perform an examination concerning the
16 quality of services of any pharmacy benefits manager and
17 providers with whom the pharmacy benefits manager has
18 contracts, agreements, or other arrangements pursuant to its
19 pharmacy benefits management plan as often as the board deems
20 necessary for the protection of the interests of the people of
21 this state. The pharmacy benefits manager being examined
22 shall pay the cost of the examination.
23 Sec. 11. NEW SECTION. 155B.11 PRESCRIPTION DRUG
24 REIMBURSEMENT COSTS.
25 Pharmacy benefits managers shall use a current and
26 nationally recognized benchmark on which to base
27 reimbursements for prescription drugs and products dispensed
28 by pharmacies and pharmacists as follows:
29 1. For brand-name, single-source products, the average
30 wholesale price as listed in first data bank or facts and
31 comparisons correct and current on the date the service was
32 provided shall be used as the index.
33 2. For generic drug, multisource products, maximum
34 allowable cost shall be established by referencing first data
35 bank facts and comparisons baseline prices. Only products

1 that are compliant with pharmacy laws as equivalent and
2 generically interchangeable with a federal food and drug
3 administration orange book rating of "A-B" shall be reimbursed
4 from a maximum allowable cost price methodology. In the event
5 a multisource product has no baseline price, the product shall
6 be treated as a single-source branded drug for the purpose of
7 valuing reimbursement.
8 Sec. 12. NEW SECTION. 155B.12 PROHIBITED PRACTICES.
9 1. A pharmacy benefits manager or its representative shall
10 not cause or knowingly permit any of the following:
11 a. The use of advertising that is untrue or misleading.
12 b. Solicitation that is untrue or misleading.
13 c. Any form of evidence of coverage that is deceptive.
14 2. A pharmacy benefits manager, unless licensed as an
15 insurer, shall not use in its name, contracts, or literature
16 any of the following:
17 a. Any form of the word "insurance", "casualty", "surety",
18 or "mutual".
19 b. Any other words descriptive of the insurance, casualty,
20 or surety business, or deceptively similar to the name or
21 description of any insurer or fidelity and surety insurer,
22 doing business in this state.
23 3. A pharmacy benefits manager shall not discriminate on
24 the basis of race, creed, color, sex, or religion in the
25 selection of pharmacies or pharmacists with whom the company
26 does business.
27 4. A pharmacy benefits manager shall not unfairly
28 discriminate against pharmacists when contracting for
29 pharmacists' services.
30 5. A pharmacy benefits manager shall be entitled access to
31 usual and customary pricing only for comparison to the
32 reimbursement of a specific claims payment made by the
33 pharmacy benefits manager. Usual and customary pricing is
34 confidential and a pharmacy benefits manager is prohibited
35 from any other use or disclosure of usual and customary

1 pricing.
2 6. A pharmacy benefits manager shall not move a plan to
3 another payment network unless the pharmacy benefits manager
4 receives written consent from the plan sponsor.
5 7. A pharmacy benefits manager shall not receive or accept
6 any rebate, kickback, or any special payment or favor or
7 advantage of any valuable consideration or inducement for
8 changing a patient's drug product unless the change is
9 specified in a written contract that has been filed with the
10 commissioner at least thirty days prior to the execution of
11 the contract.
12 8. A claim paid by a pharmacy benefits manager shall not
13 be retroactively denied or adjusted after seven days from
14 adjudication of the claim. Acknowledgement of eligibility
15 shall not be retroactively reversed. A pharmacy benefits
16 manager may retroactively deny or adjust a claim only if the
17 original claim was submitted fraudulently, the original claim
18 payment was incorrect because the provider was previously paid
19 for services rendered, or the services were not rendered by
20 the pharmacist.
21 9. A pharmacy benefits manager shall not terminate a
22 pharmacy from a network based on any of the following:
23 a. The pharmacy expresses disagreement with the pharmacy
24 benefits manager's decision to deny or limit benefits to an
25 enrollee.
26 b. A pharmacist employed by the pharmacy discusses with a
27 current, former, or prospective enrollee any aspect of the
28 person's medical condition or treatment alternatives whether
29 or not the service is a covered service.
30 c. A pharmacist employed by the pharmacy makes a personal
31 recommendation regarding selecting a pharmacy benefits manager
32 based on the pharmacist's personal knowledge of the health
33 needs of the individual.
34 d. The pharmacy protests or expresses disagreement with a
35 medical decision, medical policy, or medical practice of a

1 pharmacy benefits manager.
2 e. The pharmacy has in good faith communicated with or
3 advocated on behalf of one or more of the pharmacy's current,
4 former, or prospective enrollees regarding the provisions,
5 terms, or requirements of the pharmacy benefits manager's
6 health benefit plans as they relate to the needs of the
7 individual regarding the method by which the pharmacy is
8 compensated for services provided under the agreement with the
9 pharmacy benefits manager.
10 10. A pharmacy benefits manager shall not terminate a
11 pharmacy from a network or otherwise penalize a pharmacy
12 solely because of the pharmacy's invoking of the pharmacy's
13 right under the contract or applicable law or regulation.
14 11. A pharmacy benefits manager's termination due to
15 incompetence or unprofessional behavior shall not release the
16 pharmacy benefits manager from the obligation to make any
17 payment due to the pharmacy for services provided in special
18 circumstances post-termination to the enrollees at less than
19 agreed-upon rates.
20 12. Participation or lack of participation by a pharmacy
21 in a plan or network shall not affect participation in any
22 other plan or network offered by a pharmacy benefits manager.
23 Sec. 13. NEW SECTION. 155B.13 DISCLOSURES.
24 1. The following shall be provided to the pharmacy
25 benefits manager enrollees at the time of enrollment or at the
26 time the contract is issued and shall be made available upon
27 request or at least annually:
28 a. A list of the names and locations of all affiliated
29 pharmacists' services providers.
30 b. A description of the service area or areas within which
31 the pharmacy benefits manager provides prescription services.
32 c. A description of the method of resolving complaints of
33 enrollees, including a description of any arbitration
34 procedure if complaints may be resolved through a specified
35 arbitration agreement.

1 d. Notice that the pharmacy benefits manager is subject to
2 regulation in this state by both the board of pharmacy
3 examiners and the commissioner of insurance.
4 e. A prominent notice included within the evidence of
5 coverage, providing substantially the following: "If you have
6 any questions regarding an appeal or grievance concerning the
7 pharmacists' services that you have been provided, which have
8 not been satisfactorily addressed by your plan, you may
9 contact the board of pharmacy examiners." The notice shall
10 also provide the toll-free telephone number, mailing address,
11 and electronic mail address of the board of pharmacy
12 examiners.
13 2. Any disclosure from a pharmacy benefits manager to
14 enrollees shall be written plainly, using terms generally
15 understood by the general public and a copy of the disclosure
16 shall be provided to all pharmacies that are members of the
17 network.
18 Sec. 14. <u>NEW SECTION</u>. 155B.14 PRIVACY.
19 An enrollee has the right to privacy and confidentiality in
20 the provision of pharmacists' services. This right may be
21 expressly waived in writing by the enrollee or the enrollee's
22 guardian.
23 Sec. 15. <u>NEW SECTION</u>. 155B.15 INSOLVENCY.
24 1. If a pharmacy benefits manager becomes insolvent or
25 ceases to be a company in this state in any assessable or
26 license year, the company shall remain liable for the payment
27 of the assessment for the period in which the company operated
28 as a pharmacy benefits manager in this state.
29 2. If a pharmacy benefits manager becomes insolvent, the
30 commissioner may, after notice and hearing, levy an
31 assessment, in addition to an assessment pursuant to section
32 155B.8, on pharmacy benefits managers licensed to do business
33 in this state. The assessments shall be paid quarterly to the
34 commissioner, and upon receipt by the commissioner shall be
35 paid over into an escrow account in the pharmacy benefits

1 manager fund. The escrow account shall be used solely for the
2 benefit of enrollees of the insolvent pharmacy benefits
3 manager.
4 Sec. 16. NEW SECTION. 155B.16 PHARMACY BENEFITS MANAGER
5 FUND -- USES -- ESCROW ACCOUNT.
6 1. A pharmacy benefits manager fund is created in the
7 state treasury under the authority of the commissioner of
8 insurance. Moneys received from licensure of pharmacy
9 benefits managers pursuant to section 155B.5, from
10 examinations collected pursuant to section 155B.7, and from
11 assessments collected pursuant to section 155B.8 shall be
12 deposited in the fund. Moneys in the fund shall be used and
13 an amount necessary is appropriated, annually, to the division
14 of insurance of the department of commerce for the purposes of
15 enforcing this chapter.
16 2. An escrow account is created in the pharmacy benefits
17 manager fund. Assessments collected pursuant to section
18 155B.15 shall be deposited in the account and are appropriated
19 to the division of insurance of the department of commerce to
20 be used solely for the benefit of the enrollees of an
21 insolvent pharmacy benefits manager.
22 EXPLANATION
23 This bill establishes regulation of pharmacy benefits
24 managers. The bill defines terms used in the bill, including
25 "pharmacy benefits manager" (PBM), which is an entity that
26 administers the prescription drug or device portion of a
27 health insurance plan or contract on behalf of the sponsors of
28 the health insurance plan or contract. The bill requires a
29 PBM to obtain a certificate of authority from the board of
30 pharmacy examiners every four years. A prerequisite for
31 obtaining a certificate of authority is the obtaining of a
32 license to do business in the state from the commissioner of
33 insurance. The bill provides criteria that the board may use
34 to suspend or revoke a PBM's certificate of authority.
35 The bill requires a PBM to obtain a license to do business

1 from the commissioner of insurance. Issuance of the license
2 is based on a determination by the commissioner that the PBM
3 is financially sound. A PBM is required to pay a license
4 application fee of $500. The license expires every June 30
5 following the date of issuance.
6 The bill requires a PBM to file an annual statement with
7 the commissioner of insurance by March 1, and also provide a
8 copy of the statement to the board of pharmacy examiners. The
9 annual statement is to be verified by at least two principal
10 officers of the PBM, cover the preceding calendar year, and
11 include: a financial statement of the company, including its
12 balance sheet and income statement for the preceding year; the
13 number of persons enrolled during the year, the number of
14 enrollees as of the end of the year, and the number of
15 enrollments terminated during the year; and any other
16 information relating to the operations of the PBM required by
17 the commissioner pursuant to the bill. If the PBM is audited
18 annually by an independent certified public accountant, a copy
19 of the certified audit report is to be filed annually with the
20 commissioner by June 30. The bill provides for an extension
21 in the time prescribed for submission of the annual statement
22 or other reports by the insurance commissioner for good cause
23 shown. If a PBM fails to file the annual statement in the
24 prescribed time, the commissioner may revoke its license and
25 the board may suspend or revoke the certificate of authority.
26 The bill provides for waiver of the required filing of a
27 financial statement if an affiliate of the PBM is also
28 required to file the same information.
29 The bill provides for the coordination of financial
30 examinations of PBMs, provides that the PBM is to pay the cost
31 of the examination, and provides that the payments collected
32 are to be deposited in the pharmacy benefits manager fund
33 created in the bill.
34 The bill provides that the expenses of administering the
35 regulation of PBMs, including the costs incurred by the

1 commissioner and the board, shall be assessed annually by the
2 board against all pharmacy benefits managers operating in the
3 state. The assessment is to be based upon the commissioner's
4 estimate, provided to the board, of all expenses for the
5 regulation, supervision, and examination of all entities
6 subject to regulation. Assessments are to be collected by the
7 commissioner by March 1, annually, and are to be deposited in
8 the pharmacy benefits manager fund created in the bill. The
9 bill directs the board to provide each pharmacy benefits
10 manager notice of the assessment. A pharmacy benefits manager
11 that fails to pay the assessment on or before the date
12 prescribed is subject to a penalty imposed by the board which
13 is 10 percent of the assessment and interest for the period
14 between the due date and the date of full payment. The bill
15 provides for payment of additional amounts or refunds if a
16 payment is made in an amount later found to be in error. If
17 an assessment is not paid to the board by the prescribed date,
18 the amount of the assessment, penalty, and interest may be
19 recovered and the certificate of authority of any defaulting
20 company to transact business in this state may be revoked or
21 suspended by the board until the company has paid the
22 assessment.
23 The bill requires a PBM that contracts with a pharmacy or
24 pharmacist to provide pharmacists' services to file the
25 contract with the board 30 days before the execution of the
26 contract. The contract is deemed approved unless the board
27 disapproves the contract within 30 days after the contract is
28 filed with the board. Disapproval of the contract is to be in
29 writing and a copy is to be delivered to the PBM. The bill
30 directs the board to develop formal criteria for the approval
31 and disapproval of PBM contracts.
32 The bill also requires the PBM to provide a contract to the
33 pharmacy or pharmacist that is written in plain language that
34 is generally understood by pharmacists; requires that the PBM
35 is to be identified as the agent of the health plan sponsor

1 under the contract thereby transferring the health plan's
2 fiduciary responsibilities to the PBM; requires that the
3 contract applies the same coinsurance, copayment, and
4 deductible to covered drug prescriptions filled by any
5 pharmacy or pharmacist who participates in the network;
6 provides that the provisions relating to the PBM contract are
7 not to be construed to prohibit a contract from applying
8 different coinsurance, copayment, and deductible factors
9 between generic and brand-name drugs that an enrollee may
10 obtain with a prescription if the limits are applied uniformly
11 to all pharmacies or pharmacists in the health insurance plan
12 or contract network; prohibits a pharmacy benefits management
13 plan from requiring a pharmacy or pharmacist to change an
14 enrollee's maintenance drug unless the prescribing physician
15 and the enrollee agree to the change; provides that a
16 pharmacy's or pharmacist's participation in any plan or
17 network offered by a PBM is optional and at the discretion of
18 the pharmacy or pharmacist and is not to affect the pharmacy's
19 or pharmacist's participation in any other plan or network
20 ordered by the pharmacy benefits manager; requires a PBM that
21 initiates an audit of a pharmacy or pharmacist to limit the
22 methods and procedures that are recognized as fair and
23 equitable for both the PBM and the pharmacy or pharmacist;
24 specifies measures to be taken by a PBM for terminating a
25 pharmacy or pharmacist from the network; and provides that the
26 pharmacy or pharmacist is not to be held responsible for
27 actions of the PBM or plan sponsors and the PBM or plan
28 sponsors are not to be held responsible for the actions of the
29 pharmacy or pharmacist.
30 The bill provides for enforcement of the new Code chapter,
31 specifies medication reimbursement costs, specifies prohibited
32 practices by PBMs, requires PBMs to make certain disclosures
33 to enrollees, and provides that enrollees have the right to
34 privacy and confidentiality in the provision of pharmacists'
35 services which right may be expressly waived in writing by the

1 enrollee or the enrollee's guardian. The bill provides that
2 if a PBM becomes insolvent or ceases to be a company in this
3 state in any assessable or license year, the company remains
4 liable for the payment of the assessment for the period in
5 which the company operated as a PBM in the state. The bill
6 also provides that if a PBM becomes insolvent, the
7 commissioner may, after notice and hearing, levy an additional
8 assessment on PBMs licensed to do business in the state. The
9 assessments are to be paid quarterly to the commissioner,
10 deposited in an escrow account in the pharmacy benefits
11 manager fund, and are to be used solely for the benefit of
12 enrollees of the insolvent PBM.
13 The bill creates the pharmacy benefits manager fund in the
14 state treasury under the authority of the commissioner of
15 insurance. Moneys received from licensure of PBMs from
16 examination fees collected and from assessments collected are
17 deposited in the fund. Moneys in the fund are to be used and
18 an amount necessary is appropriated, annually, to the division
19 of insurance of the department of commerce for the purposes of
20 enforcing the provisions of the bill. The bill also creates
21 an escrow account within the fund. Assessments collected
22 relative to an insolvent PBM are to be deposited in the
23 account and are to be used solely for the benefit of the
24 enrollees of the insolvent PBM.
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