Senate Study Bill 3039

SENATE FILE _____
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

An Act relating to the regulation of pharmacy benefit managers and making appropriations.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
TLSB 6169SC 80
pf/cf/24

PAG LIN

Section 1. NEW SECTION. 155B.1 SHORT TITLE.
This chapter shall be known and may be cited as the "Pharmacy Benefits Manager Regulation Act".
Sec. 2. NEW SECTION. 155B.2 PURPOSE AND INTENT.
The purposes of this chapter are:
1. To establish standards and criteria for the regulation and licensing of pharmacy benefits managers.
2. To promote, preserve, and protect the public health, safety, and welfare by and through effective regulation and licensing of pharmacy benefits managers.
Sec. 3. NEW SECTION. 155B.3 DEFINITIONS.
For purposes of this chapter, unless the context otherwise requires:
1. "Board of pharmacy" or "board" means the board of pharmacy examiners.
2. "Cease and desist order" means an order of the board prohibiting a pharmacy benefits manager or other person from continuing a particular course of conduct which violates this chapter or the rules adopted under this chapter.
3. "Commissioner" means the commissioner of insurance.
4. "Enrollee" means an individual who is enrolled in a pharmacy benefits management plan.
5. "Health insurance plan or contract" means a third=party payment provider contract or policy that is an individual or group policy of accident or health insurance or individual or group hospital or health care services contract issued pursuant to chapter 509, 509A, 514, or 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B.
6. "Insolvent" or "insolvency" means a financial situation in which, based upon the financial information required by this chapter for the preparation of a pharmacy benefits manager's annual statement, the assets of the pharmacy benefits manager are less than the sum of all the company's liabilities and required reserves.
7. "Maintenance drug" means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period of more than thirty days.
8. "Multisource drug" means a drug that is stocked and is available from three or more suppliers.
9. "Pharmacist" means pharmacist as defined in section 155A.3.
10. "Pharmacists' services" include drug therapy and other patient care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined by rule of the board.
11. "Pharmacy" means pharmacy as defined in section 155A.3.
12. "Pharmacy benefits management plan" means an arrangement for the delivery of prescription services in which a pharmacy benefits manager provides, arranges for, pays for, or reimburses any of the costs of prescription services for an enrollee on a prepaid or insured basis which provides all of the following:

a. Contains one or more incentive arrangements intended to influence the cost or level of prescription services between the plan sponsor and one or more pharmacies with respect to the delivery of prescription services.

b. Requires or creates benefit payment differential incentives for enrollees to use under contract with the pharmacy benefits manager.

"Pharmacy benefits management plan" does not mean an employee welfare benefit plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. } 1002(1), which is self=insured or self=funded.

13. "Pharmacy benefits manager" or "company" means an entity that administers the prescription drug or device portion of a health insurance plan or contract on behalf of the sponsors of the health insurance plan or contract.

14. "Plan sponsor" means an employer, insurance company, union, or health maintenance organization that contracts with a pharmacy benefits manager for delivery of prescription services.

15. "Usual and customary price" means the price the pharmacist would have charged a cash=paying patient for the same services on the same date inclusive of any discounts applicable.

Sec. 4. NEW SECTION. 155B.4 CERTIFICATE OF AUTHORITY.

1. A person shall not establish or operate as a pharmacy benefits manager in this state to provide pharmacy benefits management plans without first obtaining a certificate of authority from the board of pharmacy examiners. A pharmacy benefits manager providing pharmacy benefits management plans in this state shall obtain a certificate of authority from the board every four years.

2. A person may apply to the board to obtain a certificate of authority to establish and operate as a pharmacy benefits manager in compliance with this chapter if the person obtains an annual license to do business in this state from the commissioner under section 155B.5.

3. The board may suspend or revoke a certificate of authority issued to a pharmacy benefits manager under this chapter or may deny an application for a certificate of authority if the board finds any of the following:

a. The pharmacy benefits manager is operating significantly in contravention of its basic organizational document.

b. The pharmacy benefits manager does not arrange for pharmacists' services.

c. The pharmacy benefits manager has failed to meet the requirements for issuance of a certificate of authority established in this chapter.

d. The pharmacy benefits manager is unable to fulfill its obligation to furnish pharmacists' services as required under its pharmacy benefits management plan.

e. The pharmacy benefits manager is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

f. The pharmacy benefits manager, or any person on the company's behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

g. The continued operation of the pharmacy benefits manager would be hazardous to its enrollees.

h. The pharmacy benefits manager has failed to file an annual statement with the commissioner in a timely manner.

i. The pharmacy benefits manager has otherwise failed to substantially comply with this chapter.

4. When the certificate of authority of a pharmacy benefits manager is revoked, the company shall proceed, immediately following the effective date of the order of revocation, to conclude the company's affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the company. The board may permit further operation of the company as the board may find to be in the best interest of enrollees so that the enrollees will be afforded the greatest practical opportunity to obtain pharmacists' services.

Sec. 5. NEW SECTION. 155B.5 LICENSE TO DO BUSINESS.

1. The commissioner shall not issue an annual license to do business in this state to any pharmacy benefits manager providing pharmacy benefits management plans until the commissioner is satisfied that the pharmacy benefits manager has complied with all of the following:

a. Paid all fees, taxes, and charges required by law.

b. Has made any deposit required by this chapter.

c. Has met the minimum capital and surplus requirements specified by the commissioner.

d. Has filed any necessary financial statement and any reports, certificates, or other documents the commissioner considers necessary to secure a full and accurate knowledge of the company's affairs and financial condition.

e. Is solvent, and the company's financial condition, method of operation, and manner of doing business satisfy the commissioner that the company can meet the company's obligations to all enrollees.

f. Has otherwise complied with all the requirements of law.

2. The license shall be in addition to the certificate of authority required by the board. A nonrefundable license application fee of five hundred dollars shall accompany each application for a license to transact business in this state. The fee shall be collected by the commissioner and shall be deposited in the pharmacy benefits manager fund created in section 155B.16.

3. The license shall be signed by the commissioner or the commissioner's agent and shall expire on the next June 30 after the date on which the license becomes effective.

4. A pharmacy benefits manager providing pharmacy benefits management plans shall obtain an annual renewal of the company's license from the commissioner. The commissioner may refuse to renew the license of any pharmacy benefits manager or may renew the license, subject to any restrictions considered appropriate by the commissioner, if the commissioner finds an impairment of required capital and surplus, or if the commissioner finds that the pharmacy benefits manager has not satisfied all the conditions specified in this chapter. The commissioner shall not fail to renew the license of any pharmacy benefits manager to transact business in this state without providing the pharmacy benefits manager ten days' notice and providing the company an opportunity to be heard. The hearing may be informal, and the commissioner and the pharmacy benefits manager may waive the required notice.

Sec. 6. NEW SECTION. 155B.6 ANNUAL STATEMENT.

1. A pharmacy benefits manager providing pharmacy management benefits plans in this state shall file a statement with the commissioner annually by March 1. The statement shall be verified by at least two principal officers of the pharmacy benefits manager and shall cover the preceding calendar year. The pharmacy benefits manager shall also submit a copy of the statement to the board.

2. The statement shall be on forms prescribed by the commissioner and shall include all of the following:

a. A financial statement of the company, including its balance sheet and income statement for the preceding year.

b. The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year.

c. Any other information relating to the operations of the pharmacy benefits manager required by the commissioner pursuant to this chapter.

3. If the pharmacy benefits manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the commissioner by June 30.

4. The commissioner may extend the time prescribed for any pharmacy benefits manager for filing an annual statement or other reports, or exhibits of the statement or report for good cause shown. However, the commissioner shall not extend the time for filing annual statements beyond sixty days after the time prescribed by subsection 1. A pharmacy benefits manager which fails to file its annual statement within the time prescribed by this section may have its licensed revoked by the commissioner or its certificate of authority revoked or suspended by the board until the annual statement is filed. The commission may waive the requirements for a pharmacy benefits manager to file financial information if an affiliate of the pharmacy benefits manager is also required to file the same information.

Sec. 7. NEW SECTION. 155B.7 FINANCIAL EXAMINATION.

1. In lieu of or in addition to performing a financial examination of a pharmacy benefits manager, the commissioner may accept the report of a financial examination by another person responsible for pharmacy benefits managers under the laws of another state who is certified by the insurance

supervisory official, similar regulatory agency, or the state health commissioner of the other state.

2. The commissioner shall coordinate financial examinations of pharmacy benefits managers that provide pharmacy management benefits plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation. The pharmacy benefits manager being examined shall pay the cost of the examination. Payments of the cost of the examination shall be collected by the commissioner and shall be deposited in the pharmacy benefits manager fund created in section 155B.16.

Sec. 8. NEW SECTION. 155B.8 ASSESSMENT.

1. The expense of administering this chapter, including the costs incurred by the commissioner and the board, shall be assessed annually by the board against all pharmacy benefits managers operating in this state. Before determining the assessment, the board shall request from the commissioner an estimate of all expenses for the regulation, supervision, and examination of all companies subject to regulation under this chapter. The assessment shall be in proportion to the business done in this state.

2. Assessments shall be collected by the commissioner and shall be deposited in the pharmacy benefits manager fund created in section 155B.16.

3. The board shall provide each pharmacy benefits manager notice of the assessment, which shall be paid to the board on or before March 1 of each year. A pharmacy benefits manager that fails to pay the assessment on or before the date prescribed shall be subject to a penalty imposed by the board which is ten percent of the assessment and interest for the period between the due date and the date of full payment. If a payment is made in an amount later found to be in error, the following shall apply:

a. If the error found is an underpayment and an additional amount is due, the commission shall notify the company of the additional amount and the company shall pay the additional amount within fourteen days of the date of the notice.

b. If the error found is an overpayment, a refund shall be ordered.

4. If an assessment made under this chapter is not paid to the board by the prescribed date, the amount of the assessment, penalty, and interest may be recovered from the defaulting company on motion of the board made in the name and for the use of the state in the appropriate court after ten days' notice to the company. The certificate of authority of a defaulting company to transact business in this state may be revoked or suspended by the board until the company has paid the assessment.

Sec. 9. NEW SECTION. 155B.9 PHARMACY BENEFITS MANAGER CONTRACTS.

1. A pharmacy benefits manager that contracts with a pharmacy or pharmacist to provide pharmacists' services through a pharmacy management plan for enrollees in this state shall file the contract with the board thirty days before the execution of the contract. The contract shall be deemed approved unless the board disapproves the contract within thirty days after the contract is filed with the board.

2. Disapproval of the contract shall be in writing, stating the reasons for the disapproval, and a copy of the written disapproval shall be delivered to the pharmacy benefits manager.

3. The board, consistent with the board's responsibility for protecting the public interest, shall develop formal criteria for the approval and disapproval of pharmacy benefits manager contracts.

4. The pharmacy benefits manager shall provide a contract to the pharmacy or pharmacist that is written in plain language that is generally understood by pharmacists.

5. A pharmacy benefits manager that contracts with a pharmacy or pharmacist to provide pharmacist services through a pharmacy benefits management plan for enrollees in this state on behalf of any health plan sponsors shall be identified as the agent of the health plan sponsor. The health plan fiduciary responsibilities shall transfer to the contracting pharmacy benefits manager.

6. A contract shall apply the same coinsurance, copayment, and deductible to covered drug prescriptions filled by any pharmacy or pharmacist who participates in the network.

7. This section shall not be construed to prohibit a contract from applying different coinsurance, copayment, and deductible factors between generic and brand=name drugs that

an enrollee may obtain with a prescription if the limits are applied uniformly to all pharmacies or pharmacists in the health insurance plan or contract network.

8. A pharmacy benefits management plan shall not require a pharmacy or pharmacist to change an enrollee's maintenance drug unless the prescribing physician and the enrollee agree to the change.

9. A pharmacy's or pharmacist's participation in any plan or network offered by a pharmacy benefits manager is optional and at the discretion of the pharmacy or pharmacist. The pharmacy's or pharmacist's participation or lack of participation in one plan shall not affect the pharmacy's or pharmacist's participation in any other plan or network ordered by the pharmacy benefits manager.

10. A pharmacy benefits manager that initiates an audit of a pharmacy or pharmacist under the provisions of the contract shall limit the methods and procedures that are recognized as fair and equitable for both the pharmacy benefits manager and the pharmacy or pharmacist. An audit shall not allow for extrapolation calculations. A pharmacy benefits manager shall not recoup any moneys due from an audit by setoff from future remittances until the results of the audit are resolved and finalized by both the pharmacy benefits manager and the pharmacy or pharmacist. If the findings of an audit cannot be finalized and agreed to by both parties, the commissioner shall establish an independent review board to adjudicate unresolved grievances.

11. a. Prior to terminating a pharmacy or pharmacist from the network, a pharmacy benefits manager shall provide the pharmacy or pharmacist with a written explanation of the reason for the termination at least thirty days before the actual termination unless the contract termination action is taken as the result of any of the following:

(1) Loss of the pharmacy's or pharmacist's license to practice pharmacy or loss of professional liability insurance.

(2) Conviction of fraud or misrepresentation in regard to the contract.

b. A pharmacy or pharmacist may request and receive, within thirty days, a review of the proposed termination by the board prior to the termination.

12. The pharmacy or pharmacist shall not be held responsible for actions of the pharmacy benefits manager or plan sponsors and the pharmacy benefits manager or plan sponsors shall not be held responsible for the actions of the pharmacy or pharmacist.

Sec. 10. NEW SECTION. 155B.10 ENFORCEMENT.

1. The board shall develop formal investigation and compliance procedures for responding to complaints by health insurance plans or contract sponsors, pharmacists, or enrollees concerning the failure of a pharmacy benefits manager to comply with this chapter. If, based upon an investigation or complaint, the board has reason to believe that there is a violation of this chapter, the board shall issue and serve upon the pharmacy benefits manager concerned a statement of the charges and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty days after notice is served. The notice shall require the pharmacy benefits manager to show cause why an order should not be issued directing the company to cease and desist from the violation. At the hearing, the pharmacy benefits manager shall have an opportunity to be heard and to show cause why an order should not be issued requiring the pharmacy benefits manager to cease and desist from the violation.

2. The board may perform an examination concerning the quality of services of any pharmacy benefits manager and providers with whom the pharmacy benefits manager has contracts, agreements, or other arrangements pursuant to its pharmacy benefits management plan as often as the board deems necessary for the protection of the interests of the people of this state. The pharmacy benefits manager being examined shall pay the cost of the examination.

Sec. 11. NEW SECTION. 155B.11 PRESCRIPTION DRUG REIMBURSEMENT COSTS.

Pharmacy benefits managers shall use a current and nationally recognized benchmark on which to base reimbursements for prescription drugs and products dispensed by pharmacies and pharmacists as follows:

1. For brand=name, single=source products, the average wholesale price as listed in first data bank or facts and comparisons correct and current on the date the service was

provided shall be used as the index.

2. For generic drug, multisource products, maximum allowable cost shall be established by referencing first data bank facts and comparisons baseline prices. Only products that are compliant with pharmacy laws as equivalent and generically interchangeable with a federal food and drug administration orange book rating of "A=B" shall be reimbursed from a maximum allowable cost price methodology. In the event a multisource product has no baseline price, the product shall be treated as a single=source branded drug for the purpose of valuing reimbursement.

Sec. 12. NEW SECTION. 155B.12 PROHIBITED PRACTICES.

1. A pharmacy benefits manager or its representative shall not cause or knowingly permit any of the following:

a. The use of advertising that is untrue or misleading.

b. Solicitation that is untrue or misleading.

c. Any form of evidence of coverage that is deceptive.

2. A pharmacy benefits manager, unless licensed as an insurer, shall not use in its name, contracts, or literature any of the following:

a. Any form of the word "insurance", "casualty", "surety", or "mutual".

b. Any other words descriptive of the insurance, casualty, or surety business, or deceptively similar to the name or description of any insurer or fidelity and surety insurer, doing business in this state.

3. A pharmacy benefits manager shall not discriminate on the basis of race, creed, color, sex, or religion in the selection of pharmacies or pharmacists with whom the company does business.

4. A pharmacy benefits manager shall not unfairly discriminate against pharmacists when contracting for pharmacists' services.

5. A pharmacy benefits manager shall be entitled access to usual and customary pricing only for comparison to the reimbursement of a specific claims payment made by the pharmacy benefits manager. Usual and customary pricing is confidential and a pharmacy benefits manager is prohibited from any other use or disclosure of usual and customary pricing.

6. A pharmacy benefits manager shall not move a plan to another payment network unless the pharmacy benefits manager receives written consent from the plan sponsor.

7. A pharmacy benefits manager shall not receive or accept any rebate, kickback, or any special payment or favor or advantage of any valuable consideration or inducement for changing a patient's drug product unless the change is specified in a written contract that has been filed with the commissioner at least thirty days prior to the execution of the contract.

8. A claim paid by a pharmacy benefits manager shall not be retroactively denied or adjusted after seven days from adjudication of the claim. Acknowledgement of eligibility shall not be retroactively reversed. A pharmacy benefits manager may retroactively deny or adjust a claim only if the original claim was submitted fraudulently, the original claim payment was incorrect because the provider was previously paid for services rendered, or the services were not rendered by the pharmacist.

9. A pharmacy benefits manager shall not terminate a pharmacy from a network based on any of the following:

a. The pharmacy expresses disagreement with the pharmacy benefits manager's decision to deny or limit benefits to an enrollee.

b. A pharmacist employed by the pharmacy discusses with a current, former, or prospective enrollee any aspect of the person's medical condition or treatment alternatives whether or not the service is a covered service.

c. A pharmacist employed by the pharmacy makes a personal recommendation regarding selecting a pharmacy benefits manager based on the pharmacist's personal knowledge of the health needs of the individual.

d. The pharmacy protests or expresses disagreement with a medical decision, medical policy, or medical practice of a pharmacy benefits manager.

e. The pharmacy has in good faith communicated with or advocated on behalf of one or more of the pharmacy's current, former, or prospective enrollees regarding the provisions, terms, or requirements of the pharmacy benefits manager's health benefit plans as they relate to the needs of the individual regarding the method by which the pharmacy is

compensated for services provided under the agreement with the pharmacy benefits manager.

10. A pharmacy benefits manager shall not terminate a pharmacy from a network or otherwise penalize a pharmacy solely because of the pharmacy's invoking of the pharmacy's right under the contract or applicable law or regulation.

11. A pharmacy benefits manager's termination due to incompetence or unprofessional behavior shall not release the pharmacy benefits manager from the obligation to make any payment due to the pharmacy for services provided in special circumstances post=termination to the enrollees at less than agreed=upon rates.

12. Participation or lack of participation by a pharmacy in a plan or network shall not affect participation in any other plan or network offered by a pharmacy benefits manager.

Sec. 13. NEW SECTION. 155B.13 DISCLOSURES.

1. The following shall be provided to the pharmacy benefits manager enrollees at the time of enrollment or at the time the contract is issued and shall be made available upon request or at least annually:

a. A list of the names and locations of all affiliated pharmacists' services providers.

b. A description of the service area or areas within which the pharmacy benefits manager provides prescription services.

c. A description of the method of resolving complaints of enrollees, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

d. Notice that the pharmacy benefits manager is subject to regulation in this state by both the board of pharmacy examiners and the commissioner of insurance.

e. A prominent notice included within the evidence of coverage, providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the pharmacists' services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the board of pharmacy examiners." The notice shall also provide the toll=free telephone number, mailing address, and electronic mail address of the board of pharmacy examiners.

2. Any disclosure from a pharmacy benefits manager to enrollees shall be written plainly, using terms generally understood by the general public and a copy of the disclosure shall be provided to all pharmacies that are members of the network.

Sec. 14. NEW SECTION. 155B.14 PRIVACY.

An enrollee has the right to privacy and confidentiality in the provision of pharmacists' services. This right may be expressly waived in writing by the enrollee or the enrollee's guardian.

Sec. 15. NEW SECTION. 155B.15 INSOLVENCY.

1. If a pharmacy benefits manager becomes insolvent or ceases to be a company in this state in any assessable or license year, the company shall remain liable for the payment of the assessment for the period in which the company operated as a pharmacy benefits manager in this state.

2. If a pharmacy benefits manager becomes insolvent, the commissioner may, after notice and hearing, levy an assessment, in addition to an assessment pursuant to section 155B.8, on pharmacy benefits managers licensed to do business in this state. The assessments shall be paid quarterly to the commissioner, and upon receipt by the commissioner shall be paid over into an escrow account in the pharmacy benefits manager fund. The escrow account shall be used solely for the benefit of enrollees of the insolvent pharmacy benefits manager.

Sec. 16. NEW SECTION. 155B.16 PHARMACY BENEFITS MANAGER FUND == USES == ESCROW ACCOUNT.

1. A pharmacy benefits manager fund is created in the state treasury under the authority of the commissioner of insurance. Moneys received from licensure of pharmacy benefits managers pursuant to section 155B.5, from examinations collected pursuant to section 155B.7, and from assessments collected pursuant to section 155B.8 shall be deposited in the fund. Moneys in the fund shall be used and an amount necessary is appropriated, annually, to the division of insurance of the department of commerce for the purposes of enforcing this chapter.

2. An escrow account is created in the pharmacy benefits manager fund. Assessments collected pursuant to section 155B.15 shall be deposited in the account and are appropriated

to the division of insurance of the department of commerce to be used solely for the benefit of the enrollees of an insolvent pharmacy benefits manager.

EXPLANATION

This bill establishes regulation of pharmacy benefits managers. The bill defines terms used in the bill, including "pharmacy benefits manager" (PBM), which is an entity that administers the prescription drug or device portion of a health insurance plan or contract on behalf of the sponsors of the health insurance plan or contract. The bill requires a PBM to obtain a certificate of authority from the board of pharmacy examiners every four years. A prerequisite for obtaining a certificate of authority is the obtaining of a license to do business in the state from the commissioner of insurance. The bill provides criteria that the board may use to suspend or revoke a PBM's certificate of authority.

The bill requires a PBM to obtain a license to do business from the commissioner of insurance. Issuance of the license is based on a determination by the commissioner that the PBM is financially sound. A PBM is required to pay a license application fee of $500. The license expires every June 30 following the date of issuance.

The bill requires a PBM to file an annual statement with the commissioner of insurance by March 1, and also provide a copy of the statement to the board of pharmacy examiners. The annual statement is to be verified by at least two principal officers of the PBM, cover the preceding calendar year, and include: a financial statement of the company, including its balance sheet and income statement for the preceding year; the number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year; and any other information relating to the operations of the PBM required by the commissioner pursuant to the bill. If the PBM is audited annually by an independent certified public accountant, a copy of the certified audit report is to be filed annually with the commissioner by June 30. The bill provides for an extension in the time prescribed for submission of the annual statement or other reports by the insurance commissioner for good cause shown. If a PBM fails to file the annual statement in the prescribed time, the commissioner may revoke its license and the board may suspend or revoke the certificate of authority. The bill provides for waiver of the required filing of a financial statement if an affiliate of the PBM is also required to file the same information.

The bill provides for the coordination of financial examinations of PBMs, provides that the PBM is to pay the cost of the examination, and provides that the payments collected are to be deposited in the pharmacy benefits manager fund created in the bill.

The bill provides that the expenses of administering the regulation of PBMs, including the costs incurred by the commissioner and the board, shall be assessed annually by the board against all pharmacy benefits managers operating in the state. The assessment is to be based upon the commissioner's estimate, provided to the board, of all expenses for the regulation, supervision, and examination of all entities subject to regulation. Assessments are to be collected by the commissioner by March 1, annually, and are to be deposited in the pharmacy benefits manager fund created in the bill. The bill directs the board to provide each pharmacy benefits manager notice of the assessment. A pharmacy benefits manager that fails to pay the assessment on or before the date prescribed is subject to a penalty imposed by the board which is 10 percent of the assessment and interest for the period between the due date and the date of full payment. The bill provides for payment of additional amounts or refunds if a payment is made in an amount later found to be in error. If an assessment is not paid to the board by the prescribed date, the amount of the assessment, penalty, and interest may be recovered and the certificate of authority of any defaulting company to transact business in this state may be revoked or suspended by the board until the company has paid the assessment.

The bill requires a PBM that contracts with a pharmacy or pharmacist to provide pharmacists' services to file the contract with the board 30 days before the execution of the contract. The contract is deemed approved unless the board disapproves the contract within 30 days after the contract is filed with the board. Disapproval of the contract is to be in writing and a copy is to be delivered to the PBM. The bill

directs the board to develop formal criteria for the approval and disapproval of PBM contracts.

The bill also requires the PBM to provide a contract to the pharmacy or pharmacist that is written in plain language that is generally understood by pharmacists; requires that the PBM is to be identified as the agent of the health plan sponsor under the contract thereby transferring the health plan's fiduciary responsibilities to the PBM; requires that the contract applies the same coinsurance, copayment, and deductible to covered drug prescriptions filled by any pharmacy or pharmacist who participates in the network; provides that the provisions relating to the PBM contract are not to be construed to prohibit a contract from applying different coinsurance, copayment, and deductible factors between generic and brand=name drugs that an enrollee may obtain with a prescription if the limits are applied uniformly to all pharmacies or pharmacists in the health insurance plan or contract network; prohibits a pharmacy benefits management plan from requiring a pharmacy or pharmacist to change an enrollee's maintenance drug unless the prescribing physician and the enrollee agree to the change; provides that a pharmacy's or pharmacist's participation in any plan or network offered by a PBM is optional and at the discretion of the pharmacy or pharmacist and is not to affect the pharmacy's or pharmacist's participation in any other plan or network ordered by the pharmacy benefits manager; requires a PBM that initiates an audit of a pharmacy or pharmacist to limit the methods and procedures that are recognized as fair and equitable for both the PBM and the pharmacy or pharmacist; specifies measures to be taken by a PBM for terminating a pharmacy or pharmacist from the network; and provides that the pharmacy or pharmacist is not to be held responsible for actions of the PBM or plan sponsors and the PBM or plan sponsors are not to be held responsible for the actions of the pharmacy or pharmacist.

The bill provides for enforcement of the new Code chapter, specifies medication reimbursement costs, specifies prohibited practices by PBMs, requires PBMs to make certain disclosures to enrollees, and provides that enrollees have the right to privacy and confidentiality in the provision of pharmacists' services which right may be expressly waived in writing by the enrollee or the enrollee's guardian. The bill provides that if a PBM becomes insolvent or ceases to be a company in this state in any assessable or license year, the company remains liable for the payment of the assessment for the period in which the company operated as a PBM in the state. The bill also provides that if a PBM becomes insolvent, the commissioner may, after notice and hearing, levy an additional assessment on PBMs licensed to do business in the state. The assessments are to be paid quarterly to the commissioner, deposited in an escrow account in the pharmacy benefits manager fund, and are to be used solely for the benefit of enrollees of the insolvent PBM.

The bill creates the pharmacy benefits manager fund in the state treasury under the authority of the commissioner of insurance. Moneys received from licensure of PBMs from examination fees collected and from assessments collected are deposited in the fund. Moneys in the fund are to be used and an amount necessary is appropriated, annually, to the division of insurance of the department of commerce for the purposes of enforcing the provisions of the bill. The bill also creates an escrow account within the fund. Assessments collected relative to an insolvent PBM are to be deposited in the account and are to be used solely for the benefit of the enrollees of the insolvent PBM.

LSB 6169SC 80
pf/cf/24