***COMPILATION OF***

***STATE PHARMACY BENEFIT MANAGER***

***BUSINESS PRACTICE LAWS***

**February 2023**

**TABLE OF CONTENTS**

1. Advance Written Notice of Formulary Changes and Substitutions 3

2. Affiliate Compensation 5

3. Compensation 8

4. Fiduciary Duty 9

5. Pharmacy Accreditation Requirements 10

6. PBM Compensation 11

7. PBM Complaint Process 14

8. PBM Examination Authority 17

9. PBM Network Adequacy Requirements 22

10. PBM Prohibited Market Conduct Practices 27

11. PBM Reimbursement Lists or Payment Methodology 37

12. Pharmacists and Pharmacy Network Participation 86

13. Pharmacy Audit Procedures 90

14. Prior Authorization Requirements 157

15. Prohibited Pharmacy Fees 159

16. Prohibiting Clawbacks 160

17. Prohibiting Gag Clauses and Limiting the Amount Charged to Consumers 164

18. Prohibiting PBM 340B Entity Discrimination 170

19. Prohibiting Spread Pricing 172

20. Prohibition on Retroactive Denials of Pharmacy Claims 173

21. Provider Contract Standards 177

22. Rebates 182

23. Registration of PSAOs 185

24. Reporting of Health Benefit Plans Administered and Rebates Collected 186

25. Transparency Provisions 189

ADVANCE WRITTEN NOTICE OF FORMULARY CHANGES AND SUBSTITUTIONS – MARCH 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **WI** | Wis. Stat. § 632.861(4) | DOI | **(4)** DRUG SUBSTITUTION.**(a)** Except as provided in par. (b), a disability insurance policy that offers a prescription drug benefit, a self-insured health plan that offers a prescription drug benefit, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self-insured health plan shall provide to an enrollee advanced written notice of a formulary change that removes a prescription drug from the formulary of the policy or plan or that reassigns a prescription drug to a benefit tier for the policy or plan that has a higher deductible, copayment, or coinsurance. The advanced written notice of a formulary change under this paragraph shall be provided no fewer than 30 days before the expected date of the removal or reassignment and shall include information on the procedure for the enrollee to request an exception to the formulary change. The policy, plan, or pharmacy benefit manager is required to provide the advanced written notice under this paragraph only to those enrollees in the policy or plan who are using the drug at the time the notification must be sent according to available claims history.  **(b)1.** A disability insurance policy, self-insured health plan, or pharmacy benefit manager is not required to provide advanced written notice under par. (a) if the prescription drug that is to be removed or reassigned is any of the following: **a.** No longer approved by the federal food and drug administration. **b.** The subject of a notice, guidance, warning, announcement, or other statement from the federal food and drug administration relating to concerns about the safety of the prescription drug. **c.** Approved by the federal food and drug administration for use without a prescription.**2.** A disability insurance policy, self-insured health plan, or pharmacy benefit manager is not required to provide advanced written notice under par. (a) if, for the prescription drug that is being removed from the formulary or reassigned to a benefit tier that has a higher deductible, copayment, or coinsurance, the policy, plan, or pharmacy benefit manager adds to the formulary a generic prescription drug that is approved by the federal food and drug administration for use as an alternative to the prescription drug or a prescription drug in the same pharmacologic class or with the same mechanism of action at any of the following benefit tiers: **a.** The same benefit tier from which the prescription drug is being removed or reassigned. **b.** A benefit tier that has a lower deductible, copayment, or coinsurance than the benefit tier from which the prescription drug is being removed or reassigned.  **(c)** A pharmacist or pharmacy shall notify an enrollee in a disability insurance policy or self-insured health plan if a prescription drug for which an enrollee is filling or refilling a prescription is removed from the formulary and the policy or plan or a pharmacy benefit manager acting on behalf of a policy or plan adds to the formulary a generic prescription drug that is approved by the federal food and drug administration for use as an alternative to the prescription drug or a prescription drug in the same pharmacologic class or with the same mechanism of action at any of the following benefit tiers:**1.** The same benefit tier from which the prescription drug is being removed or reassigned.**2.** A benefit tier that has a lower deductible, copayment, or coinsurance than the benefit tier from which the prescription drug is being removed or reassigned.  **(d)** If an enrollee has had an adverse reaction to the generic prescription drug or the prescription drug in the same pharmacologic class or with the same mechanism of action that is being substituted for an originally prescribed drug, the pharmacist or pharmacy may extend the prescription order for the originally prescribed drug to fill one 30-day supply of the originally prescribed drug for the cost-sharing amount that applies to the prescription drug at the time of the substitution. |
|  |  |  |  |
|  |  |  |  |

AFFILIATE COMPENSATION – OCTOBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **CO** | Colo. Rev. Stat. § 10-16-122.3(1) | DOI | **(1)(a)** A pharmacy benefit management firm shall not reimburse a pharmacy in an amount less than the amount that the pharmacy benefit management firm reimburses any affiliate for the same pharmacy services.  **(b)** This subsection (1) does not prohibit a pharmacy benefit management firm from reimbursing an affiliate for satisfying the terms of a performance-based contract. |
| **DE** | Del. Code tit. 18, Chapter 33A § 3325A | DOI | (a) For purposes of this section:  (1) "Affiliate" means a pharmacy or pharmacist that directly or indirectly, through 1 or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with, a pharmacy benefits manager.  (2) "Pharmaceutical wholesaler" means a person that sells and distributes a pharmaceutical product and offers regular and private delivery to a pharmacy.  (3) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice.  (4) "Pharmacy goods or services" means 1 or more of the following provided by a pharmacist or pharmacy: a. A single-sourced drug, multi-sourced drug, or compounded drug. b. A medical product. c. A medical device. d. A service.  (b) A pharmacy benefits manager may not reimburse a pharmacist or pharmacy for pharmacy goods or services in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same pharmacy goods or services.  (c) If the amount reimbursed by a pharmacy benefits manager for pharmacy goods or services is less than the pharmacy acquisition cost for the same pharmacy goods or services, a pharmacist or pharmacy may decline to provide the pharmacy goods or services to a patient.  (d) A pharmacist or pharmacy acting under subsection (c) of this section shall do all of the following:  (1) Inform the patient that the pharmacist or pharmacy has made the decision not to provide pharmacy goods or services to the patient under subsection (c) of this section because of the costs associated with providing the pharmacy goods or services.  (2) Provide the patient with a list of pharmacies in the area that may provide the pharmacy goods or services. |
| **MD** | MD. ANN. CODE § 15-1612 | DOI | **(a)** This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.  **(b)** This section does not apply to reimbursement:**(1)** for specialty drugs;**(2)** for mail order drugs; or**(3)** to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.  **(c)** A pharmacy benefits manager may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the pharmacy benefits manager reimburses itself or an affiliate for providing the same product or service. |
| **NM** | N.M. Stat. §  59A-61-4(B) | DOI | **B.** A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service. |
| **SC** | SC Code § 38-71-2230(A)(3) (2020) | DOI | (A) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:  (3) engage, with the express intent or purpose of driving out competition or financially injuring competitors, in a pattern or practice of reimbursing independent pharmacies or pharmacists in this State consistently less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services; |
| **TX** | Tex. Code Ann. §1369.554 (2021) | DOI | (a) In this section:  (1) “Affiliated pharmacist or pharmacy” means a pharmacist or pharmacy that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a pharmacy benefit manager.  (2) “Nonaffiliated pharmacist or pharmacy” means a pharmacist or pharmacy that does not directly, or indirectly through one or more intermediaries, control and is not controlled by or under common control with a pharmacy benefit manager.  (b) A pharmacy benefit manager may not pay an affiliated pharmacist or pharmacy a reimbursement amount that is more than the amount the pharmacy benefit manager pays a nonaffiliated pharmacist or pharmacy for the same pharmacist service. |

COMPENSATION – MARCH 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **AR** | A.C.A. § 23-92-506(a) | DOI | **(1)** The Insurance Commissioner may review and approve the compensation program of a pharmacy benefits manager with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan under the standards issued by rule of the State Insurance Department.**(2)** All information and data acquired during the review under subdivision (a)(1) of this section is:**(A)** Considered proprietary and confidential under § 23-61-107(a)(4) and § 23-61-207; and**(B)** Not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq. |
| **NJ** | NJ Rev Stat § 17B:27F-8 (2020) | DOI | The Commissioner of Banking and Insurance may review and approve the compensation program of a pharmacy benefits manager with a health benefits plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefits plan. |
| **NM** | N.M. Stat. Ann. § 59A-61-4A and B | DOI | **A.** A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources.  **B.** A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service. |
|  |  |  |  |

FIDUCIARY DUTY – JULY 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **DC** | [D.C. Code Ann. § 48-832.01](https://code.dccouncil.us/us/dc/council/code/titles/48/chapters/8A/subchapters/II/) | DOI | **Fiduciary duty.** A pharmacy benefits manager owes a fiduciary duty to a covered entity and shall discharge that duty in accordance with all applicable laws. In performance of that duty, a pharmacy benefits manager shall adhere to the practices set forth in this section. |
| **KY** | [Ky. Rev. Stat. §205.5512 4(c)(1) (2020)](https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=49885) | DOI | (4) As part of the procurement process to select the state pharmacy benefit manager, the department shall (c) Establish a master contract to be used by the department when contracting with the state pharmacy benefit manager, which shall: (1) Establish the state pharmacy benefit manager’s fiduciary duty owed to the department. |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4349-2 | DOI | **2.  Fiduciary duty.**A carrier that contracts with a pharmacy benefits manager to perform any activities related to the carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty to the carrier in the pharmacy benefits manager's management of activities related to the carrier's prescription drug benefits. |
|  |  |  |  |
|  |  |  |  |

PHARMACY ACCREDITATION REQUIREMENTS – NOVEMBER 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **SC** | SC Code § 38-71-2230(E) (2020) | DOI | (E) A pharmacy benefits manager may maintain more than one network for different pharmacy services. Each individual network may require different pharmacy accreditation standards or certification requirements for participating in the network provided that the pharmacy accreditation standards or certification requirements are applied without regard to a pharmacy's or pharmacist's status as an independent pharmacy or pharmacy benefits manager affiliate. Each individual pharmacy location as identified by its National Council for Prescription Drug Program identification number may have access to more than one network so long as the pharmacy location meets the pharmacy accreditation standards or certification requirements of each network. |
| **TX** | [Texas Insurance Code § 1369.558](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.558) | DOI | A health benefit plan issuer or pharmacy benefit manager may not as a condition of a contract with a pharmacist or pharmacy:  (1) require pharmacist or pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements; or  (2) prohibit a licensed pharmacist or pharmacy from dispensing any drug that may be dispensed under the pharmacist's or pharmacy's license unless:  (A) applicable state or federal law prohibits the pharmacist or pharmacy from dispensing the drug; or  (B) the manufacturer of the drug requires that a pharmacist or pharmacy possess one or more accreditations or certifications to dispense the drug and the pharmacist or pharmacy does not meet the requirement. |
| **WI** | Wis. Stat. § 632.865(4) | DOI | A pharmacy benefit manager or a representative of a pharmacy benefit manager shall provide to a pharmacy, within 30 days of receipt of a written request from the pharmacy, a written notice of any certification or accreditation requirements used by the pharmacy benefit manager or its representative as a determinant of network participation. A pharmacy benefit manager or a representative of a pharmacy benefit manager may change its accreditation requirements no more frequently than once every 12 months. |

PBM COMPENSATION – NOVEMBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4350-D | DOI | **1.  Definitions.**As used in this section, unless the context otherwise indicates, the following terms have the following meanings.  A. "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.  B. "Pharmacy benefits manager compensation" means the difference between:  (1) The value of payments made by a carrier of a health plan to its pharmacy benefits manager; and  (2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health plan.  **2.  Pharmacy benefits manager compensation included as administrative cost.**If a carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:  A. Constitutes an administrative cost incurred by the carrier in connection with a health plan; and  B. May not constitute a benefit provided under a health plan.  A carrier may claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.  **3.  Calculation of pharmacy benefits manager compensation.**Each rate filing submitted by a carrier with respect to a health plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager must include:  A. A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and  B. Such records and supporting information as the superintendent reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.  **4.  Records.**Upon request, a carrier shall provide any records to the superintendent that relate to the calculation of the pharmacy benefits manager compensation.  **5.  Documentation from pharmacy benefits manager.**A pharmacy benefits manager shall provide any necessary documentation requested by a carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section. |
| **TX** | Texas Insurance Code §§ 4151.001, [4151.117](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.117) | DOI | **Sec. 4151.001. DEFINITIONS.** In this chapter:  (1) "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term includes a delegated entity under Chapter [1272](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1272) and a workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305) that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. The term does not include a person described by Section [4151.002](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=4151.002).  (2) "Insurer" means a person who engages in the business of life, health, accident, or workers' compensation insurance under the law of this state. For purposes of this chapter only, the term also includes an "insurance carrier," as defined by Section [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(27), Labor Code, other than a governmental entity or a workers' compensation self-insurance group subject to regulation under Chapter [407A](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407A), Labor Code.  (3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.  (4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.  (5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.  (6) "Workers' compensation benefits" means benefits provided under Title 5, Labor Code, or services provided through a certified workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305).  **(**7) "Workers' compensation insurance coverage" means coverage subject to Subtitle E, Title 10. The term includes coverage described by Sections [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(44)(A) and (B), Labor Code.  (8) "Workers' compensation self-insurer" means a legal entity subject to regulation under Chapter [407](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407), Labor Code.  **Sec. 4151.117. COMPENSATION OF ADMINISTRATOR**. (a) An administrator's compensation may be determined:  (1) as a percentage of the premiums or charges the administrator collects or the amount of claims the administrator pays or processes; or  (2) except as provided by Subsection (b), on another basis as specified in the written agreement.  (b) An insurer or plan sponsor may not permit or provide compensation or another thing of value to an administrator that is based on the savings accruing to the insurer or plan sponsor because of adverse determinations regarding claims for benefits, reductions of or limitations on benefits, or other analogous actions inconsistent with this chapter, that are made or taken by the administrator. |
|  |  |  |  |

PBM COMPLAINT PROCESS – MARCH 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **NH** | New Hampshire Rev Stat  [§ 402-N:5](http://www.gencourt.state.nh.us/rsa/html/XXXVII/402-N/402-N-mrg.htm) | DOI | I. Consumers may file a complaint related to a registered pharmacy benefit manager pursuant to RSA 400-A:15-e. II. The commissioner shall adopt rules to implement paragraph I. Such rules shall include procedures for addressing complaints, provisions for enforcement, the receipt of complaints referred to the insurance department under RSA 318:47-h, III(b), and for reporting to the board of pharmacy on the status of complaints referred. |
| **OK** | 36 OK Stat. §36-6966 | DOI | A. The Insurance Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the provisions of the Patient's Right to Pharmacy Choice Act.  B. The Commissioner shall establish a Patient's Right to Pharmacy Choice Advisory Committee to review complaints, hold hearings, subpoena witnesses and records, initiate prosecution, reprimand, place on probation, suspend, revoke and/or levy fines not to exceed Ten Thousand Dollars ($10,000.00) for each count for which any pharmacy benefits manager (PBM) has violated a provision of this act. The Advisory Committee may impose as part of any disciplinary action the payment of costs expended by the Insurance Department for any legal fees and costs including, but not limited to, staff time, salary and travel expense, witness fees and attorney fees. The Advisory Committee may take such actions singly or in combination, as the nature of the violation requires.  C. The Advisory Committee shall consist of seven (7) persons appointed as follows:  1. Two persons who shall be nominated by the Oklahoma Pharmacists Association;  2. Two consumer members not employed or related to insurance, pharmacy or PBM nominated by the Office of the Governor;  3. Two persons representing the PBM or insurance industry nominated by the Insurance Commissioner; and  4. One person representing the Office of the Attorney General nominated by the Attorney General.  D. Committee members shall be appointed for terms of five (5) years. The terms of the members of the Advisory Committee shall expire on the thirtieth day of June of the year designated for the expiration of the term for which appointed, but the member shall serve until a qualified successor has been duly appointed. No person shall be appointed to serve more than two consecutive terms.  E. Hearings shall be held in the Insurance Commissioner's offices or at such other place as the Insurance Commissioner may deem convenient.  F. The Insurance Commissioner shall issue and serve upon the PBM a statement of the charges and a notice of hearing in accordance with the Administrative Procedures Act, Sections 250 through 323 of Title 75 of the Oklahoma Statutes.  G. At the time and place fixed for a hearing, the PBM shall have an opportunity to be heard and to show cause why the Insurance Commissioner or his or her duly appointed hearing examiner should not revoke or suspend the PBM's license and levy administrative fines for each violation. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.  H. All hearings will be public and held in accordance with, and governed by, Sections 250 through 323 of Title 75 of the Oklahoma Statutes.  I. The Insurance Commissioner, upon written request reasonably made by the licensed PBM affected by the hearing and at such PBM's expense shall cause a full stenographic record of the proceedings to be made by a competent court reporter.  J. If the Insurance Commissioner determines, based on an investigation of complaints, that a PBM has engaged in violations of this act with such frequency as to indicate a general business practice and that such PBM should be subjected to closer supervision with respect to such practices, the Insurance Commissioner may require the PBM to file a report at such periodic intervals as the Insurance Commissioner deems necessary. |
| **SC** | S.C. Code Regs. § 69-77 Section V. C. | DOI | C. Pharmacy Provider Complaints Related to Maximum Allowable Cost List Compliance under Section 38-71-2240 of the Code of Laws of South Carolina 1976, as amended.  (1) The pharmacy benefits manager shall designate the name, address, and phone number, including an electronic mail contact, of the organization which shall be responsible for responding to the Department for complaints the Department has received from pharmacy providers for alleged Maximum Allowable Cost List violations. The pharmacy benefits manager shall be subject to Section 38-13-70 of the Code of Laws of South Carolina 1976, as amended related to the time period for a response to the Department.  (2) A pharmacy provider or other person acting on its behalf shall make reasonable efforts to exhaust any internal appeal requirements of the pharmacy benefits manager prior to the filing of a complaint with the Department. However, a pharmacy provider shall not be required to exhaust internal appeal requirements of the pharmacy benefits manager if a pharmacy benefits manager has failed to abide by its Maximum Allowable Cost List appeal processes as described in Section 38-71-2240. A pharmacy benefits manager shall not be held responsible for failure to provide communication or timely processing in the event that a provider or pharmacy has not submitted sufficient information for the pharmacy benefits manager to process the appeal.  (3) The Department shall review the complaints, and upon determination of a violation of the Act or this regulation, institute regulatory action in accordance with the requirements set forth in Section VIII of this regulation.  (4) The Department may refer any complaints to the Office of the South Carolina Attorney General for investigation or other enforcement action in accordance with Section 38-3-110 of the Code of Laws of South Carolina 1976, as amended. |
|  |  |  |  |

PBM EXAMINATION AUTHORITY – NOVEMBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AL** | AL Code § 27-45A-5 (2021) | DOI | (a) The commissioner may adopt rules necessary to implement this chapter.  (b) The powers and duties set forth in this chapter shall be in addition to all other authority of the commissioner.  (c) The commissioner shall enforce compliance with the requirements of this chapter and rules adopted thereunder.  (d)(1) The commissioner may examine or audit any books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan as may be deemed relevant and necessary by the commissioner to determine compliance with this chapter.  (2) Examinations conducted by the commissioner shall be pursuant to the same examination authority of the commissioner relative to insurers as provided in Chapter 2, including, but not limited to, the confidentiality of documents and information submitted as provided in Section 27-2-24; examination expenses shall be processed in accordance with Section 27-2-25; and pharmacy benefits managers shall have the same rights as insurers to request a hearing in accordance with Sections 27-2-28 et seq., and to appeal as provided in Section 27-2-32.  (e) The commissioner's examination expenses shall be collected from pharmacy benefits managers in the same manner as those collected from insurers. |
| **NH** | New Hampshire Rev Stat  [§ 402-N:7](http://www.gencourt.state.nh.us/rsa/html/XXXVII/402-N/402-N-mrg.htm) | DOI | The commissioner may examine and directly bill a pharmacy benefits manager required to be registered under this chapter for the costs of any examination pursuant to RSA 400-A:37 as necessary to determine and enforce compliance with this chapter. In addition, if the commissioner finds through an investigation or examination that a carrier has not received information required under RSA 420-J:7-b, XI from a pharmacy benefit manager, the commissioner may require that the pharmacy benefit manager provide the required information, and the commissioner may investigate or examine and directly bill the pharmacy benefit manager for the cost of any portion of the examination or investigation pertaining to obtaining the required information. |
| **NM** | N.M. Stat. § 59A-61-5I and  N.M. Code R. § 13.10.30.18 | DOI | Pursuant to the provisions of Section 59A-4-3 NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the information confidential. |
| **OK** | 36 OK Stat § 36-6965 | DOI | A. The Insurance Commissioner shall have power to examine and investigate into the affairs of every pharmacy benefits manager (PBM) engaged in pharmacy benefits management in this state in order to determine whether such entity is in compliance with the Patient's Right to Pharmacy Choice Act.  B. All PBM files and records shall be subject to examination by the Insurance Commissioner or by duly appointed designees. The Insurance Commissioner, authorized employees and examiners shall have access to any of a PBM's files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.  C. Every officer, director, employee or agent of the PBM, upon receipt of any inquiry from the Commissioner shall, within thirty (30) days from the date the inquiry is sent, furnish the Commissioner with an adequate response to the inquiry.  D. When making an examination under this section, the Insurance Commissioner may retain subject matter experts, attorneys, appraisers, independent actuaries, independent certified public accountants or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners or other professionals and specialists as examiners, the cost of which shall be borne by the PBM which is the subject of the examination. |
| **SC** | **S**.C. Code Regs. § 69-77 Section IV | DOI | A. Examination of Pharmacy Benefits Managers.(1) Pursuant to Section 38-71-2250 of the Code of Laws of South Carolina 1976, as amended, the Director or his designee may examine the affairs of a pharmacy benefits manager for compliance with the requirements of the Act, applicable South Carolina law or requirements of this regulation.(2) Any examination permitted under this Section shall follow the examination procedures and requirements applicable to health care insurers under Chapter 13, Title 38 of the Code of Laws of South Carolina 1976, as amended.  B. A pharmacy benefits manager shall not be regularly examined under the same time periods as insurers as required under Section 38-13-10 of the Code of Laws of South Carolina 1976, as amended, however, the Director or his designee may examine the pharmacy benefits manager pursuant to Section 38-71-2250 at any time he or she believes it reasonably necessary to ensure compliance with the Act, the provisions of this regulation, or Title 38. |
| **TX** | [Texas Insurance Code § 4151.0031](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.0031)  [Texas Insurance Code §§ 4151.201 - 4151.204](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.201) | DOI | **Sec. 4151.001. DEFINITIONS.** In this chapter:  (1) "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term includes a delegated entity under Chapter [1272](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1272) and a workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305) that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. The term does not include a person described by Section [4151.002](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=4151.002).  (2) "Insurer" means a person who engages in the business of life, health, accident, or workers' compensation insurance under the law of this state. For purposes of this chapter only, the term also includes an "insurance carrier," as defined by Section [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(27), Labor Code, other than a governmental entity or a workers' compensation self-insurance group subject to regulation under Chapter [407A](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407A), Labor Code.  (3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.  (4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.  (5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.  (6) "Workers' compensation benefits" means benefits provided under Title 5, Labor Code, or services provided through a certified workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305).  **(**7) "Workers' compensation insurance coverage" means coverage subject to Subtitle E, Title 10. The term includes coverage described by Sections [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(44)(A) and (B), Labor Code.  (8) "Workers' compensation self-insurer" means a legal entity subject to regulation under Chapter [407](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407), Labor Code.  **Sec. 4151.0031. MARKET ANALYSIS.**  The commissioner may conduct market analyses and examinations of an administrator under Chapter [751](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.751.htm#751).  S**ec. 4151.201. EXAMINATION OF ADMINISTRATOR.** (a) The commissioner may examine an administrator with regard to its business in this state.  (b) The commissioner may designate one or more employees to perform an examination.  **Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE EVALUATION.** (a) An examination under Section 4151.201 must include a review of:  (1) each existing written agreement between the administrator and an insurer or plan sponsor; and  (2) the administrator's financial statements.  (b) The commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator.  (c) Before an examiner enters an administrator's property, the commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. The notice must:  (1) be in the form required by rule adopted by the commissioner; and  (2) include the date and estimated time that the examiner will enter the administrator's property.  (d) An examiner shall comply with operational rules of an administrator while on the administrator's property.  **Sec. 4151.203. COST OF EXAMINATION.** The cost of an examination under Section 4151.201 shall be paid from the fee collected under Section 4151.206(a)(2) and with revenue from the maintenance tax levied under Chapter 259.  **Sec. 4151.204. EXAMINATION UNDER OATH.** If necessary to make a complete evaluation of the activities and operations of an administrator, the commissioner may summon and examine under oath the administrator and the administrator's personnel. |
| **VA** | Section 38.2-3468A of the Code of Virginia (applies to a health carrier or a PBM contracting with the health carrier) | DOI | Each carrier, on its own or through its contract for pharmacy benefits, shall ensure that the Commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a carrier that are relevant to determining if the pharmacy benefits manager is in compliance with this article. The carrier shall be responsible for the charges incurred in the examination, including the expenses of the Commissioner or his designee and the expenses and compensation of his examiners and assistants. |

PBM NETWORK ADEQUACY REQUIREMENTS – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AR** | A.C.A. § 23-92-505(a) | DOI | (a) A pharmacy benefits manager shall provide:  (1)(A) A reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs for a health benefit plan that shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence.  (B) A mail-order pharmacy shall not be included in the calculations determining pharmacy benefits manager network adequacy; and  (2) A pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this state in the time and manner required by rule issued by the State Insurance Department. |
| **DE** | Del. Code tit. 18, Chapter 33A §§ 3361A – 3363A | DOI | § 3361A. For purposes of this subchapter:  (1) "Claim" means as defined under § 3321A of this title.  (2) "Insured" means an individual covered by health insurance offered by an insurer.  (3) "Insurer" means as defined under § 3321A of this title.  (4) "Pharmacist" means as defined under § 2502 of Title 24.  (5) "Pharmacy" means as defined under § 2502 of Title 24.  (6) "Pharmacy benefits manager" means as defined under § 3302A of this title.  (7) "Pharmacy benefits manager network" means a network of pharmacists or pharmacies that are offered by an agreement or contract to provide pharmacy goods or services.  (8) "Pharmacy goods or services" means as defined under § 3325A of this title.  (9) a. "Rebate" means a discount or other price concession, or a payment that is both of the following:1. Based on utilization of a prescription drug.2. Paid by a manufacturer or third party, directly or indirectly, to the pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.  b. "Rebate" includes incentives, disbursements, and reasonable estimates of a volume-based or category-based discount.  § 3362A. (a) A pharmacy benefits manager shall provide a reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs, which provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence.  (b) A pharmacy benefits manager may not deny a pharmacy the opportunity to participate in a pharmacy benefits manager network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefits manager has established for other pharmacies as a condition of preferred network participation status.  (c) A mail-order pharmacy may not be included in the calculations for determining pharmacy benefits manager network adequacy under this section.  § 3363A. (a) A pharmacy benefits manager shall provide a pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this State. The Commissioner shall adopt regulations setting the time and manner for providing the report.  (b) A pharmacy benefits manager shall report to the Commissioner on a quarterly basis all of the following information for each insurer:  (1) The itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees, or any other fees.  (2) The aggregate amount of rebates distributed to the appropriate insurer.  (3) The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount.  (4) The individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services.  (5) The individual and aggregate amount a pharmacy benefits manager paid for pharmacy goods or services itemized by all of the following: a. Pharmacy. b.  Product. c. Goods and services. |
| **KS** | K.S.A. §§ 40-3823(b)(7) | DOI | (b) Each person seeking a license to act as a pharmacy benefits manager shall file with the commissioner an application for a license upon a form to be furnished by the commissioner. At a minimum, the application form  shall include the following information:  \*\*\*\*  (7) A network adequacy report on a form prescribed by the department through rules and regulations. |
| **NM** | N.M. Stat. § 59A-61-5H | DOI | In a time and manner required by rules promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide. |
| **OK** | 36 OK Stat. §36-6961 and 36 OK Stat. §36-6962A | DOI | §36-6961. A. Pharmacy benefits managers (PBMs) shall comply with the following retail pharmacy network access standards:  1. At least ninety percent (90%) of covered individuals residing in an urban service area live within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy network;  2. At least ninety percent (90%) of covered individuals residing in an urban service area live within five (5) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;  3. At least ninety percent (90%) of covered individuals residing in a suburban service area live within five (5) miles of a retail pharmacy participating in the PBM's retail pharmacy network;  4. At least ninety percent (90%) of covered individuals residing in a suburban service area live within seven (7) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;  5. At least seventy percent (70%) of covered individuals residing in a rural service area live within fifteen (15) miles of a retail pharmacy participating in the PBM's retail pharmacy network; and  6. At least seventy percent (70%) of covered individuals residing in a rural service area live within eighteen (18) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network.  B. Mail-order pharmacies shall not be used to meet access standards for retail pharmacy networks.  C. Pharmacy benefits managers shall not require patients to use pharmacies that are directly or indirectly owned by the pharmacy benefits manager, including all regular prescriptions, refills or specialty drugs regardless of day supply.  D. Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers participating in the preferred and nonpreferred pharmacy and health networks.  §36-6962A. The Oklahoma Insurance Department shall review and approve retail pharmacy network access for all pharmacy benefits managers (PBMs) to ensure compliance with Section 4 of this act. |
| **PA** | 40 P.S. § 764*l* | DOI | **(a)** A health insurance policy or government program providing benefits for prescriptions shall not impose on a covered individual utilizing a retail pharmacy a copayment, deductible, fee, limitation on benefits or other condition or requirement not otherwise imposed on the covered individual when using a mail order pharmacy.  **(b)**Subsection (a) shall apply only if the retail pharmacy is willing to accept from the insurer the same pricing, terms, conditions or requirements related to the cost of the prescriptions and the cost and quality of dispensing prescriptions that the insurer has established for a mail order pharmacy and any of such pharmacy's affiliates, including any affiliated pharmacy benefit manager, pursuant to the health insurance policy.  **(c)**Beginning eighteen months after the effective date of this section, the Legislative Budget and Finance Committee shall conduct an evaluation of the impact of this section regarding the access to prescription drugs at both independent and chain retail pharmacies and whether the provisions of this section have had a material positive or negative impact upon the cost of prescription medications to consumers and health care plans and shall issue a report to the General Assembly within nine months of the commencement of the study regarding its findings and recommendations.  **(d)** As used in this section:  **(1)**"Government program" means any of the following:**(i)**The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."**(ii)**The Children's Health Care Program established under Article XXIII.**(iii)**The program of pharmaceutical assistance for the elderly established under Chapter 5 of the act of August 26, 1971 (P.L.351, No.91), known as the "State Lottery Law.  **(2)** "Health insurance policy" means a group or individual health or sickness or accident insurance policy, subscriber contract or certificate issued by an entity subject to any one of the following:**(i)** This act.**(ii)** The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."**(iii)**40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)  The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.  **(3)** "Insurer" means any entity that issues a group or individual health, sickness or accident policy or subscriber contract described under paragraph (2).  **(4)** "Mail order pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act," where prescriptions are dispensed to covered individuals via the mail.  **(5)** "Prescription" and "dispensing" mean those terms as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act."  **(6)** "Retail pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act," where prescriptions are able to be dispensed to covered individuals on the premises of such pharmacy. |
| **WV** | W. Va. Code §33-51-8(d) (2019) | DOI | **§33-51-8. Licensure of pharmacy benefit managers.**  **\*\*\*\*\***  (d) *Network adequacy*. —  (1) A pharmacy benefit manager’s network shall be reasonably adequate, shall provide for convenient patient access to pharmacies within a reasonable distance from a patient’s residence and shall not be comprised only of mail-order benefits but must have a mix of mail-order benefits and physical stores in this state.  (2) A pharmacy benefit manager shall provide a pharmacy benefit manager’s network report describing the pharmacy benefit manager’s network and the mix of mail-order to physical stores in this state in a time and manner required by rule issued by the Insurance Commissioner pursuant to this section. A pharmacy benefit manager’s network report shall include a detailed description of any separate, sub-networks for specialty drugs.  (3) Failure to provide a timely report may result in the suspension or revocation of a pharmacy benefit manager’s license by the Insurance Commissioner.  (4) A pharmacy benefit manager may not require a pharmacy or pharmacist, as a condition for participating in the pharmacy benefit manager’s network, to obtain or maintain accreditation, certification, or credentialing that is inconsistent with, more stringent than, or in addition to state requirements for licensure or other relevant federal or state standards.  \*\*\*\*\* |

PBM PROHIBITED MARKET CONDUCT PRACTICES – NOVEMBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AR** | A.C.A. § 23-92-506(b) | DOI | A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:  (1) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;  (2) Unless reviewed and approved by the commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:  (A) The receipt and processing of a pharmacy claim;  (B) The development or management of claims processing services in a pharmacy benefits manager network; or  (C) Participation in a pharmacy benefits manager network;  (3) Unless reviewed and approved by the commissioner in coordination with the Arkansas State Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the board;  (4)(A) Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services.  (B) The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number;  (5)(A) Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost.  (B)(i) The Employee Benefits Division community pharmacy reimbursement model for pharmacist services in partnership with the University of Arkansas for Medical Sciences-based prescription drug program satisfies the intent of this subdivision (b)(5).  (ii) A plan using the model described in subdivision (b)(5)(B)(i) of this section is exempt from complying with subdivision (b)(5)(A) of this section if the reimbursement model is maintained as determined by the Insurance Commissioner.  (iii) If a plan deviates from this reimbursement model, the plan shall be subject to subdivision (b)(5)(A) of this section;  (6) Make or permit any reduction of payment for pharmacist services by a pharmacy benefits manager or a healthcare payor directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including without limitation generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment; or  (7) Do any combination of the actions listed in subdivisions (b)(1)-(6) of this section. |
| **DE** | Del. Code tit. 18, Chapter 33A § 3372A | DOI | A pharmacy benefits manager or representative of a pharmacy benefits manager may not do any of the following:  (1) Engage in spread pricing.  (2) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.  (3) Unless reviewed and approved by the Commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for any of the following: a. The receipt and processing of a pharmacy claim. b. The development or management of claims processing services in a pharmacy benefits manager network. c. Participation in a pharmacy benefits manager network.  (4) Unless reviewed and approved by the Commissioner in coordination with the Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy.  (5) Violate § 3325A(b) of this title.  (6) Violate § 3362A of this title.  (7) Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost, or if the national average drug acquisition cost is unavailable, the wholesale acquisition cost.  (8) Make or permit any reduction of payment for pharmacy goods or services by a pharmacy benefits manager or an insurer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.  (9) After adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless 1 or more of the following applies: a. The original claim was intentionally submitted fraudulently. b. The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services. c. The pharmacy goods or services were not properly rendered by the pharmacy or pharmacist. |
| **GA** | GA Code § 33-64-11 | DOI | (a) A pharmacy benefits manager shall be proscribed from:  (1) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from providing an insured individual information on the amount of the insured's cost share for such insured's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available.  No pharmacist, pharmacy, or other dispenser or dispenser practice shall be penalized by a pharmacy benefits manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available;  (2) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from offering and providing delivery services to an insured as an ancillary service of the pharmacy or dispenser practice;  (3) Charging or collecting from an insured a copayment that exceeds the total submitted charges by the network pharmacy or other dispenser practice for which the pharmacy or dispenser practice is paid;  (4) Charging or holding a pharmacist or pharmacy or dispenser or dispenser practice responsible for a fee or penalty relating to the adjudication of a claim or an audit conducted pursuant to [Code Section 26-4-118](https://1.next.westlaw.com/Link/Document/FullText?findType=L&originatingContext=document&transitionType=DocumentItem&pubNum=1000468&refType=LQ&originatingDoc=Ic4cbfd703e9e11ebbbed8892a124e2de&cite=GAST26-4-118) , provided that this shall not restrict recoupments made in accordance with [Code Section 26-4-118](https://1.next.westlaw.com/Link/Document/FullText?findType=L&originatingContext=document&transitionType=DocumentItem&pubNum=1000468&refType=LQ&originatingDoc=Ic4cbfd713e9e11ebbbed8892a124e2de&cite=GAST26-4-118) ;  (5) Recouping funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements set forth in [Code Section 26-4-118](https://1.next.westlaw.com/Link/Document/FullText?findType=L&originatingContext=document&transitionType=DocumentItem&pubNum=1000468&refType=LQ&originatingDoc=Ic4cc24803e9e11ebbbed8892a124e2de&cite=GAST26-4-118) , unless such recoupment is otherwise permitted or required by law;  (6) Penalizing or retaliating against a pharmacist or pharmacy for exercising rights under this chapter or [Code Section 26-4-118](https://1.next.westlaw.com/Link/Document/FullText?findType=L&originatingContext=document&transitionType=DocumentItem&pubNum=1000468&refType=LQ&originatingDoc=Ic4cc24813e9e11ebbbed8892a124e2de&cite=GAST26-4-118) ;  (7) Steering.   This paragraph shall not be construed to prohibit a pharmacy benefits manager from entering into an agreement with an affiliated pharmacy or an affiliated pharmacy of another pharmacy benefits manager licensed pursuant to this chapter to provide pharmacy care to patients;  (8) Transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose;  provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review;  (9) Knowingly making a misrepresentation to an insured, pharmacist, pharmacy, dispenser, or dispenser practice;  (10) Taking any action in violation of subparagraphs (a)(21)(D) and (a)(21)(E) of [Code Section 26-4-28](https://1.next.westlaw.com/Link/Document/FullText?findType=L&originatingContext=document&transitionType=DocumentItem&pubNum=1000468&refType=LQ&originatingDoc=Ic4cc72a03e9e11ebbbed8892a124e2de&cite=GAST26-4-28) or charging a pharmacy a fee in connection with network enrollment;  (11) Withholding coverage or requiring prior authorization for a lower cost therapeutically equivalent drug available to an insured or failing to reduce an insured's cost share when an insured selects a lower cost therapeutically equivalent drug;  and  (12) Removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing an insured to seek coverage from a different health plan. |
| **MD** | MD. ANN. CODE § 15-1642 | DOI | (a) It is a violation of this subtitle for a pharmacy benefits manager to:(1) misrepresent pertinent facts or policy provisions that relate to a claim or the compensation program at issue in a complaint or an appeal of a decision regarding a complaint;(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;(3) fail to settle a claim or dispute promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or(4) fail to act in good faith.(b) It is a violation of this subtitle for a pharmacy benefits manager, when committed at a frequency to indicate a general business practice, to:(1) misrepresent pertinent facts or policy provisions that relate to a claim, the compensation program, or the coverage at issue in a complaint or an appeal of a decision regarding a complaint;(2) fail to make a prompt, fair, and equitable good-faith attempt to settle claims for which liability has become reasonably clear;(3) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or(4) refuse to pay a claim for an arbitrary or capricious reason based on all available information. |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4348-A | DOI | A pharmacy benefits manager or representative of a pharmacy benefits manager may not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading. |
| **NM** | N.M. Stat. §§ 59A-61-5E and 59A-61-7 | DOI | A pharmacy benefits manager shall not:(1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;(2) require pharmacy validation and revalidation standards inconsistent with, more stringent than or in addition to federal and state requirements for licensure and operation as a pharmacy in this state;(3) prohibit a pharmacy or pharmacist from:(a) mailing or delivering drugs to a patient as an ancillary service;(b) providing a patient information regarding the patient's total cost for pharmacist services for a prescription drug; or(c) discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available;(4) require or prefer a generic drug over its generic therapeutic equivalent;(5) prohibit, restrict or limit disclosure of information by a pharmacist or pharmacy to the superintendent; or(6) prohibit, restrict or limit pharmacies or pharmacists from providing to state or federal government officials general information for public policy purposes. |
| **OK** | 36 OK Stat § 36-6962B | DOI | A PBM, or an agent of a PBM, shall not:  1. Cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;  2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:  a. The submission of a claim,  b. Enrollment or participation in a retail pharmacy network, or  c. The development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;  3. Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy;  4. Deny a pharmacy the opportunity to participate in any pharmacy network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies as a condition of preferred network participation status;  5. Deny, limit or terminate a pharmacy's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy;  6. Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless:  a. The original claim was submitted fraudulently, or  b. To correct errors identified in an audit, so long as the audit was conducted in compliance with Sections 356.2 and 356.3 of Title 59 of the Oklahoma Statutes; or  7. Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a pharmacy benefits manager network. |
| **OR** | Oregon Rev. Stat. § 735.536 | DOI | (1) As used in this section, "out-of-pocket cost" means the amount paid by an enrollee under the enrollee’s coverage, including deductibles, copayments, coinsurance or other expenses as prescribed by the Department of Consumer and Business Services by rule.  (2) A pharmacy benefit manager registered under ORS 735.532:  (a) May not require a prescription to be filled or refilled by a mail order pharmacy as a condition for reimbursing the cost of the drug.  (b) Except as provided in paragraph (c) of this subsection, may require a prescription for a specialty drug to be filled or refilled at a specialty pharmacy as a condition for the reimbursement of the cost a drug.  (c) Shall reimburse the cost of a specialty drug that is filled or refilled at a network pharmacy that is a long term care pharmacy.  (d)(A) Shall allow a network pharmacy to mail, ship or deliver prescription drugs to its patients as an ancillary service.  (B) Is not required to reimburse a delivery fee charged by a pharmacy for a delivery described in subparagraph (A) of this paragraph unless the fee is specified in the contract between the pharmacy benefit manager and the pharmacy.  (e) May not require a patient signature as proof of delivery of a mailed or shipped prescription drug if the network pharmacy:  (A)(i) Maintains a mailing or shipping log signed by a representative of the pharmacy; or  (ii) Maintains each notification of delivery provided by the United States Postal Service or a package delivery service; and  (B) Is responsible for the cost of mailing, shipping or delivering a replacement for a drug that was mailed or shipped but not received by the enrollee.  (f) May not penalize a network pharmacy for or otherwise directly or indirectly prevent a network pharmacy from informing an enrollee of the difference between the out-of-pocket cost to the enrollee to purchase a prescription drug using the enrollee’s pharmacy benefit and the pharmacy’s usual and customary charge for the prescription drug.  (3) The Department of Consumer and Business Services may adopt rules to carry out the provisions of this section. [2019 c.526 §2] |
| **SC** | SC Code § 38-71-2230(A) (2020) | DOI | (A) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:  (1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;  (2) charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for the receipt and processing of a pharmacy claim;  (3) engage, with the express intent or purpose of driving out competition or financially injuring competitors, in a pattern or practice of reimbursing independent pharmacies or pharmacists in this State consistently less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services;  (4) collect or require a pharmacy or pharmacist to collect from an insured a copayment for a prescription drug at the point of sale in an amount that exceeds the lesser of:  (a) the contracted copayment amount;  (b) the amount an individual would pay for a prescription drug if that individual was paying cash; or  (c) the contracted amount for the drug.  (5) require the use of mail order for filling prescriptions unless required to do so by the health benefit plan or the health benefit plan design;  (6) charge a fee related to the adjudication of a claim without providing the cause for each adjustment or fee;  (7) penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this chapter;  (8) prohibit a pharmacist or pharmacy from offering and providing direct and limited delivery services including incidental mailing services, to an insured as an ancillary service of the pharmacy; or  (9) any combination thereof. |
| **TX** | [Texas Insurance Code § 4151.153](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.153) and §4151.154 | DOI | **Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION PROHIBITED.**  (a) A pharmacy benefit manager may not sell a list of patients that contains information through which the identity of an individual patient is disclosed.  (b) A pharmacy benefit manager shall maintain all data that identifies a patient in a confidential manner that prevents disclosure to a third party unless the disclosure is otherwise authorized by law or by the patient.  (c) This section does not prohibit:  (1) general advertising about a specific pharmaceutical product or service; or  (2) the request and receipt by a person of information regarding:  (A) a specific pharmaceutical product or service;  (B) the person's own records or claims; or  (C) the person's dependent's records or claims.  **Sec. 4151.154. DISCOUNT HEALTH CARE PROGRAMS.** A pharmacy benefit manager may not require a pharmacist or pharmacy to:  (1) accept or process a claim for prescription drugs under a discount health care program as defined by Section [7001.001](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=7001.001) unless the pharmacist or pharmacy agrees in writing to accept or process the claim;  (2) participate in a specified provider network as a condition of processing a claim for prescription drugs under a discount health care program; or  (3) participate in, or process claims under, a discount health care program as a condition of participation in a provider network. |
| **UT** | Utah Code Ann. § 31A-46-302(4), (5) and (6) | DOI | (4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a pharmacist of: (i) an insured customer's cost share for a covered prescription drug or prescription device; (ii) the availability of any therapeutically equivalent alternative medications; or (iii) alternative methods of paying for the prescription medication or prescription device, including paying the cash price, that are less expensive than the cost share of the prescription drug. (b) Penalties that are prohibited under Subsection (4)(a) include increased utilization review, reduced payments, and other financial disincentives. (5) A pharmacy benefit manager may not require an insured customer to pay, for a covered prescription drug or prescription device, more than the lesser of: (a) the applicable cost share of the prescription drug or prescription device being dispensed; (b) the applicable allowable claim amount of the prescription drug or prescription device being dispensed; (c) the applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or (d) the retail price of the prescription drug or prescription device without prescription drug coverage. (6) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit manager may not engage in direct or indirect remuneration that results in a reduction in total compensation received by a pharmacy from the pharmacy benefit manager for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice of the direct or indirect remuneration. |
| **VA** | Section 38.2-3467 of the Code of Virginia (applies to a health carrier or a PBM contracting with the health carrier) | DOI | A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall:  1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue;  2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission;  3. Reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration; or  4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article.  B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards.  C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy under any law or contract in the Commonwealth. |
| **WV** | Code of West Virginia § 33-51-9(b)-(e) and (j) | DOI | (b) A pharmacy benefit manager may not collect from a pharmacy, a pharmacist, or a pharmacy technician a cost share charged to a covered individual that exceeds the total submitted charges by the pharmacy or pharmacist to the pharmacy benefit manager.  (c) A pharmacy benefit manager may only directly or indirectly charge or hold a pharmacy, a pharmacist, or a pharmacy technician responsible for a fee related to the adjudication of a claim if:  (1) The total amount of the fee is identified, reported, and specifically explained for each line item on the remittance advice of the adjudicated claim; or  (2) The total amount of the fee is apparent at the point of sale and not adjusted between the point of sale and the issuance of the remittance advice.  (d) A pharmacy benefit manager, or any other third party, that reimburses a 340B entity for drugs that are subject to an agreement under 42 U.S.C. § 256b shall not reimburse the 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity participates in the program set forth in 42 U.S.C. §256b.  (e) With respect to a patient eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, a pharmacy benefit manager, or any other third party that makes payment for such drugs, shall not discriminate against a 340B entity in a manner that prevents or interferes with the patient’s choice to receive such drugs from the 340B entity: *Provided*, That for purposes of this section, “third party” does not include the state Medicaid program when Medicaid is providing reimbursement for covered outpatient drugs, as that term is defined in 42 U.S.C. §1396r-8(k), on a fee-for-service basis: *Provided, however*, That “third party” does include a Medicaid-managed care organization as described in 42 U.S.C. § 1396b(m).  (j) A pharmacy benefits manager may not:  (1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy from the pharmacy benefit manager’s network on the basis that the pharmacy dispenses drugs subject to an agreement under 42 U.S.C. § 256b; or  (2) Engage in any practice that:  (A) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores, or metrics. This does not prohibit pharmacy reimbursement for pharmacy care, including dispensing fees from being based on patient outcomes, scores, or metrics so long as the patient outcomes, scores, or metrics are disclosed to and agreed to by the pharmacy in advance;  (B) Includes imposing a point-of-sale fee or retroactive fee; or  (C) Derives any revenue from a pharmacy or insured in connection with performing pharmacy benefits management services: *Provided,*That this may not be construed to prohibit pharmacy benefits managers from receiving deductibles or copayments. |
|  |  |  |  |

PBM REIMBURSEMENT LISTS OR PAYMENT METHODOLOGY – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AK** | AK Stat § 21.27.945 (2020) and § 21.27.950 (Appeals) | DOI | § 21.27.945  (a) A pharmacy benefits manager shall  (1) make available to each network pharmacy at the beginning of the term of the network pharmacy's contract, and upon renewal of the contract, the methodology and sources used to determine the drug pricing list;  (2) provide a telephone number at which a network pharmacy may contact an employee of a pharmacy benefits manager to discuss the pharmacy's appeal;  (3) provide a process for a network pharmacy to have ready access to the list specific to that pharmacy;  (4) review and update applicable list information at least once every seven business days to reflect modification of list pricing;  (5) update list prices within one business day after a significant price update or modification provided by the pharmacy benefits manager's national drug database provider; and  (6) ensure that dispensing fees are not included in the calculation of the list pricing.  (b) When establishing a list, the pharmacy benefits manager shall use  (1) the most up-to-date pricing data to calculate reimbursement to a network pharmacy for drugs subject to list prices;  (2) multi-source generic drugs that are sold or marketed in the state during the list period.  § 21.27.950  (a) A pharmacy benefits manager shall establish a process by which a network pharmacy, or a network pharmacy's contracting agent, may appeal the reimbursement for a multi-source generic drug. A pharmacy benefits manager shall resolve an appeal from a network pharmacy within 10 calendar days after the network pharmacy or the contracting agent submits the appeal.  (b) A network pharmacy, or a network pharmacy's contracting agent, may appeal a reimbursement from a pharmacy benefits manager for a multi-source generic drug if the reimbursement for the drug is less than the amount that the network pharmacy can purchase from two or more of its contracted suppliers.  (c) A pharmacy benefits manager may grant a network pharmacy's appeal if an equivalent multi-source generic drug is not available at a price at or below the pharmacy benefits manager's list price for purchase from national or regional wholesalers who operate in the state. If an appeal is granted, the pharmacy benefits manager shall adjust the reimbursement of the network pharmacy to equal the network pharmacy acquisition cost for each paid claim included in the appeal.  (d) If the pharmacy benefits manager denies a network pharmacy's appeal, the pharmacy benefits manager shall provide the network pharmacy with the  (1) reason for the denial;  (2) national drug code of an equivalent multi-source generic drug that has been purchased by another network pharmacy located in the state at a price that is equal to or less than the pharmacy benefits manager's list price within seven days after the network pharmacy appeals the claim; and  (3) name of a pharmaceutical wholesaler who operates in the state in which the drug may be acquired by the challenging network pharmacy.  (e) A network pharmacy may request a hearing under AS 21.06.170 - 21.06.240 for an adverse decision from a pharmacy benefits manager within 30 calendar days after receiving the decision. The parties may present all relevant information to the director for the director's review.  (f) The director shall enter an order that  (1) grants the network pharmacy's appeal and directs the pharmacy benefits manager to make an adjustment to the disputed claim;  (2) denies the network pharmacy's appeal; or  (3) directs other actions considered fair and equitable. |
| **AR** | A.C.A. § 17-92-507 | DOI | (a) As used in this section:  (1) (A) “Maximum Allowable Cost List” means a listing of drugs or other methodology used by a pharmacy benefits manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product, or other prescription drug.  (B) “Maximum Allowable Cost List” includes without limitation:  (i) Average acquisition cost, including national average drug acquisition cost;  (ii) Average manufacturer price;  (iii) Average wholesale price;  (iv) Brand effective rate or generic effective rate;  (v) Discount indexing;  (vi) Federal upper limits;  (vii) Wholesale acquisition cost; and  (viii) Any other term that a pharmacy benefits manager or a healthcare insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services;  (2) “Pharmaceutical wholesaler” means a person or entity that sells and distributes prescription pharmaceutical products, including without limitation a full line of brand-name, generic, and over-the-counter pharmaceuticals, and that offers regular and private delivery to a pharmacy;  (3) “Pharmacist” means a licensed pharmacist as defined in § 17-92-101;  (4) “Pharmacist services” means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy as defined in § 17-92-101;  (5) “Pharmacy” means the same as in § 17-92-101;  (6) “Pharmacy acquisition cost” means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice;  (7) “Pharmacy benefits manager” means an entity that administers or manages a pharmacy benefits plan or program;  (8) “Pharmacy benefits manager affiliate” means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager; and  (9) “Pharmacy benefits plan or program” means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in this state.  (b) Before a pharmacy benefits manager places or continues a particular drug on a Maximum Allowable Cost List, the drug:  (1) If the drug is a generically equivalent drug as defined in § 17-92-101, shall be listed as therapeutically equivalent and pharmaceutically equivalent “A” or “B” rated in the United States Food and Drug Administration's most recent version of the “Orange Book” or “Green Book” or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;  (2) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Arkansas; and  (3) Shall not be obsolete.  (c) A pharmacy benefits manager shall:  (1) Provide access to its Maximum Allowable Cost List to each pharmacy subject to the Maximum Allowable Cost List;  (2) Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology;  (3) Provide a process for each pharmacy subject to the Maximum Allowable Cost List to receive prompt notification of an update to the Maximum Allowable Cost List; and  (4) (A) (i) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge Maximum Allowable Cost List and reimbursements made under a Maximum Allowable Cost List for a specific drug or drugs as:  (a) Not meeting the requirements of this section; or  (b) Being below the pharmacy acquisition cost.  (ii) The reasonable administrative appeal procedure shall include the following:  (a) A dedicated telephone number, email address, and website for the purpose of submitting administrative appeals;  (b) The ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and  (c) No less than thirty (30) business days to file an administrative appeal.  (B) The pharmacy benefits manager shall respond to the challenge under subdivision (c)(4)(A) of this section within thirty (30) business days after receipt of the challenge.  (C) If a challenge is made under subdivision (c)(4)(A) of this section, the pharmacy benefits manager shall within thirty (30) business days after receipt of the challenge either:  (i) If the appeal is upheld:  (a) Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;  (b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;  (c) Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and  (d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List;  (ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Arkansas that have the drug currently in stock at a price below the maximum allowable cost as listed on the Maximum Allowable Cost List; or  (iii) If the National Drug Code provided by the pharmacy benefits manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefits manager shall adjust the maximum allowable cost as listed on the Maximum Allowable Cost List above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.  (d) (1) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services.  (2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.  (e) A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefits manager if, as a result of a Maximum Allowable Cost List, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services.  (f) (1) This section does not apply to a Maximum Allowable Cost List maintained by the Arkansas Medicaid Program or the Employee Benefits Division.  (2) This section shall apply to the pharmacy benefits manager employed by the Arkansas Medicaid Program or the division if, at any time, the Arkansas Medicaid Program or the division engages the services of a pharmacy benefits manager to maintain a Maximum Allowable Cost List.  (g) (1) A violation of this section is a deceptive and unconscionable trade practice under the Deceptive Trade Practices Act, § 4-88-101 et seq., and a prohibited practice under the Arkansas Pharmacy Benefits Manager Licensure Act, § 23-92-501 et seq., and the Trade Practices Act, § 23-66-201 et seq.  (2) This section is not subject to § 4-88-113(f)(1)(B). |
| **CA** | Cal. B.P.C. Code §4430 and §4440 (2012) | DOI | **4430.**  For purposes of this chapter, the following definitions shall apply:  (a) “Carrier” means a health care service plan, as defined in Section 1345 of the Health and Safety Code, or a health insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code.  (b) “Clerical or recordkeeping error” includes a typographical error, scrivener’s error, or computer error in a required document or record.  (c) “Extrapolation” means the practice of inferring a frequency or dollar amount of overpayments, underpayments, nonvalid claims, or other errors on any portion of claims submitted, based on the frequency or dollar amount of overpayments, underpayments, nonvalid claims, or other errors actually measured in a sample of claims.  (d) “Health benefit plan” means any plan or program that provides, arranges, pays for, or reimburses the cost of health benefits. “Health benefit plan” includes, but is not limited to, a health care service plan contract issued by a health care service plan, as defined in Section 1345 of the Health and Safety Code, and a policy of health insurance, as defined in Section 106 of the Insurance Code, issued by a health insurer.  (e) “Maximum allowable cost” means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.  (f) “Maximum allowable cost list” means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.  (g) “Obsolete” means a drug that may be listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured.  (h) “Pharmacy” has the same meaning as provided in Section 4037.  (i) “Pharmacy audit” means an audit, either onsite or remotely, of any records of a pharmacy conducted by or on behalf of a carrier or a pharmacy benefits manager, or a representative thereof, for prescription drugs that were dispensed by that pharmacy to beneficiaries of a health benefit plan pursuant to a contract with the health benefit plan or the issuer or administrator thereof. “Pharmacy audit” does not include a concurrent review or desk audit that occurs within three business days of transmission of a claim, or a concurrent review or desk audit if a chargeback or recoupment is not demanded.  (j) “Pharmacy benefit manager” means a person, business, or other entity that, pursuant to a contract or under an employment relationship with a carrier, health benefit plan sponsor, or other third-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, plan sponsor, or other third-party payer, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.  **4440.**  (a) A pharmacy benefit manager that reimburses a contracting pharmacy for a drug on a maximum allowable cost basis shall comply with this section.  (b) A pharmacy benefit manager shall include in a contract, initially entered into, or renewed on its scheduled renewal date, on or after January 1, 2016, with the contracting pharmacy information identifying any national drug pricing compendia or other data sources used to determine the maximum allowable cost for the drugs on a maximum allowable cost list.  (c) A pharmacy benefit manager shall make available to a contracting pharmacy, upon request, the most up-to-date maximum allowable cost list or lists used by the pharmacy benefit manager for patients served by that pharmacy in a readily accessible, secure, and usable Web-based format or other comparable format.  (d) A drug shall not be included on a maximum allowable cost list or reimbursed on a maximum allowable cost basis unless all of the following apply:  (1) The drug is listed as “A” or “B” rated in the most recent version of the federal Food and Drug Administration’s approved drug products with therapeutic equivalent evaluations, also known as the Orange Book, or has an “NA,” “NR,” or “Z” rating or a similar rating by a nationally recognized pricing reference, such as Medi-Span or First DataBank.  (2) The drug is generally available for purchase in the state from a national or regional wholesaler.  (3) The drug is not obsolete.  (e) For contracts initially entered into, or renewed on the scheduled renewal date, on or after January 1, 2016, a pharmacy benefit manager shall review and shall make necessary adjustments to the maximum allowable cost of each drug on a maximum allowable cost list using the most recent data sources available at least once every seven days.  (f) For contracts initially entered into, or renewed on the scheduled renewal date, on or after January 1, 2016, a pharmacy benefit manager shall have a clearly defined process for a contracting pharmacy to appeal the maximum allowable cost for a drug on a maximum allowable cost list that includes all of the following:  (1) A contracting pharmacy may base its appeal on either of the following:  (A) The maximum allowable cost for a drug is below the cost at which the drug is available for purchase by similarly situated pharmacies in the state from a national or regional wholesaler.  (B) The drug does not meet the requirements of subdivision (d).  (2) A contracting pharmacy shall be provided no less than 14 business days following receipt of payment for the claim upon which the appeal is based to file an appeal with a pharmacy benefit manager. The pharmacy benefit manager shall make a final determination regarding a contracting pharmacy’s appeal within seven business days of the pharmacy benefit manager’s receipt of the appeal.  (3) If an appeal is denied by a pharmacy benefit manager, the pharmacy benefit manager shall provide to the contracting pharmacy the reason for the denial and the national drug code (NDC) of an equivalent drug that may be purchased by a similarly situated pharmacy at the price that is equal to or less than the maximum allowable cost of the appealed drug.  (4) If an appeal is upheld by a pharmacy benefit manager, the pharmacy benefit manager shall adjust the maximum allowable cost of the appealed drug for the appealing contracting pharmacy and all similarly situated contracting pharmacies in the state within one calendar day of the date of determination. The pharmacy benefit manager shall permit the appealing pharmacy to reverse and resubmit the claim upon which the appeal was based in order to receive the corrected reimbursement.  (g) A contracting pharmacy shall not disclose to any third party the maximum allowable cost list and any related information it receives either directly from a pharmacy benefit manager or through a pharmacy services administrative organization or similar entity with which the contracting pharmacy has a contract to provide administrative services for that pharmacy.  [**4441.**](javascript:submitCodesValues('4441.','4.25','2018','905','2',%20'id_09d34c16-0483-11e9-ab56-b19463a6a13d'))    (a) For purposes of this section, the following definitions shall apply:  (1) “Labeler” means a person or entity that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and who has a labeler code from the federal Food and Drug Administration under Part 207 of Title 21 of the Code of Federal Regulations.  (2) “Proprietary information” means information on pricing, costs, revenue, taxes, market share, negotiating strategies, customers, and personnel that is held by a pharmacy benefit manager and used for its business purposes.  (3) “Purchaser” means a health benefit plan sponsor or other third-party payer with whom a pharmacy benefit manager contracts to provide the administration and management of prescription drug benefits, except for a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.  (b) This section shall apply to pharmacy benefit manager contracts that are entered into, amended, or renewed on or after January 1, 2019.  (c) A pharmacy benefit manager shall exercise good faith and fair dealing.  (d) A pharmacy benefit manager shall notify a purchaser in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager’s duty to the purchaser to exercise good faith and fair dealing pursuant to subdivision (c).  (e) The pharmacy benefit manager shall, on a quarterly basis, disclose, upon the request of the purchaser, the following information with respect to prescription product benefits specific to the purchaser:  (1) The aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each therapeutic category of drugs containing three or more drugs, as outlined in the state’s essential health benefits benchmark plan pursuant to Section 1367.005 of the Health and Safety Code.  (2) The aggregate amount of rebates received by the pharmacy benefit manager by therapeutic category of drugs containing three or more drugs, as outlined in the state’s essential health benefits benchmark plan pursuant to Section 1367.005 of the Health and Safety Code. The aggregate amount of rebates shall include any utilization discounts the pharmacy benefit manager receives from a pharmaceutical manufacturer or labeler.  (3) Any administrative fees received from the pharmaceutical manufacturer or labeler.  (4) Whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a purchaser’s employees, insureds, or enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement.  (5) Prescription drug utilization information for the purchaser’s enrollees or insureds that is not specific to any individual enrollee or insured.  (6) The aggregate of payments, or the equivalent economic benefit, made by the pharmacy benefit manager to pharmacies owned or controlled by the pharmacy benefit manager.  (7) The aggregate of payments made by the pharmacy benefit manager to pharmacies not owned or collected by the pharmacy benefit manager.  (8) The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, and the application of those amounts collected pursuant to the contract with the purchaser.  (f) The information disclosed pursuant to subdivision (e) shall apply to all retail, mail order, specialty, and compounded prescription products.  (g) Except for utilization information specified in paragraph (5) of subdivision (e), a pharmacy benefit manager is not required to make the disclosures required by subdivision (e) unless and until the purchaser agrees, in writing, to maintain as confidential any proprietary information.  (h) A pharmacy benefit manager shall not impose a penalty or offer an inducement to a purchaser for the purpose of deterring the purchaser from requesting the information set forth in subdivision (e).  (i) A pharmacy benefit manager shall disclose to a pharmacy network provider or its contracting agent any material change to a contract provision that affects the terms of reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least 30 days before the date of the change to the provision.  (j) A pharmacy benefit manager shall not notify an individual receiving benefits through the pharmacy benefit manager that a pharmacy has been terminated from the pharmacy benefit manager’s network until the notification of termination has been provided to that pharmacy pursuant to subdivision (i).  (k) A pharmacy benefit manager shall not include in a contract with a pharmacy network provider or its contracting agent a provision that prohibits the provider from informing a patient of a less costly alternative to a prescribed medication.  (l) This section shall not apply to the following:  (1) A health care service plan or health insurer, if the health care service plan or health insurer offers, provides, or administers pharmacy benefit management services and if those services are offered, provided, or administered only to enrollees, subscribers, policyholders, or insureds who are also covered by health benefits offered, provided, or administered by that health care service plan or health insurer.  (2) An affiliate, subsidiary, related entity, or contracted medical group of a health care service plan or health insurer that would otherwise qualify as a pharmacy benefit manager, but offers, provides, or administers services only to enrollees, subscribers, policyholders, or insureds who are also covered by health benefits offered, provided, or administered by the health care service plan or health insurer.  (3) A contract authorized by Section 4600.2 of the Labor Code.  (m) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application. |
| **CO** | CO Rev Stat § 25-37-103.5 | DOI | (1) (a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. The pharmacy benefit manager shall update the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible.  (b) A pharmacy benefit manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with pricing changes in the marketplace.  (2) In order to place a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that:  (a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the orange book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and  (b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.  (3) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:  (a) A twenty-one-day limit on the right to appeal following the initial claim;  (b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;  (c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;  (d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial and the identification of the national drug code of a drug that may be purchased by the pharmacy at a price at or below the benchmark price as determined by the pharmacy benefit manager; and  (e) A requirement that a pharmacy benefit manager make an adjustment to a date no later than one day after the date of determination. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for another similarly situated pharmacy. |
| **DE** | Del. Code tit. 18, Chapter 33A §§ 3321A – 3324A | DOI | § 3321A. As used in this subchapter:  **(1)** "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device.**(2)** "Contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with a pharmacy benefits manager, a pharmacy services administration organization, or a group purchasing organization.**(3)** "Drug shortage list" means a list of drug products listed on the federal Food and Drug Administration's Drug Shortages website.**(4)** "Insurer" means any entity that provides health insurance coverage in this State as defined in § 903 of this title.  **(5)** "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacist or pharmacy for the cost of a multi-sourced drug, medical product, or device.**(6)** "Maximum allowable cost list" means the multi-source generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser.**(7)** "Network providers" means those pharmacists and pharmacies who provide covered health-care services or supplies to an insured or a member pursuant to a contract with an insurer or pharmacy benefits manager.**(8)** "Pharmacist" means as defined under § 2502 of Title 24.**(9)** "Pharmacy" means as defined under § 2502 of Title 24.**(10)** "Pharmacy benefits management services" means as defined under § 3351A of this title.**(11)** "Pharmacy benefits manager" means as defined under § 3302A of this title.**(12)** "Purchaser" means as defined under § 3351A of this title.  § 3322A. This subchapter does not apply to the Department of Health and Human Services in the performance of its duties in administering fee-for-service Medicaid under Titles XIX and XXI of the Social Security Act.  § 3323A. **(a)** To place a drug on a maximum allowable cost list, a pharmacy benefits manager must ensure that the drug meets all of the following requirements:**(1)** It is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference.**(2)** It is generally available for purchase by pharmacies in this State from national or regional wholesalers.**(3)** It is not obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage.**(4)** If it is manufactured by more than 1 manufacturer, the drug is available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from a wholesale distributor with a permit in this State, with whom the pharmacy has an existing relationship.**(5)** If it is manufactured by only 1 manufacturer, the drug is generally available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from at least 2 wholesale distributors with a permit in this State.  **(b)** A pharmacy benefits manager engaging in maximum allowable cost pricing must do all of the following:**(1)** Make available to each network provider at the beginning of the term of the network provider's contract, and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing.**(2)** Provide a process for a network pharmacy provider to readily access the most recent maximum allowable cost specific to that provider in an electronic format as updated in accordance with the requirements of this section.**(3)** Review and update maximum allowable cost price information at least once every 7 business days and update the information when there is a modification of maximum allowable cost pricing.**(4)** Ensure that dispensing fees are not included in the calculation of maximum allowable cost.**(5)** On the next day after a pricing information update under paragraph (b)(3) of this section, use the updated pricing information in calculating the payments made to all contracted pharmacies.**(6)** Maintain a procedure to eliminate products from the maximum allowable cost list as necessary to do all of the following: **a.** Remain consistent with price changes. **b.** Remove from the maximum allowable cost list a drug that no longer meets the requirements of subsection (a) of this section. **c.** Reflect the most recent availability of drugs in the marketplace.  § 3324A. **(a)** A pharmacy benefits manager must establish a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. A contracted pharmacy has 10 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug. A pharmacy benefits manager must respond with notice that the appeal has been denied or granted within 10 calendar days of the contracted pharmacy making the claim for which an appeal has been submitted.  **(b)** At the beginning of the term of a network provider's contract, and upon renewal, a pharmacy benefits manager must provide to network providers a telephone number and e-mail address at which a network provider can contact the pharmacy benefits manager to process an appeal under this section.**(c)** If an appeal is denied, the pharmacy benefits manager must provide the reason for the denial and the name and national drug code number of the national or regional wholesalers operating in this State that have the drug in stock at a price below the maximum allowable cost.**(d)** If the appeal is granted the pharmacy benefits manger shall do the following:**(1)** For an appealing pharmacy, do all of the following: **a.** Adjust the maximum allowable cost for the drug as of the date of the original claim for payment. **b.** Without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager as follows:**1.** For the original claim, in the first remittance to the pharmacy after the date the appeal was granted.**2.** For subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was granted.  **(2)** For a similarly situated contracted pharmacy in this State, do all of the following: **a.** Adjust the maximum allowable cost for the drug as of the date the appeal was granted. **b.** Provide notice to the pharmacy or the pharmacy's contracted agent of all of the following:**1.** That an appeal was granted.**2.** That without filing a separate appeal, the pharmacy or the pharmacy's contracted agent may reverse and rebill a similar claim.  **(e)** A pharmacy benefits manager shall make available on its website information about the appeal process, including all of the following:**(1)** A telephone number at which the contracted pharmacy may contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual specifically or leave a message for an individual or office who is responsible for processing appeals.**(2)** An email address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access.  **(f)** A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the re-adjudication of a claim resulting from a granted appeal under subsection (d) of this section or the granting of an appeal under subsection (h) of this section.  **(g)** A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal to the pharmacy benefits manager under subsection (a) of this section or to the Commissioner under subsection (h) of this section.  **(h)(1)** If a pharmacy benefits manager denies an appeal and a contracted pharmacy files an appeal with the Commissioner, the Commissioner shall do all of the following: **a.** Review the pharmacy benefits manager's compensation program to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subchapter and the terms of the contract. **b.** Based on a determination made by the Commissioner under paragraph (h)(1)a. of this section, do 1 of the following.**1.** Deny the appeal.**2.** Grant the appeal and order the pharmacy benefits manager to pay the claim in accordance with the Commissioner's findings.  **(2)** All pricing information and data collected by the Commissioner during a review required by paragraph (h)(1) of this section is confidential and not subject to subpoena or the Freedom of Information Act, Chapter 100 of Title 29. |
| **GA** | [Ga. Code Ann. §33-64-9.1 (2021)](https://codes.findlaw.com/ga/title-33-insurance/ga-code-sect-33-64-9-1.html) | OCI | (a)(1) Any methodologies utilized by a pharmacy benefits manager in connection with reimbursement pursuant to Code Section 33-64-9 shall be filed with the Commissioner for use in determining maximum allowable cost appeals;  provided, however, that methodologies not otherwise subject to disclosure under Article 4 of Chapter 18 of Title 50 shall be treated as confidential and shall not be subject to disclosure.  (2) A pharmacy benefits manager shall utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the national average drug acquisition cost list and shall produce a report every four months, which shall be provided to the Commissioner and published by the pharmacy benefits manager on a website available to the public for no less than 24 months, of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and above the national average drug acquisition cost.  For each drug in the report, a pharmacy benefits manager shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed per unit or dosage, whether the dispensing pharmacy was an affiliate, whether the drug was dispensed pursuant to a state or local government health plan, and the average national average drug acquisition cost for the month the drug was dispensed.  Such report shall exclude drugs dispensed pursuant to 42 U.S.C. Section 256b .  (3) This subsection shall not apply to Medicaid under Chapter 4 of Title 49 when the department reimburses providers directly for each covered service;  provided, however, that it shall apply to Medicaid managed care programs administered through care management organizations.  4) This subsection shall take effect on January 1, 2021;  provided, however, that prior to July 1, 2021, upon written request, a pharmacy benefits manager shall be granted an extension by the Commissioner of up to six months for its initial filing required pursuant to paragraph (1) of this subsection if the pharmacy benefits manager certifies it is in need  of such extension.  (b) On and after July 1, 2021, a pharmacy benefits manager shall not:  (1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy from the pharmacy benefit manager's network on the basis that the pharmacy dispenses drugs subject to an agreement under 42 U.S.C. Section 256b ;  or  (2) Engage in any practice that:  (A) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores, or metrics;  provided, however, that nothing shall prohibit pharmacy reimbursement for pharmacy care, including dispensing fees from being based on patient outcomes, scores, or metrics so long as the patient outcomes, scores, or metrics are disclosed to and agreed to by the pharmacy in advance;  (B) Includes imposing a point-of-sale fee or retroactive fee;  or  (C) Derives any revenue from a pharmacy or insured in connection with performing pharmacy benefits management services;  provided, however, that this shall not be construed to prohibit pharmacy benefits managers from receiving deductibles or copayments.  (c) This Code section shall also apply to pharmacy benefits managers' reimbursements to dispensers. |
| **IL** | [Ill. Rev. Stat. ch. 215 §5/513b1](https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021500050HArt%2E+XXXIIB&ActID=1249&ChapterID=22&SeqStart=144350000&SeqEnd=144498437) | DOI | **Sec. 513b1. Pharmacy benefit manager contracts.**  (a) As used in this Section:  "Biological product" has the meaning ascribed to that term in Section 19.5 of the Pharmacy Practice Act.  "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.  "Maximum allowable cost list" means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.  "Pharmacy benefit manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, for health benefit plans.  "Retail price" means the price an individual without prescription drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.  (b) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:  (1) Update maximum allowable cost pricing information at least every 7 calendar days.  (2) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.  (3) Provide access to its maximum allowable cost list to each pharmacy or pharmacy services administrative organization subject to the maximum allowable cost list. Access may include a real-time pharmacy website portal to be able to view the maximum allowable cost list. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.  (4) Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. The appeals process must, at a minimum, include the following:  (A) A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.  (B) A requirement that a pharmacy benefit manager must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.  (C) A telephone number and e-mail address or website to network providers, at which the provider can contact the pharmacy benefit manager to process and submit an appeal.  (D) A requirement that, if an appeal is denied, the pharmacy benefit manager must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers.  (E) A requirement that, if an appeal is sustained, the pharmacy benefit manager must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager.  (5) Allow a plan sponsor contracting with a pharmacy benefit manager an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to the pharmacy benefit manager by a pharmaceutical manufacturer.  (6) Allow a plan sponsor contracting with a pharmacy benefit manager to request that the pharmacy benefit manager disclose the actual amounts paid by the pharmacy benefit manager to the pharmacy.  (7) Provide notice to the party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer for dispense as written prescriptions once a generic or biologically similar product becomes available.  (c) In order to place a particular prescription drug on a maximum allowable cost list, the pharmacy benefit manager must, at a minimum, ensure that:  (1) if the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;  (2) the drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and  (3) the drug is not obsolete.  (d) A pharmacy benefit manager is prohibited from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act.  (e) A health insurer or pharmacy benefit manager shall not require an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:  (1) the applicable cost-sharing amount; or  (2) the retail price of the drug in the absence of prescription drug coverage.  (f) This Section applies to contracts entered into or renewed on or after July 1, 2020.  (g) This Section applies to any group or individual policy of accident and health insurance or managed care plan that provides coverage for prescription drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020. |
| **KS** | K.S.A. §§ 40-3822 and 40-3829 - 40-3830 | DOI | § 40-3822.  As used in this act:  **(a)** "Act" means the pharmacy benefits manager licensure act.**(b)** "Commissioner" means the commissioner of insurance as defined by K.S.A. 40-102, and amendments thereto.**(c)(1)** "Covered entity" means:**(A)** A nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization;**(B)** a health program administered by a department or the state in the capacity of provider of health coverage; or**(C)** an employer, labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state.**(2)** "Covered entity " does not include any:**(A)** Self-funded plan that is exempt from state regulation pursuant to ERISA;**(B)** plan issued for coverage for federal employees; or**(C)** health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.**(d)** "Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.**(e)** "Department" means the insurance department.**(f)** "ERISA" means the federal employee retirement income security act of 1974.**(g)** "Health benefit plan" means the same as defined in K.S.A. 40-4602, and amendments thereto.**(h)** "Health insurer" means the same as defined in K.S.A. 40-4602, and amendments thereto.**(i)** "Maximum allowable cost" or "MAC" means any term or methodology that a pharmacy benefits manager or a healthcare insurer may use to establish the maximum amount that a pharmacy benefits manager will reimburse a pharmacy or a pharmacist for generic drugs.**(j)** "Pharmacy benefits management" means:**(1)** Any of the following services provided with regard to the administration of the following pharmacy benefits:**(A)** Mail service pharmacy;**(B)** claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals;**(C)** clinical formulary development and management services;**(D)** rebate contracting and administration;**(E)** certain patient compliance, therapeutic intervention and generic substitution programs; or**(F)** disease management programs involving prescription drug utilization; and**(2)(A)** the procurement of prescription drugs by a prescription benefits manager at a negotiated rate for dispensation to covered individuals within this state; or**(B)** the administration or management of prescription drug benefits provided by a covered insurance entity for the benefit of covered individuals.**(k)** "Pharmacy benefits manager" means a person, business or other entity that performs pharmacy benefits management. "Pharmacy benefits manager" includes any person or entity acting in a contractual or employment relationship for a pharmacy benefits manager in the performance of pharmacy benefits management for a covered entity. "Pharmacy benefits manager" does not include a covered insurance entity.**(l)** "Person" means an individual, partnership, corporation, organization or other business entity.  § 40-3829. As used in this act:  **(a)** "List" means the list of drugs for which maximum allowable costs have been established;**(b)** "maximum allowable cost" or "MAC" means the same as defined in K.S.A. 40-3822, and amendments thereto;**(c)** "network pharmacy" means a pharmacy that contracts with a pharmacy benefits manager;**(d)** "pharmacy benefits manager" means the same as defined in K.S.A. 40-3822 , and amendments thereto;**(e)** "pharmacy benefits plan or pharmacy benefits program" means a plan or program that pays for, reimburses, covers the cost of or otherwise provides for pharmacist services to individuals who reside in or are employed in this state; and**(f)** "wholesaler" means a person or entity that sells and distributes prescription pharmaceutical products, including, but not limited to, a full line of brand name, generic and over-the-counter pharmaceuticals and that offers regular and private delivery to a pharmacy.  § 40-3830.  A pharmacy benefits manager, including the pharmacy benefits manager for the state healthcare benefits program, shall:  **(a)** Not place a drug on a MAC list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers and the national drug code for the drug is not obsolete;**(b)** provide to each network pharmacy at the beginning of the term of a contract and upon request thereafter, the sources utilized to determine the maximum allowable cost price;**(c)** provide a process for each network pharmacy provider to readily access the maximum allowable price specific to that provider;**(d)** review and update each applicable maximum allowable cost list every seven business days and apply the updates to reimbursements not later than one business day;**(e)** ensure that dispensing fees are not included in the calculation of maximum allowable cost;**(f)** establish a reasonable administrative appeal procedure to allow a pharmacy or pharmacy's contracting agent to challenge MAC for a specific drug as:**(1)** Not meeting the requirements of this section;**(2)** being below the cost at which the pharmacy may obtain the drug;**(g)** include in any administrative appeals procedure the following:**(1)** A dedicated telephone number and email address or website for the purpose of submitting administrative appeals; and**(2)** the ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization;**(h)** permit a network pharmacy or a network pharmacy's contracting agent to file an administrative appeal not later than 10 business days after the fill date;**(i)** require that the pharmacy benefits manager only request the following information to determine a MAC administrative appeal:**(1)** The prescription number;**(2)** the provider's name;**(3)** the national drug code used during the filing of the claim;**(4)** the date of the fill;**(5)** the reimbursement amount; and**(6)** such other information related to the appealed claim as required by contract; and**(j)(1)** provide a response to the appealing network pharmacy not later than 10 business days after receiving an appeal request containing information sufficient for the pharmacy benefits manager to process the appeal as specified by the contract.**(2)** If the appeal is upheld, the pharmacy benefits manager:**(A)** Shall make the adjustment in the drug price effective not later than one business day after the appeal is resolved;**(B)** shall make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the plan sponsor or pharmacy benefits manager, as appropriate; and**(C)** shall permit the appealing pharmacy to reverse and rebill the appealed claim.**(3)** If the appeal is denied, the pharmacy benefits manager shall provide the appealing pharmacy the reason for the denial and the national drug code number from a national or regional wholesaler operating in Kansas where the drug is generally available for purchase at a price equal to or less than the maximum allowable cost, and when applicable, may be substituted lawfully. |
| **KY** | KRS 304.17A-162 and  806 KAR 17:575 | DOI | **304.17A-162** Identification of sources used to calculate drug product reimbursement -- Process to appeal disputes over maximum allowable cost pricing -- Adjustment of maximum allowable cost and drug product reimbursement -- Duties of pharmacy benefit manager. (1) A pharmacy benefit manager shall: (a) Identify to contracted pharmacies the sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the pharmacy benefit manager; and (b) Establish a process for contracted pharmacies, pharmacy services administration organizations, or group purchasing organizations to appeal and resolve disputes regarding the maximum allowable cost pricing. The process shall include the following provisions: 1. 2. 3. 4. 5. The right to appeal shall be limited to sixty (60) days following the initial claim; The appeal shall be investigated and resolved by the pharmacy benefit manager within ten (10) calendar days; The pharmacy benefit manager shall respond to all appeals in a manner approved by the department; If the appeal is denied, the pharmacy benefit manager shall provide the reason for the denial and identify the national drug code of a drug product and source where it may be purchased from a licensed wholesaler by contracted pharmacies at a price at or below the maximum allowable cost; and If an appeal is granted, the provisions of subsection (2) of this section shall apply. (2) If a price update is warranted as a result of an appeal granted under subsection (1) of this section, the pharmacy benefit manager shall: (a) Make the change in the maximum allowable cost to the initial date of service the appealed drug was dispensed; (b) Adjust the maximum allowable cost of the drug for the appealing pharmacy and for all other contracted pharmacies in the network of that pharmacy benefit manager that filled a prescription for patients covered under the same health benefit plan to the initial date of service the appealed drug was dispensed; (c) Individually notify all other contracted pharmacies in the network of that pharmacy benefit manager that a retroactive maximum allowable cost adjustment has been made as a result of a granted appeal effective to the initial date of service the appealed drug was dispensed; (d) Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost if applicable to their contract; (e) Allow the appealing pharmacy and all other contracted pharmacies in the network that filled prescriptions for patients covered under the same health benefit plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and (f) Make retroactive price adjustments in the next payment cycle. (3) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to all contracted pharmacies information identifying the national drug pricing compendia or sources used to obtain the drug price data in a manner established by administrative regulations promulgated by the department. (4) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to all contracted pharmacies in a manner established by administrative regulations promulgated by the department the comprehensive list of drugs subject to maximum allowable cost and the actual maximum allowable cost for each drug. (5) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to the department, upon request, information that is needed to resolve an appeal. If the department is unable to obtain information from the pharmacy benefit manager that is necessary to resolve the appeal, the appeal shall be granted to the appealing pharmacy. (6) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall review and make necessary adjustments to the maximum allowable cost for every drug at least every seven (7) calendar days and shall immediately utilize the updated maximum allowable cost in calculating the payments made to all contracted pharmacies. (7) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to all contracted pharmacies in a manner established by administrative regulations promulgated by the department weekly updates to the list of drugs subject to maximum allowable cost and the actual maximum allowable cost for each drug. (8) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that drugs subject to maximum allowable costs are: (a) Generally available for purchase by pharmacists and pharmacies in Kentucky from a national or regional wholesaler licensed in Kentucky by the Kentucky Board of Pharmacy; 1. (b) Not obsolete, temporarily unavailable, or listed on a drug shortage list; and (c) Drugs that have an "A" or "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or 2. Drugs rated "NR" or "NA" or have a similar rating by a nationally recognized reference. (9) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a drug subject to maximum allowable cost is based solely on that drug and drugs that are therapeutically equivalent if the therapeutically equivalent drugs are listed in the most recent version of the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book. (10) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a "B" rated drug subject to maximum allowable cost is based solely on that drug and drugs that are not therapeutically equivalent to a "B" rating in the most recent version of the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book. (11) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a "NR" or "NA" drug with a similar rating by a nationally recognized reference subject to maximum allowable cost is based solely on that drug and other drugs with a "NR" or "NA" rating or similar rating by a nationally recognized reference that meets criteria for therapeutic equivalence used in the United States Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book. (12) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a drug subject to maximum allowable cost is based solely on that drug if there is no other therapeutically equivalent drug. (13) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a drug subject to maximum allowable cost is not based on a drug that is obsolete, temporarily unavailable, listed on a drug shortage list, or that cannot be lawfully substituted.  **806 KAR 17:575.Pharmacy benefit managers.**  RELATES TO: KRS 304.1-050, 304.2-160, 304.2-165, 304.9-020, 304.17A-161, 304.17A-162 STATUTORY AUTHORITY: KRS 304.2-110, 304.9-054, 304.17A-162  NECESSITY, FUNCTION, AND CONFORMITY:  KRS 304.2-110(1) authorizes the commissioner of the Department of Insurance to promulgate reasonable administrative regulations necessary for, or as an aid to, the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-162 requires the department to promulgate administrative regulations to establish the manner in which a pharmacy benefit manager shall respond to an appeal regarding maximum allowable cost pricing, the manner in which a pharmacy benefit manager shall make available the sources for drug pricing data to contracted pharmacies, a comprehensive list of drugs subject to maximum allowable cost and the actual maximum allowable cost for each drug, and weekly drug list updates. KRS 304.9-054 authorizes the department to promulgate administrative regulations to implement and enforce the provisions of KRS 304.17A-162 and specify the contents of any required forms or reports. This administrative regulation establishes requirements for a pharmacy benefit manager's maximum allowable cost appeals process, the process for the department's review of a complaint associated with a maximum allowable cost appeal, the requirements for the cost listings made available by a pharmacy benefit manager, and reporting requirements.  Section 1.  Definitions.  (1) "Contracted pharmacy" or "pharmacy" is defined by KRS 304.17A-161(1).  (2) "Department" is defined by KRS 304.1-050(2).  (3) "Maximum Allowable Cost" is defined by KRS 304.17A-161(3).  (4) "Pharmacy Benefit Manager" is defined by KRS 304.17A-161(4).  Section 2.  Maximum Allowable Cost Pricing Appeal Process.  (1) A pharmacy benefit manager shall establish a maximum allowable cost pricing appeal process that allows a contracted pharmacy or the pharmacy's designee to appeal if:  (a) The maximum allowable cost established for a drug reimbursement is below the cost at which the drug is available for purchase by pharmacists and pharmacies in Kentucky from national or regional wholesalers licensed in Kentucky by the Kentucky Board of Pharmacy; or  (b) The pharmacy benefit manager has placed a drug on the maximum allowable cost list in violation of KRS 304.17A-162(8).  (2) The pharmacy benefit manager shall accept an appeal submitted by a contracted pharmacy on or before sixty (60) days of the initial claim; and  (3) The pharmacy benefit manager's appeal process shall include the following:  (a) Notification to the appealing party that the appeal has been received, and the names, addresses, email addresses, and telephone numbers of the pharmacy benefit manager's contact persons for questions regarding the maximum allowable cost appeal process; and  (b) A provision allowing a contracted pharmacy, pharmacy service administration organization, or group purchasing organization to initiate the appeal process, regardless of whether an appeal has previously been submitted by a pharmacy or the pharmacy's designee outside of Kentucky, by contacting the pharmacy benefit manager's designated contact person electronically, by mail, or telephone. If the appeal process is initiated by telephone, the appealing party shall follow up with a written request within three (3) days.  (4) The pharmacy benefit manager's maximum allowable cost pricing appeal process shall be readily accessible to contracted pharmacies:  (a) Electronically;  (b) Through publication on the pharmacy benefit manager's website; and  (c) 1. In the contracted pharmacy's contract with the pharmacy benefit manager; or  2. Through a pharmacy provider manual distributed to contracted pharmacies, pharmacy service administration organizations, and group purchasing organizations.  (5) For an appeal received from a pharmacy services administration organization or a group purchasing organization related to a dispute regarding maximum allowable cost pricing, a pharmacy benefit manager may request documentation that the pharmacy services administration organization or group purchasing organization is acting on behalf of a contracted pharmacy before responding to the appeal.  (6) The pharmacy benefit manager shall investigate, resolve, and respond to the appeal within ten (10) calendar days of receipt of the appeal. Upon resolution, the pharmacy benefit manager shall issue a written response to the appealing party that shall include the following:  (a) The date of the decision;  (b) The name, phone number, mailing address, email address, and title of the person making the decision; and  (c) A statement setting forth the specific reason for the decision, including:  1. If the appeal is granted:  a. The amount of the adjustment to be paid retroactive to the initial date of service to the appealing pharmacy;  b. The drug name, national drug code, and prescription number of the appealed drug; and  c. The appeal number assigned by the pharmacy benefit manager, if applicable; or  2. If the appeal is denied:  a. The national drug code of the appealed drug, or the national drug code of a therapeutically equivalent drug as referenced in KRS 304.17A-162(9), of the same dosage, dosage form, and strength of the appealed drug; and  b. The Kentucky licensed wholesaler offering the drug at or below maximum allowable cost on the date of fill.  (7) If a pharmacy benefit manager grants an appeal for which a price update is warranted in accordance with KRS 304.17A-162(2), the pharmacy benefit manager shall individually notify contracted pharmacies of the date of the granted appeal, the appealed drug, initial date of service, national drug code, generic code number, applicable information to identify the health benefit plan, and retroactive price update by the time of release of the next scheduled maximum allowable cost update following the appeal decision by:  (a) Mail Courier;  (b) Electronic mail;  (c) Facsimile; or  (d) Web portal posting for sixty (60) days and corresponding electronic communication to a contracted pharmacy with hyperlink to the portal for the granted appeal. A pharmacy benefit manager shall include in the beginning and upon renewal of the contract with a pharmacy or the pharmacy's representative, notice and instructions for how to access and use the web portal.  (8) All contracted pharmacies permitted to reverse and resubmit claims following a granted appeal pursuant to KRS 304.17A-162(2) shall submit claims to the pharmacy benefit manager within sixty (60) days of notification that the appeal was granted.  (9) A pharmacy benefit manager shall submit the maximum allowable cost pricing appeal process and a template response satisfying the requirements of subsection (6) of this section to the department for review and approval.  Section 3.  Department Review of Maximum Allowable Cost Pricing Appeal.  (1) A contracted pharmacy or the pharmacy's designee may file a complaint with the department following a final decision of the pharmacy benefit manager, in accordance with KRS 304.2-160, 304.2-165, and 304.17A-162(5).  (2) A complaint shall be submitted to the department no later than thirty (30) calendar days from the date of the pharmacy benefit manager's final decision.  (3) The department shall be entitled to request additional information necessary to resolve a complaint from any party in accordance with KRS 304.2-165 and 304.17A-162(5).  Section 4.  Maximum allowable cost list availability and format.  (1) The comprehensive maximum allowable cost pricing list required under KRS 304.17A-162(4) shall:  (a) Be a complete listing by drug in an electronically accessible format;  (b) Identify the applicable health plan for which the pricing is applicable;  (c) Contain the ability to search and sort drugs electronically by individual drug name, national drug code, and generic code number;  (d) Contain data elements, including the drug name, national drug code, per unit price, and strength of drug;  (e) List a specific maximum allowable cost for each drug that will be reimbursed by the pharmacy benefit manager;  (f) Provide the effective date for that maximum allowable cost price; and  (g) Provide the date the maximum allowable cost list was updated.  (2) The pharmacy benefit manager shall retain, in accordance with subsection (1)(a) of this section, historical pricing data for a minimum of 120 days.  Section 5.  Weekly Updates to Maximum Allowable Cost Price List.  (1) Pharmacy benefit managers shall send to all contracted pharmacies one (1) weekly update to the maximum allowable cost price list, in accordance with the requirements of this section.  (2) The weekly update, required under 34.17A-162(7), shall:  (a) Be in an electronically accessible format on the pharmacy benefit manager's Web site; and  (b) Include the information below for all drugs added, removed, or changed in price since the last weekly update:  1. The basis for each drug's inclusion on the update;  2. If a drug is added to the maximum allowable cost list, the maximum allowable cost price;  3. All drugs removed from the maximum allowable cost list;  4. If a change in the maximum allowable cost price is made, the old price and new price;  5. The drug name, national drug code, generic code number, and the applicable health benefit plan information; and  6. The effective date of the change.  Section 6.  Data Source Availability. Each pharmacy benefit manager shall identify electronically or within contracts to all contracted pharmacies the national drug pricing compendia, or sources used to obtain drug price data for those drugs, subject to maximum allowable cost provisions. If any changes are made to the data sources following the execution of a contract, the pharmacy benefit manager shall individually notify the contracted pharmacies of the changes through correspondence submitted electronically, by facsimile, or by mail courier.  Section 7.  Annual report. All pharmacy benefit managers licensed to do business in Kentucky shall transmit a Pharmacy Benefit Manager Annual Report to the department at least annually, by March 31 of each year.  Section 8.  Incorporation by Reference.  (1) "Pharmacy Benefit Manager Annual Report," 06/2017, is incorporated by reference.  (2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, The Mayo-Underwood Building, 500 Mero Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. |
| **LA** | [La. Rev. Stat. Ann. §22:1860.3 (2018)](https://legis.la.gov/Legis/law.aspx?d=1108785) | DOI | §1860.3. Reimbursements  A. A pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this state an amount less than the amount that the pharmacy benefit manager reimburses an affiliate of the pharmacy benefit manager for providing the same services. The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number.  B.(1) Any pharmacy or pharmacist who has a contract, either directly or through a pharmacy services administration organization, with a pharmacy benefit manager administering any type of drug or pharmacy benefit plan to provide covered drugs, devices, or services at a contractual reimbursement rate may decline to provide a covered drug, device, or service if the pharmacy or pharmacist will be or is paid less than the acquisition cost for the covered drug, device, or service.  (2) If the pharmacy or pharmacist declines to provide the drug, device, or service as authorized in this Subsection, then the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug, device, or service may be filled.  (3) No pharmacy benefit manager, pharmacy services administration organization, or any person acting for or on behalf of a pharmacy benefit manager or pharmacy services administration organization shall cancel any contract with the pharmacy or pharmacist, sue for breach of contract, use the decision to decline as a cause for not renewing the  contract, or retaliate against or penalize the pharmacy or pharmacist in any way.  C. The commission of any act prohibited by this Section shall be considered an unfair method of competition and unfair practice or act which shall subject the violator to any and all actions, including investigative demands, private actions, remedies, and penalties, provided for in the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq.  D. Any provision of a contract that is contrary to any provision of this Section shall be null, void, and unenforceable in this state. |
| **MD** | MD. ANN. CODE § 15-1628.1 and §15-1628.2 | DOI | § 15-1628.1. (a) (1) In this section the following words have the meanings indicated.  (2) “Drug shortage list” means a list of drug products listed on the federal Food and Drug Administration’s Drug Shortages website.  (3) (i) “Maximum allowable cost” means the maximum amount that a pharmacy benefits manager or a purchaser will reimburse a contracted pharmacy for the cost of a multisource generic drug, a medical product, or a device.  (ii) “Maximum allowable cost” does not include dispensing fees.  (4) “Maximum allowable cost list” means a list of multisource generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser.  (b) In each participating pharmacy contract, the pharmacy benefits manager shall include the sources used to determine maximum allowable cost pricing.  (c) A pharmacy benefits manager shall:  (1) update its pricing information at least every 7 days;  (2) establish a reasonable process by which a contracted pharmacy has access to the current and applicable maximum allowable cost price lists in an electronic format as updated in accordance with the requirements of this section; and  (3) immediately after a pricing information update under item (1) of this subsection, use the updated pricing information in calculating the payments made to all contracted pharmacies.  (d) (1) A pharmacy benefits manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing as necessary to:  (i) remain consistent with pricing changes;  (ii) remove from the list drugs that no longer meet the requirements of subsection (e) of this section; and  (iii) reflect the current availability of drugs in the marketplace.  (2) A product on the maximum allowable cost list shall be eliminated from the list by the pharmacy benefits manager within 7 days after the pharmacy benefits manager knows of a change in the availability of the product.  (e) Before placing a prescription drug on a maximum allowable cost list, a pharmacy benefits manager shall ensure that:  (1) the drug is listed as “A” or “B” rated in the most recent version of the U.S. Food and Drug Administration’s approved drug products with therapeutic equivalence evaluations, also known as the Orange Book, or has an “NR” or “NA” rating or similar rating by a nationally recognized reference;  (2) (i) if a drug is manufactured by more than one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from a wholesale distributor with a permit in the State; or  (ii) if a drug is manufactured by only one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from at least two wholesale distributors with a permit in the State; and  (3) the drug is not obsolete, temporarily unavailable, or listed on a drug shortage list as currently in shortage.  (f) For disputes regarding maximum allowable cost pricing, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:  (1) a requirement that an appeal be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim;  (2) a requirement that, within 21 days after the date the appeal is filed, the pharmacy benefits manager investigate and resolve the appeal and report to the contracted pharmacy on the pharmacy benefits manager’s determination on the appeal;  (3) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including:  (i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;  (ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and  (iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business days or less of receiving the call or e–mail;  (4) a requirement that a pharmacy benefits manager provide:  (i) a reason for any appeal denial;  (ii) the national drug code of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the maximum allowable cost determined by the pharmacy benefits manager; and  (iii) the mathematical calculation used to determine the maximum allowable cost; and  (5) if an appeal is upheld, a requirement that a pharmacy benefits manager:  (i) for the appealing pharmacy:  1. adjust the maximum allowable cost for the drug as of the date of the original claim for payment; and  2. without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager:  A. for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and  B. for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined; and  (ii) for a similarly situated contracted pharmacy in the State:  1. adjust the maximum allowable cost for the drug as of the date the appeal was determined; and  2. provide notice to the pharmacy or pharmacy’s contracted agent that:  A. an appeal has been upheld; and  B. without filing a separate appeal, the pharmacy or the pharmacy’s contracted agent may reverse and rebill a similar claim.  (g) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this subsection.  (h) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from carrying out the requirement of a contract specified in subsection (f)(5) of this section or the upholding of an appeal under subsection (i) of this section.  (i) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall:  (i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and  (ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner’s findings.  (2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner’s review under paragraph (1) of this subsection.  (3) All information and data collected by the Commissioner during a review:  (i) is considered to be confidential and proprietary information; and  (ii) is not subject to disclosure under the Public Information Act.  § 15-1628.2. (a) For disputes regarding cost pricing and reimbursement under a participating pharmacy contract, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement that includes:  (1) a requirement that an appeal be filed by the contract pharmacy not later than 21 days after: (i) the date a direct or indirect remuneration fee is charged; or (ii) another date as determined by the Commissioner;  (2) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including: (i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals; (ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and (iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business days or less after receiving the call or e–mail;  (3) a requirement that a pharmacy benefits manager provide: (i) a reason for any appeal denial; and (ii) the mathematical calculation used to determine the amount of reimbursement; and  (4) if an appeal is upheld, a requirement that a pharmacy benefits manager: (i) make adjustments as necessary to comply with the compensation program as stated in the participating pharmacy contract as of the date the appeal was determined; and (ii) provide notice to the pharmacy or pharmacy’s contracted agent that an appeal has been upheld.  (b) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this section.  (c) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from the upholding of an appeal under subsection (d) of this section.  (d) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall: (i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and (ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner’s findings.  (2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner’s review.  (3) All information and data collected by the Commissioner during a review: (i) is considered to be confidential and proprietary information; and (ii) is not subject to disclosure under the Public Information Act. |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4350 (applies through a carrier contract with a PBM) | DOI | **1.  Single maximum allowable cost list.**A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand‑name drug that has at least one generic alternative available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider.  **2.  Listing of prescription drug.**A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:  A. Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and  B. Is not obsolete and is generally available for purchase in this State from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.  **3.  Changes to maximum allowable cost list.**A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a process for removing a prescription drug from a maximum allowable cost list or modifying a maximum allowable cost for a prescription drug in a timely manner to remain consistent with changes to such costs and the availability of the drug in the national marketplace.  **4.  Disclosure.**With regard to a pharmacy with which the carrier, or the pharmacy benefits manager under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits manager under contract with a carrier, shall:  A. Upon request, disclose the sources used to establish the maximum allowable costs;  B. Provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a maximum allowable cost list; and  C. At least once every 7 business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable payment available to a pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits manager under contract with a carrier.  **5.  Appeal procedure.**A carrier, or a pharmacy benefits manager under contract with a carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.  **6.  Resolution of appeals.**A carrier, or a pharmacy benefits manager under contract with a carrier, shall respond to, investigate and resolve an appeal under subsection 5 within 14 days after the receipt of the appeal. The carrier or pharmacy benefits manager shall respond to an appeal as follows:  A. If the appeal is upheld, the carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or   [PL 2019, c. 469,  B. If the appeal is denied, the carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.  **7.  Average wholesale price; use of a prescription drug not on maximum allowable cost list.**A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the average wholesale price to establish the maximum payment for a brand‑name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand‑name drug or prescription drug not included on a maximum allowable cost list, a carrier, or a pharmacy benefits manager under contract with a carrier, must use only one national drug pricing source during a calendar year, except that a carrier, or a pharmacy benefits manager under contract with a carrier, may use a different national drug pricing source if the original pricing source is no longer available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.  **8.  Payment.**This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider.  A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost‑sharing amount paid by a covered person.  B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier.  C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection.  D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error. |
| **NJ** | N.J.S.A. §17B:27F-2 | DOI | 2. Upon execution or renewal of each contract, or at such a time when there is any material change in the term of the contract, a pharmacy benefits manager shall, with respect to contracts between a pharmacy benefits manager and a pharmacy services administrative organization, or between a pharmacy benefits manager and a contracted pharmacy:  a. (1) include in the contract the sources utilized to determine multiple source generic drug pricing, brand drug pricing, and the wholesaler in the State of New Jersey where pharmacies may acquire the product including, if applicable, the brand effective rate, generic effective rate, dispensing fee effective rate, maximum allowable cost or any other pricing formula for pharmacy reimbursement;  (2) update that pricing information every seven calendar days; and  (3) establish a reasonable process by which contracted pharmacies have a method to access relevant maximum allowable cost pricing lists, brand effective rate, generic effective rate, and dispensing fee effective rate, or any other pricing formulas for pharmacy reimbursement; and  b. Maintain a procedure to eliminate drugs from the list of drugs subject to multiple source generic drug pricing and brand drug pricing, or modify maximum allowable cost rates, brand effective rate, generic effective rate, dispensing fee effective rate or any other applicable pricing formula in a timely fashion and make that procedure easily accessible to the pharmacy services administrative organizations or the pharmacies that they are contractually obligated with to provide that information according to the requirements of this section. |
| **NM** | N.M. Stat. § 59A-61-4 | DOI | Pharmacy reimbursement practices for generic drugs; appeals process required.  A. A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources.  B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service.  C. A pharmacy benefits manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the drug:(1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;(2) is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book".  D. A pharmacy benefits manager using maximum allowable cost pricing shall:(1) upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;(2) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;(3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in at least seven business days to remain consistent with pricing changes and product availability in the marketplace;(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:(a) directly to the pharmacy benefits manager; or(b) through a pharmacy services administrative organization;(5) provide an appeals process that, at a minimum, includes the following:(a) a dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;(b) the ability to submit an appeal directly to the pharmacy benefits manager; and(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;(9) within one business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision;(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and(11) provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the maximum allowable cost list specific to that provider.  E. A maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefits manager is confidential.  F. Pursuant to Section 59A-4-3 NMSA 1978, a pharmacy benefits manager shall provide information contained in a maximum allowable cost list to the superintendent upon request by the superintendent. |
| **OR** | Oregon Rev. Stat.  § 735.534 (2) and (4) | DOI | (2) A pharmacy benefit manager registered under ORS 735.532:  (a) May not place a drug on a list unless there are at least two multiple source drugs, or at least one generic drug generally available for purchase.  (b) Shall ensure that all drugs on a list are generally available for purchase.  (c) Shall ensure that no drug on a list is obsolete.  (d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the specific authoritative industry sources, other than proprietary sources, the pharmacy benefit manager uses to determine the maximum allowable cost set by the pharmacy benefit manager.  (e) Shall make a list available to a network pharmacy upon request in a format that:  (A) Is electronic;  (B) Is computer accessible and searchable;  (C) Identifies all drugs for which maximum allowable costs have been established; and  (D) For each drug specifies:  (i) The national drug code; and  (ii) The maximum allowable cost.  (f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in the format described in paragraph (e) of this subsection.  (g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost.  (h) May not reimburse a 340B pharmacy differently than any other network pharmacy based on its status as a 340B pharmacy.  (4) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. The process must allow a network pharmacy a period of no less than 60 days after a claim is reimbursed in which to file the appeal. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.  (5) A pharmacy benefit manager shall allow a network pharmacy to submit the documentation in support of its appeal on paper or electronically and may not:  (a) Refuse to accept an appeal submitted by a person authorized to act on behalf of the network pharmacy;  (b) Refuse to adjudicate an appeal for the reason that the appeal is submitted along with other claims that are denied; or  (c) Impose requirements or establish procedures that have the effect of unduly obstructing or delaying an appeal.  (6) A pharmacy benefit manager must provide as part of the appeals process established under subsection (4) of this section:  (a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals;  (b) A final response to an appeal of a maximum allowable cost within seven business days; and  (c) If the appeal is denied, the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.  (7)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall:  (A) Make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward; and  (B) Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any additional charges.  (b) If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies.  (8) This section does not apply to the state medical assistance program. |
| **PA** | 40 Pa. Stat. § 4531 | DOI | **(a) General rule.**--In order to place a particular drug on a multiple source generic list, a PBM shall, at a minimum, ensure that:(1) The drug is listed as "A" or "B" rated in the most recent version of the Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," commonly known as the orange book, or "NR" or "NA" rated, or similar rating, by a nationally recognized reference;(2) There are at least two therapeutically equivalent multiple source drugs or at least one generic drug available from only one manufacturer; and(3) The drug is available for purchase by all pharmacies in this commonwealth from national or regional wholesalers and is not obsolete or temporarily unavailable.  **(b)Removal from listing.**--A PBM must maintain a procedure to eliminate drugs from the list of drugs subject to multiple source drug pricing or modify the maximum allowable cost in a timely fashion.  **(c)Substitutions.**--A PBM may not penalize a pharmacist or pharmacy on audit if the pharmacist or pharmacy performs a generic substitution pursuant to the Act of November 24, 1976 ( P.L. 1163, No.259), referred to as the Generic Equivalent Drug Law. |
| **SC** | SC Code § 38-71-2240 (2020) | DOI | (A) Before a pharmacy benefits manager places or continues to place a particular drug on a Maximum Allowable Cost List, the drug must:  (1) be listed as "A" or "B" rated in the most recent version of the Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating, or a similar rating, by a nationally recognized reference;  (2) be available for purchase in the State from national or regional wholesalers operating in this State; and  (3) not be obsolete.  (B) A pharmacy benefits manager shall:  (1) provide a process for network pharmacy providers to readily access the maximum allowable cost specific to that provider;  (2) update its Maximum Allowable Cost List at least once every seven calendar days;  (3) provide a process for each pharmacy subject to the Maximum Allowable Cost List to access any updates to the Maximum Allowable Cost List;  (4) ensure that dispensing fees are not included in the calculation of maximum allowable cost; and  (5) establish a reasonable administrative appeal procedure by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing if the reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. The reasonable administrative appeal procedure must include:  (a) a dedicated telephone number and email address or website for the purpose of submitting administrative appeals; and  (b) the ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the pharmacy benefits manager that allows for the submission of such appeals.  (C) A pharmacy must be allowed no less than ten calendar days after the applicable fill date to file an administrative appeal.  (D) If an appeal is initiated, the pharmacy benefits manager shall within ten calendar days after receipt of notice of the appeal either:  (1) if the appeal is upheld:  (a) notify the pharmacy or pharmacist or his designee of the decision;  (b) make the change in the maximum allowable cost effective as of the date the appeal is resolved;  (c) permit the appealing pharmacy or pharmacist to reverse and rebill the claim in question; and  (d) make the change effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List effective as of the date the appeal is resolved; or  (2) if the appeal is denied, provide the appealing pharmacy or pharmacist the reason for the denial, the National Drug Code number, and the name of the national or regional pharmaceutical wholesalers operating in this State.  (E) The provisions of this section:  (1) do not apply to the Maximum Allowable Cost List maintained by the State Medicaid Program, the Medicaid managed care organizations under contract with the South Carolina Department of Health and Human Services or the South Carolina Public Employee Benefit Authority; and  (2) apply to the pharmacy benefits manager employed by the South Carolina Public Employee Benefit Authority if, at any time, the South Carolina Public Employee Benefit Authority engages the services of a pharmacy benefits manager to maintain the Maximum Allowable Cost List. |
| **TX** | [Texas Insurance Code Chapter 1369, Subchapter H](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.351) | DOI | **Sec. 1369.353. CRITERIA FOR DRUGS ON MAXIMUM ALLOWABLE COST LISTS.** A health benefit plan issuer or pharmacy benefit manager may not include a drug on a maximum allowable cost list unless:  (1) the drug:  (A) has an "A" or "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or  (B) is rated "NR" or "NA" or has a similar rating by a nationally recognized reference; and  (2) the drug is:  (A) generally available for purchase by pharmacists and pharmacies in this state from a national or regional wholesaler; and  (B) not obsolete.  **Sec. 1369.354. FORMULATION OF MAXIMUM ALLOWABLE COSTS; DISCLOSURES.** (a) In formulating the maximum allowable cost price for a drug, a health benefit plan issuer or pharmacy benefit manager may only use the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.  (b) Notwithstanding Subsection (a), if a therapeutically equivalent generic drug is unavailable or has limited market presence, a health benefit plan issuer or pharmacy  benefit manager may place on a maximum allowable cost list a drug that has:  (1) a "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or  (2) an "NR" or "NA" rating or a similar rating by a nationally recognized reference.  (c) A health benefit plan issuer or pharmacy benefit manager must, in accordance with Subsection (d), disclose to a pharmacist or pharmacy the sources of the pricing data used in formulating maximum allowable cost prices.  (d) The information described by Subsection (c) must be disclosed:  (1) on the date the health benefit plan issuer or pharmacy benefit manager enters into the contract with the pharmacist or pharmacy; and  (2) after that contract date, on the request of the pharmacist or pharmacy.  **Sec. 1369.355. UPDATES.** (a) A health benefit plan issuer or pharmacy benefit manager shall establish a process that will in a timely manner eliminate drugs from maximum allowable cost lists or modify maximum allowable cost prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.  (b) A health benefit plan issuer or pharmacy benefit manager shall review and update maximum allowable cost price information for each drug at least once every seven days to reflect any modification of maximum allowable cost pricing.  **Sec. 1369.356. ACCESS TO MAXIMUM ALLOWABLE COST LISTS.** A health benefit plan issuer or pharmacy benefit manager must provide to each pharmacist or pharmacy under contract with the health benefit plan issuer or pharmacy benefit manager a process to readily access the maximum allowable cost list that applies to the pharmacist or pharmacy.  **Sec. 1369.357. APPEAL FROM MAXIMUM ALLOWABLE COST PRICE DETERMINATION.** (a) A health benefit plan issuer or pharmacy benefit manager must provide in the contract with each pharmacist or pharmacy a procedure for the pharmacist or pharmacy to appeal a maximum allowable cost price of a drug on or before the 10th day after the date a pharmacy benefit claim for the drug is made.  (b) The health benefit plan issuer or pharmacy benefit manager shall respond to an appeal described by Subsection (a) in a documented communication not later than the 10th day after the date the appeal is received by the health benefit plan issuer or pharmacy benefit manager.  (c) If the appeal is successful, the health benefit plan issuer or pharmacy benefit manager shall:  1) adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;  (2) apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health benefit plan issuer or pharmacy benefit manager; and  (3) allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefit claim giving rise to the appeal.  (d) If the appeal is not successful, the health benefit plan issuer or pharmacy benefit manager shall disclose to the pharmacist or pharmacy:  (1) each reason the appeal is denied; and  (2) the national drug code number from the national or regional wholesalers from which the drug is generally available for purchase by pharmacists and pharmacies in this state at the maximum allowable cost price that is the subject of the appeal.  **Sec. 1369.358. CONFIDENTIALITY OF MAXIMUM ALLOWABLE COST LIST.** A maximum allowable cost list that applies to a pharmacist or pharmacy and is maintained by a health benefit plan issuer or pharmacy benefit manager is confidential. This section may not be construed to alter a health benefit plan issuer's or pharmacy benefit manager's obligations under Section 1369.356.  **Sec. 1369.359. WAIVER PROHIBITED.** The provisions of this subchapter may not be waived, voided, or nullified by contract.  **Sec. 1369.360. REMEDIES NOT EXCLUSIVE.** This subchapter may not be construed to waive a remedy at law available to a pharmacist or pharmacy.  **Sec. 1369.361. ENFORCEMENT.** The commissioner shall enforce this subchapter.  **Sec. 1369.362. LEGISLATIVE DECLARATION.** It is the intent of the legislature that, except with respect to the benefits excluded under Section 1369.352, the requirements contained in this subchapter apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law. |
| **UT** | Utah Code Ann. § 31A-46-302(1), (2) and (3) and § 31A-46-303 | DOI | § 31A-46-302. (1) If a pharmacy service entity engages in direct or indirect remuneration with a pharmacy, the pharmacy service entity shall make a reimbursement report available to the pharmacy upon the pharmacy's request. (2) For the reimbursement report described in Subsection (1), the pharmacy service entity shall: (a) include the adjusted compensation amount related to a claim and the reason for the adjusted compensation; and (b) provide the reimbursement report: (i) in accordance with the contract between the pharmacy and the pharmacy service entity; (ii) in an electronic format that is easily accessible; and (iii) within 120 days after the day on which the pharmacy benefit manager receives a report of a sale of a product or service by the pharmacy. (3) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy with: (a) the reasons for any adjustments contained in a reimbursement report; and (b) an explanation of the reasons provided in Subsection (3)(a).  § 31A-46-303. (1) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622. (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless: (a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and (b) the drug is: (i) generally available for purchase in this state from a national or regional wholesaler; and (ii) not obsolete. (3) The maximum allowable cost may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. (4) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall: (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data; (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (4)(a), at least once per week; (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (5); and (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible. (5) (a) The right to appeal in Subsection (4)(c) shall be: (i) limited to 21 days following the initial claim adjudication; and (ii) investigated and resolved by the pharmacy benefit manager within 14 business days. (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager. (6) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract. (7) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the Medicaid program. |
| **WA** | [Wash. Rev. Code Ann. §48.200.280 (2022)](https://app.leg.wa.gov/RCW/default.aspx?cite=48.200.280) | DOI | **Predetermination of reimbursement costs—Appeals—Review by commissioner.**  (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.  (a) "List" means the list of drugs for which predetermined reimbursement costs have been established, such as a maximum allowable cost or maximum allowable cost list or any other benchmark prices utilized by the pharmacy benefit manager and must include the basis of the methodology and sources utilized to determine multisource generic drug reimbursement amounts.  (b) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers.  (c) "Multisource generic drug" means any covered outpatient prescription drug for which there is at least one other drug product that is rated as therapeutically equivalent under the food and drug administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations;" is pharmaceutically equivalent or bioequivalent, as determined by the food and drug administration; and is sold or marketed in the state during the period.  (d) "Network pharmacy" means a retail drug outlet licensed as a pharmacy under RCW [**18.64.043**](http://app.leg.wa.gov/RCW/default.aspx?cite=18.64.043) that contracts with a pharmacy benefit manager.  (e) "Therapeutically equivalent" has the same meaning as in RCW [**69.41.110**](http://app.leg.wa.gov/RCW/default.aspx?cite=69.41.110).  (2) A pharmacy benefit manager:  (a) May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers;  (b) Shall ensure that all drugs on a list are readily available for purchase by pharmacies in this state from national or regional wholesalers that serve pharmacies in Washington;  (c) Shall ensure that all drugs on a list are not obsolete;  (d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the predetermined reimbursement costs for multisource generic drugs of the pharmacy benefit manager;  (e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy;  (f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format;  (g) Shall ensure that dispensing fees are not included in the calculation of the predetermined reimbursement costs for multisource generic drugs;  (h) May not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;  (i) May not charge a pharmacy a fee related to the adjudication of a claim, credentialing, participation, certification, accreditation, or enrollment in a network including, but not limited to, a fee for the receipt and processing of a pharmacy claim, for the development or management of claims processing services in a pharmacy benefit manager network, or for participating in a pharmacy benefit manager network;  (j) May not require accreditation standards inconsistent with or more stringent than accreditation standards established by a national accreditation organization;  (k) May not reimburse a pharmacy in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for providing the same pharmacy services; and  (l) May not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless:  (i) The original claim was submitted fraudulently; or  (ii) The denial or reduction is the result of a pharmacy audit conducted in accordance with RCW [**48.200.220**](http://app.leg.wa.gov/RCW/default.aspx?cite=48.200.220).  (3) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to predetermined reimbursement costs for multisource generic drugs. A network pharmacy may appeal a predetermined reimbursement cost for a multisource generic drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within thirty calendar days of the pharmacy submitting the appeal. If after thirty days the network pharmacy has not received the decision on the appeal from the pharmacy benefit manager, then the appeal is considered denied.  The pharmacy benefit manager shall uphold the appeal of a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella if the pharmacy or pharmacist can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the pharmacy benefit manager's list price. |
| **WV** | Code of West Virginia § 33-51-9(f)-(i) and (k) | DOI | (f) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of $10.49: *Provided,*That if the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a professional dispensing fee of $10.49.  (g) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the pharmacy benefit manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.  (h) The commissioner may order reimbursement to an insured, pharmacy, or dispenser who has incurred a monetary loss as a result of a violation of this article or legislative rules implemented pursuant to this article.  (i) (1) Any methodologies utilized by a pharmacy benefits manager in connection with reimbursement shall be filed with the commissioner at the time of initial licensure and at any time thereafter that the methodology is changed by the pharmacy benefit manager for use in determining maximum allowable cost appeals. The methodologies are not subject to disclosure and shall be treated as confidential and exempt from disclosure under the West Virginia Freedom of Information Act [**§29B-1-4**](https://code.wvlegislature.gov/29B-1-4)(a)(1) of this code.  (2) A pharmacy benefits manager shall utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy’s reimbursement for drugs appearing on the national average drug acquisition cost list.  (k) A pharmacy benefits manager shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug: *Provided,* That a pharmacy benefits manager shall charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, the same price for a prescription drug as it pays a pharmacy for the prescription drug. |

PHARMACISTS AND PHARMACY NETWORK PARTICIPATION – FEBRUARY 2023

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **NE** | Nebraska Revised Statute §44-4610 | DOI | A pharmacy benefit manager shall not exclude a Nebraska pharmacy from participation in the pharmacy benefit manager's specialty pharmacy network if:  (1) The pharmacy holds a specialty pharmacy accreditation from a nationally recognized independent accrediting organization; and  (2) The pharmacy is willing to accept the terms and conditions of the pharmacy benefit manager's agreement with the pharmacy benefit manager's specialty pharmacies. |
| **PA** | 40 P.S. § 764*l* | DOI | **(a)** A health insurance policy or government program providing benefits for prescriptions shall not impose on a covered individual utilizing a retail pharmacy a copayment, deductible, fee, limitation on benefits or other condition or requirement not otherwise imposed on the covered individual when using a mail order pharmacy.  **(b)**Subsection (a) shall apply only if the retail pharmacy is willing to accept from the insurer the same pricing, terms, conditions or requirements related to the cost of the prescriptions and the cost and quality of dispensing prescriptions that the insurer has established for a mail order pharmacy and any of such pharmacy's affiliates, including any affiliated pharmacy benefit manager, pursuant to the health insurance policy.  **(c)**Beginning eighteen months after the effective date of this section, the Legislative Budget and Finance Committee shall conduct an evaluation of the impact of this section regarding the access to prescription drugs at both independent and chain retail pharmacies and whether the provisions of this section have had a material positive or negative impact upon the cost of prescription medications to consumers and health care plans and shall issue a report to the General Assembly within nine months of the commencement of the study regarding its findings and recommendations.  **(d)** As used in this section:  **(1)**"Government program" means any of the following:**(i)**The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."**(ii)**The Children's Health Care Program established under Article XXIII.**(iii)**The program of pharmaceutical assistance for the elderly established under Chapter 5 of the act of August 26, 1971 (P.L.351, No.91), known as the "State Lottery Law."  **(2)** "Health insurance policy" means a group or individual health or sickness or accident insurance policy, subscriber contract or certificate issued by an entity subject to any one of the following:**(i)** This act.**(ii)** The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."**(iii)**40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).The term does not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.  **(3)** "Insurer" means any entity that issues a group or individual health, sickness or accident policy or subscriber contract described under paragraph (2).  **(4)** "Mail order pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act," where prescriptions are dispensed to covered individuals via the mail.  **(5)** "Prescription" and "dispensing" mean those terms as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act."  **(6)** "Retail pharmacy" means a pharmacy as defined in the act of September 27, 1961 (P.L.1700, No.699), known as the "Pharmacy Act," where prescriptions are able to be dispensed to covered individuals on the premises of such pharmacy. |
| **SC** | S.C. Code §38-71-147(2) (applies to the health carrier through a contract to provide pharmacy services) | DOI | An individual or group accident and health or health insurance policy or a health maintenance organization plan may not deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services including, but not limited to, prescription drugs that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer. |
| **WV** | Code of West Virginia § 33-51-11 | DOI | (a) A pharmacy benefits manager or health benefit plan may not:  (1) Prohibit or limit any covered individual from selecting a pharmacy or pharmacist of his or her choice who has agreed to participate in the plan according to the terms offered by the insurer;  (2) Deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including, but not limited to, prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;  (3) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under the health benefit plan when receiving services from a contract provider;  (4) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary’s choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;  (5) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area;  (6) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or  (7) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service.  (b) If a health benefit plan providing reimbursement to West Virginia residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least 60 days prior to the effective date of the plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.  (c) The Insurance Commissioner shall not approve any pharmacy benefits manager or health benefit plan providing pharmaceutical services which do not conform to this section.  (d) Any covered individual or pharmacy injured by a violation of this section may maintain a cause of action to enjoin the continuance of any such violation.  (e) This section shall apply to all pharmacy benefits managers and health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of West Virginia. For purposes of this section, “health benefit plan” means any entity or program that provides reimbursement for pharmaceutical services. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services. |
|  |  |  |  |

PHARMACY AUDIT PROCEDURES – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AK** | AK Stat §§ 21.27.910 through 940 (2020) | DOI | § 21.27.910  (a) When a pharmacy benefits manager conducts an audit of the records of a pharmacy, the period covered by the audit of a claim may not exceed two years from the date that the claim was submitted to or adjudicated by the pharmacy benefits manager, whichever is earlier. Except as required under AS 21.36.495, a claim submitted to or adjudicated by a pharmacy benefits manager does not accrue interest during the audit period.  (b) A pharmacy benefits manager conducting an on-site audit shall give the pharmacy written notice of at least 10 business days before conducting an initial audit.  (c) A pharmacy benefits manager may not conduct  (1) an audit during the first seven calendar days of any month unless agreed to by the pharmacy;  (2) more than one on-site audit of a pharmacy within a 12-month period; or  (3) on-site audits of more than 250 separate prescriptions at one pharmacy within a 12-month period unless fraud by the pharmacy or an employee of the pharmacy is alleged.  (d) If an audit involves clinical or professional judgment, the individual conducting the audit must  (1) be a pharmacist who is licensed and in good standing under AS 08.80; or  (2) conduct the audit in consultation with a pharmacist who is licensed and in good standing under AS 08.80.  (e) A pharmacy, in responding to an audit, may use  (1) verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner, to validate the pharmacy record;  (2) a legal prescription to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, prescriptions transmitted by facsimile, electronic prescriptions, or documented telephone calls from the prescriber or the prescriber's agent.  (f) A pharmacy benefits manager shall audit each pharmacy under the same standards and parameters as other similarly situated pharmacies in a network pharmacy contract in this state.  § 21.27.915  (a) When a pharmacy benefits manager conducts an audit of a pharmacy, the pharmacy benefits manager shall base a finding of overpayment or underpayment by the pharmacy on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except as provided in (b) of this section.  (b) A pharmacy benefits manager may resolve a finding of overpayment or underpayment by entering into a settlement agreement with the pharmacy. The settlement agreement  (1) must comply with the requirements of AS 21.36.125; and  (2) may be based on a statistically justifiable projection method.  (c) A pharmacy benefits manager may not include the dispensing fee amount in a finding of an overpayment unless  (1) a prescription was not actually dispensed;  (2) the prescriber denied authorization;  (3) the prescription dispensed was a medication error by the pharmacy; or  (4) the identified overpayment is solely based on an extra dispensing fee.  § 21.27.920  (a) When a pharmacy benefits manager conducts an audit of a pharmacy, the pharmacy benefits manager shall base the recoupment of overpayments on the actual overpayment of the claim, except as provided in AS 21.27.915(b).  (b) A pharmacy benefits manager conducting an audit of a pharmacy may not  (1) use extrapolation in calculating recoupments or penalties for audits, unless required by state or federal contracts;  (2) assess a charge-back, recoupment, or other penalty against a pharmacy solely because a prescription is mailed or delivered at the request of a patient; or  (3) receive payment  (A) based on a percentage of the amount recovered; or  (B) for errors that have no actual financial harm to the patient or medical plan.  § 21.27.925  (a) A pharmacy benefits manager shall deliver a preliminary audit report to the pharmacy audited within 60 days after the conclusion of the audit.  (b) A pharmacy benefits manager shall allow the pharmacy at least 30 days following receipt of the preliminary audit report to provide documentation to the pharmacy benefits manager to address a discrepancy found in the audit. A pharmacy benefits manager may grant a reasonable extension upon request by the pharmacy.  (c) A pharmacy benefits manager shall deliver a final audit report to the pharmacy within 120 days after receipt of the preliminary audit report, settlement agreement, or final appeal, whichever is latest.  § 21.27.930  (a) A pharmacy benefits manager conducting an audit shall establish a written appeals process.  (b) Recoupment of disputed funds or repayment of funds to the pharmacy benefits manager by the pharmacy, if permitted by contract, shall occur, to the extent demonstrated or documented in the pharmacy audit findings, after final internal disposition of the audit, including the appeals process. If the identified discrepancy for an individual audit exceeds $15,000, future payments to the pharmacy may be withheld pending finalization of the audit.  (c) A pharmacy benefits manager may not assess against a pharmacy a charge- back, recoupment, or other penalty until the pharmacy benefits manager's appeals process has been exhausted and the final report or settlement agreement issued.  § 21.27.935  When a pharmacy benefits manager conducts an audit of a pharmacy, the pharmacy benefits manager may not consider unintentional clerical or record-keeping errors, including typographical errors, writer's errors, or computer errors regarding a required document or record, to be fraudulent activity. In this section, “fraudulent activity” means an intentional act of theft, deception, misrepresentation, or concealment committed by the pharmacy.  § 21.27.940  The requirements of AS 21.27.901 - 21.27.955 do not apply to an audit  (1) in which suspected fraudulent activity or other intentional or wilful misrepresentation is evidenced by a physical review, a review of claims data, a statement, or another investigative method; or  (2) of claims paid for under the medical assistance program under AS 47.07. |
| **AZ** | Ariz. Rev. Stat. Ann. §§20-3321, 20-3322 and 20-3323 | DOI | **§20-3321 Definitions.**  In this chapter, unless the context otherwise requires:  1. "Auditing entity" means any person, company, group or plan working on behalf of or pursuant to a contract with an insurer or pharmacy benefits manager for the purposes of auditing pharmacy drug claims adjudicated by pharmacies.  2. "Clerical errors" means a minor recordkeeping or transcribing error, including typographical errors, scrivner's errors or computer errors, in a required electronic or hard copy document, record or prescription order if both of the following criteria are met:  (a) The error did not result in actual financial harm to an entity.  (b) The error did not involve dispensing an incorrect dose or type of medication or dispensing a prescription drug to the wrong person.  3. "Desktop audit" means an audit that is conducted by an auditing entity at a location other than the location of the pharmacist or pharmacy.  Desktop audit includes an audit that is performed at the offices of the auditing entity during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk or other electronic media.  4. "In-pharmacy audit" means an audit that is conducted by an auditing entity at the physical business address of the pharmacy where the claim was adjudicated.  5. "Insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation.  6. "List" means the list of drugs for which a pharmacy benefit manager has established a maximum allowable cost.  7. "Maximum allowable cost":  (a) Means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a multisource drug.  (b) Does not include the dispensing fee for the drug.  8. "Pharmacist" has the same meaning prescribed in section 32-1901.  9. "Pharmacy" has the same meaning prescribed in section 32-1901.  10. "Pharmacy benefit manager" means a person, business or other entity that, pursuant to a contract or under an employment relationship with an insurer or other third-party payor, either directly or through an intermediary manages the prescription drug coverage provided by the insurer or other third-party payor, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies and controlling the cost of covered prescription drugs.  **§20-3322. Audit procedures; interest prohibition**  A. The following procedures apply to an audit conducted by an auditing entity:  1. When conducting an in-pharmacy audit an auditing entity shall:  (a) Give a pharmacy at least fourteen days' written notice.  (b) Not conduct an audit during the first five days of the month unless the pharmacy otherwise consents.  (c) Provide the pharmacy a list of items to be audited that provides for identification of prescription number or numbers or date range that the auditing entity is seeking to audit.  (d) When conducting an in-pharmacy or desktop audit, limit the audit to claims that may not exceed two years from the date that the claim was adjudicated by the pharmacy benefits manager.  2. An in-pharmacy audit or desktop audit that involves clinical or professional judgment shall be conducted by or in consultation with a pharmacist.  3. The pharmacy may use the records of a hospital, physician or other authorized practitioner to validate the pharmacy records. The validated records may be obtained via electronic methods, fax, phone or written prescription orders and do not have to be the original hard copy prescription order.  4. Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies in this state.  B. When conducting an in-pharmacy audit or desktop audit, an auditing entity shall comply with the following requirements:  1. The auditing entity shall base a finding of overpayment or underpayment on the actual overpayment or underpayment and not on a projection based on the number of patients served who have similar diagnoses or on the number of similar orders or refills  for similar drugs, unless required by federal or state law.  2. The auditing entity may not recoup monies from the pharmacy for any clerical errors identified in an audit.  3. Any finding of an overpayment may not include the dispensing fee amount unless any of the following criteria are met:  (a) A prescription was not received by the patient or the patient's designee.  (b) The prescriber denied authorization.  (c) The prescription dispensed was a medication error by the pharmacy.  (d) The identified overpayment is based solely on an extra dispensing fee.  C. Interest may not accrue during the audit period.  **20-3323. Audit reports**  A. The auditing entity must deliver a preliminary audit report to the pharmacy within sixty days after the conclusion of the audit.  B. A pharmacy is allowed at least thirty days after receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.  C. Each auditing entity shall establish and make available to network pharmacies a written appeals process that shall include a process to appeal, investigate and resolve disputes regarding final audit findings. A pharmacy shall have at least thirty days from the delivery of the final audit findings to appeal an unfavorable audit finding to the auditing entity. This written appeals process shall be included in all contracts between a pharmacy benefits manager and a network pharmacy or a pharmacy benefits manager and a pharmacy's contracting representative.  D. Each auditing entity shall provide a telephone number at which a network pharmacy may contact the pharmacy benefits manager and speak to someone who is responsible for processing appeals.  E. The auditing entity must deliver a final audit report to the pharmacy within ninety days after receipt of the preliminary audit report or final appeal, whichever is later.  F. Chargebacks, recoupment or other penalties may not be assessed until the appeals process has been exhausted and the final audit report has been issued.  G. Unless otherwise required by state or federal law, audit information may not be shared with any entity other than the insurer on whose behalf the audit was conducted. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same auditing entity. |
| **CA** | Cal. B.P.C. Code §§4433 - 4438 (2012) | DOI | **4430.**  For purposes of this chapter, the following definitions shall apply:  (a) “Carrier” means a health care service plan, as defined in Section 1345 of the Health and Safety Code, or a health insurer that issues policies of health insurance, as defined in Section 106 of the Insurance Code.  (b) “Clerical or recordkeeping error” includes a typographical error, scrivener’s error, or computer error in a required document or record.  (c) “Extrapolation” means the practice of inferring a frequency or dollar amount of overpayments, underpayments, nonvalid claims, or other errors on any portion of claims submitted, based on the frequency or dollar amount of overpayments, underpayments, nonvalid claims, or other errors actually measured in a sample of claims.  (d) “Health benefit plan” means any plan or program that provides, arranges, pays for, or reimburses the cost of health benefits. “Health benefit plan” includes, but is not limited to, a health care service plan contract issued by a health care service plan, as defined in Section 1345 of the Health and Safety Code, and a policy of health insurance, as defined in Section 106 of the Insurance Code, issued by a health insurer.  (e) “Maximum allowable cost” means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.  (f) “Maximum allowable cost list” means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.  (g) “Obsolete” means a drug that may be listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured.  (h) “Pharmacy” has the same meaning as provided in Section 4037.  (i) “Pharmacy audit” means an audit, either onsite or remotely, of any records of a pharmacy conducted by or on behalf of a carrier or a pharmacy benefits manager, or a representative thereof, for prescription drugs that were dispensed by that pharmacy to beneficiaries of a health benefit plan pursuant to a contract with the health benefit plan or the issuer or administrator thereof. “Pharmacy audit” does not include a concurrent review or desk audit that occurs within three business days of transmission of a claim, or a concurrent review or desk audit if a chargeback or recoupment is not demanded.  (j) “Pharmacy benefit manager” means a person, business, or other entity that, pursuant to a contract or under an employment relationship with a carrier, health benefit plan sponsor, or other third-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, plan sponsor, or other third-party payer, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.  **4433.**  (a) An entity conducting a pharmacy audit shall not receive payment or any other consideration on any basis that is tied to the amount claimed or actual amount recovered from the pharmacy that is the subject of the audit. Nothing in this subdivision shall be construed to prevent the pharmacy benefit manager or health benefit plan from charging or assessing the plan sponsor, directly or indirectly, based on amounts recouped if both of the following conditions are met:  (1) The plan sponsor and the pharmacy benefit manager or health benefit plan have a contract that explicitly states the percentage charge or assessment to the plan sponsor.  (2) No commission or financial incentive is paid to an agent or employee of the entity conducting the pharmacy audit based, directly or indirectly, on amounts recouped.  (b) A pharmacy shall not be subject to recoupment of funds for a clerical or recordkeeping error, unless the error resulted in actual financial harm to the pharmacy benefit manager, the carrier, or the beneficiary of a health benefit plan.  **4434.**  (a) Except as otherwise prohibited by state or federal law, an entity conducting a pharmacy audit shall keep confidential any information collected during the course of the audit and shall not share any information with any person other than the carrier, pharmacy benefit manager, or third-party payer for which the audit is being performed. An entity conducting a pharmacy audit shall have access only to previous audit reports relating to a particular pharmacy conducted by or on behalf of the same entity. Nothing in this subdivision shall be construed to authorize access to information that is otherwise prohibited by law. Nothing in this subdivision shall be construed to prohibit any employer, trust fund, government agency, or any other entity for which the audit is being performed from disclosing its general opinions or conclusions regarding the business practices of the pharmacy based on the audit.  (b) An entity that is not a carrier or pharmacy benefit manager and that is conducting a pharmacy audit on behalf of a carrier or pharmacy benefit manager shall, prior to conducting the audit, notify the pharmacy in writing that the entity and the carrier or pharmacy benefit manager have executed a business associate agreement or other agreement as required under state and federal privacy laws.  (c) An entity conducting a pharmacy audit shall, prior to leaving a pharmacy at the end of an onsite portion of the audit, provide the pharmacist in charge with a complete list of records reviewed to allow the pharmacy to account for disclosures as required by state and federal privacy laws.  **4435.**  (a) An entity conducting an onsite pharmacy audit shall not initiate or schedule a pharmacy audit during the first five business days of any calendar month, unless it is expressly agreed to by the pharmacy being audited.  (b) An entity conducting an onsite pharmacy audit shall provide the pharmacy at least two weeks’ prior written notice before conducting an initial audit.  **4436.**  (a) A pharmacy audit that involves clinical judgment shall be conducted by, or in consultation with, a licensed pharmacist.  (b) An entity conducting a pharmacy audit shall make all determinations regarding the legal validity of a prescription or other record consistent with determinations made pursuant to Article 4 (commencing with Section 4070) of Chapter 9.  (c) Nothing in this section shall be construed to prohibit a pharmacy benefits manager from denying a claim, either in whole or in part, for failure to comply with federal Food and Drug Administration or manufacturer requirements, the prescription drug formulary, prior authorization requirements, days’ supply requirements, or other coverage or plan design requirement, or for failure to include a National Provider Identification number.  (d) An entity conducting a pharmacy audit shall accept paper or electronic signature logs that document the delivery of pharmacy services to a health plan beneficiary or his or her agent.  **4437.**  The time period covered by a pharmacy audit shall not exceed 24 months from the date that the claim was submitted to, or adjudicated by, the pharmacy benefits manager, unless a longer period is required under state or federal law or unless the originating prescription is required.  **4438.**  (a) (1) An entity conducting a pharmacy audit shall deliver a preliminary audit report to the pharmacy before issuing a final audit report. This preliminary report shall be issued no later than 60 days after conclusion of the audit.  (2) A pharmacy shall be provided a time period of at least 30 days following receipt of the preliminary audit report under paragraph (1) to respond to the findings in the report, including addressing any alleged mistakes or discrepancies and producing documentation to that effect.  (3) To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician and surgeon, or other authorized prescriber, or additional documentation parameters located in the provider manual.  (4) Any legal prescription may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations, or documented telephone calls from the prescriber or the prescriber’s agent. Unless specifically addressed in the audit policies and procedures contained in the contract or provider manual, documentation of an oral prescription order that has been verified by the prescriber shall meet the requirements of this subdivision.  (5) If an entity conducting a pharmacy audit uses extrapolation to calculate penalties or amounts to be recouped, the pharmacy may present evidence to validate orders for dangerous drugs or devices that are subject to invalidation due to extrapolation.  (6) Prior to issuing a final audit report, an entity conducting a pharmacy audit shall take into consideration any response by the pharmacy to the preliminary audit report provided within the timeframes allowed under this section, unless otherwise agreed to by the entity conducting the audit.  (b) (1) An entity conducting a pharmacy audit shall deliver a final audit report to the pharmacy no later than 120 days after receipt of a pharmacy’s response to the preliminary audit report.  (2) An entity conducting a pharmacy audit shall establish, in the contract between the pharmacy and the contracting entity, a process for appealing the findings in a final audit report that complies with the following requirements:  (A) A pharmacy shall be provided a time period of at least 30 days following receipt of the final audit report to file an appeal with the entity identified in the appeal process.  (B) An entity conducting a pharmacy audit shall provide the pharmacy with a written determination of appeal issued by the entity identified in the appeal process, which shall be appended to the final audit report, and a copy of the determination shall be sent to the carrier, health benefit plan sponsor, or other third-party payer.  (C) If, following the appeal, either party is not satisfied with the appeal, the party may seek relief under the terms of the contract.  (c) An entity conducting a pharmacy audit, a carrier, a health benefit plan sponsor, or other third-party payer, or any person acting on behalf of those entities, shall not attempt to make chargebacks or seek recoupment from a pharmacy, or assess or collect penalties from a pharmacy, until the time period for filing an appeal to a final audit report has passed, or until the appeal process has been exhausted, whichever is later. Should the identified discrepancy for a single audit exceed thirty thousand dollars ($30,000), future payments to the pharmacy in excess of thirty thousand dollars ($30,000) may be withheld pending adjudication of an appeal.  (d) Interest shall not accrue during the audit period for either party, beginning with the notice of the audit and ending with the conclusion of the appeal process.  (e) If, following final disposition of a pharmacy audit pursuant to this section, an entity conducting a pharmacy audit, a carrier, a health benefit plan sponsor, or other third-party payer, or any person acting on behalf of those entities, finds that an audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or the unsubstantiated portion thereof without the necessity of any further proceedings. |
| **CT** | [Conn. Gen. Stat. §38a-479iii (2008)](https://www.cga.ct.gov/current/pub/chap_700c.htm#sec_38a-479iii) | DOI | Sec. 38a-479iii. Pharmacy audits. (a) As used in this section:  (1) “Extrapolation” means the practice of inferring a frequency of dollar amount of overpayments, underpayments, nonvalid claims or other errors on any portion of claims submitted, based on the frequency or dollar amount of overpayments, underpayments, nonvalid claims or other errors actually measured in a sample of claims;  (2) “Pharmacy audit” means an audit, conducted on-site or remotely by or on behalf of a pharmacy benefits manager or plan sponsor of any records of a pharmacy for prescription drugs or prescription devices dispensed by such pharmacy to beneficiaries of a health benefit plan. “Pharmacy audit” does not include (A) a concurrent review or desk audit that occurs within three business days of the pharmacy's transmission of a claim to a pharmacy benefits manager or plan sponsor, or (B) a concurrent review or desk audit where no charge-back or recoupment is demanded by the pharmacy benefits manager or plan sponsor;  (3) “Plan sponsor” has the same meaning as described in section 38a-479aaa.  (b) (1) No entity other than a pharmacy benefits manager or a plan sponsor shall conduct a pharmacy audit unless such entity and manager or sponsor, as applicable, have executed a written agreement for the conducting of pharmacy audits. Prior to conducting a pharmacy audit on behalf of such manager or sponsor, such entity shall notify the pharmacy in writing that such entity and manager or sponsor, as applicable, have executed such agreement.  (2) Except as otherwise provided by state or federal law, an entity conducting a pharmacy audit may have access to a pharmacy's previous pharmacy audit report only if such report was prepared by such entity.  (3) Any information collected during a pharmacy audit shall be confidential by law, except that the entity conducting the pharmacy audit may share such information with the pharmacy benefits manager and the plan sponsor, for which such pharmacy audit is being conducted.  (4) No entity conducting a pharmacy audit shall compensate, directly or indirectly, any of its employees or any contractor such entity contracts with to conduct a pharmacy audit, based on the amount claimed or the actual amount recouped from the pharmacy being audited.  (c) (1) Any entity conducting a pharmacy audit shall:  (A) Provide the pharmacy being audited at least ten business days' prior written notice before conducting a pharmacy audit;  (B) Provide the pharmacy being audited with a masked list of prescriptions to assist the pharmacy to prepare for the pharmacy audit. A list is considered masked if the last two numbers of a prescription are marked with an “X”;  (C) Not initiate or schedule a pharmacy audit during the first five business days of any month for any pharmacy that averages in excess of six hundred prescriptions filled per week, without the express consent of the pharmacy;  (D) Make all determinations regarding the validity of a prescription or other record consistent with sections 20-612 to 20-623, inclusive, or as specified in federal risk management programs;  (E) Accept paper or electronic signature logs that document the delivery of prescription drug and device and pharmacist services to a health plan beneficiary or such beneficiary's agent; and  (F) Provide to the representative of the pharmacy, prior to leaving the pharmacy at the conclusion of an on-site portion of a pharmacy audit, a complete list of records reviewed.  (2) Any pharmacy audit that involves clinical judgment shall be conducted by or in consultation with a licensed pharmacist.  (3) No pharmacy audit shall cover (A) a period of more than twenty-four months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or plan sponsor unless a longer period is required by law, or (B) more than two hundred fifty prescriptions.  (d) (1) (A) Not later than sixty calendar days after an entity concludes a pharmacy audit and before such entity issues a final pharmacy audit report, such entity shall provide an initial pharmacy audit review to the pharmacy. The pharmacy may, within thirty calendar days after it receives such initial review, respond to the findings in such initial review.  (B) To validate the pharmacy record and delivery, a pharmacy may use authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital or health care provider with prescriptive authority.  (C) To validate claims in connection with prescriptions or changes in prescriptions, or refills of prescription drugs, a pharmacy may use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations or documented telephone calls from the prescribing health care provider or such provider's agent. Documentation of an oral prescription order that has been verified by the prescribing health care provider shall meet the provisions of this subparagraph for the initial audit review.  (D) No entity conducting a pharmacy audit may use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans. No such entity shall include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this subparagraph, “misfill” means a prescription that was not dispensed, a prescription error, a prescription whereby the prescriber denied the authorization request or where an extra dispensing fee was charged.  (2) (A) Not later than sixty calendar days after any responses from the pharmacy under subdivision (1) of this subsection are received by the entity conducting the pharmacy audit or, if no such responses are received, after the entity concludes a pharmacy audit, such entity shall issue a final pharmacy audit report that takes into consideration any responses provided to such entity by the pharmacy.  (B) A pharmacy may appeal a final pharmacy audit report in accordance with the procedures established by the entity conducting the pharmacy audit.  (e) (1) No pharmacy shall be subject to charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical error, scrivener's error or computer error, unless such error resulted in actual financial harm to the pharmacy benefits manager, plan sponsor or a plan beneficiary.  (2) No entity conducting a pharmacy audit or person acting on behalf of such entity shall charge-back or recoup, attempt to charge-back or recoup, or assess or collect penalties from a pharmacy until the time period to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later. If an identified discrepancy in a pharmacy audit exceeds twenty-five thousand dollars, future payments to the pharmacy in excess of such amount may be withheld pending adjudication of an appeal. No interest shall accrue for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.  (f) The provisions of this section shall not apply to an audit of pharmacy records conducted when (1) fraud or other intentional or willful misrepresentation is indicated by physical review or review of claims data or statements, or (2) other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation. |
| **DE** | Del. Code tit. 18 Chapter 33A §§ 3301A – 3310A | DOI | § 3301A  The Pharmacy Audit Integrity Program is established to provide standards for an audit of pharmacy records carried out by a pharmacy benefits manager or any entity that represents pharmacy benefits managers.  § 3302A  For purposes of this subchapter:  **(1)** "Entity" means a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations.**(2)** "Pharmacy benefits manager" or "PBM" means an entity that contracts with pharmacists or pharmacies on behalf of a person to do any of the following: **a.** Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists. **b.** Pay pharmacies or pharmacists for prescription drugs or medical supplies. **c.** Negotiate rebates with manufacturers for drugs paid for or procured as described in this chapter.**(3)** "Plan sponsor" means as defined under § 4405 of this title.  § 3303A  An amendment to pharmacy audit terms in a contract between a PBM and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change.  § 3304A  **(a)** Audit procedures. Unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit must adhere to the following procedures:**(1)** A pharmacy must be given notice 14 days before an initial on-site audit is conducted.**(2)** An audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist.**(3)** Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies.**(4)** A pharmacy must be given a range of prescription numbers in advance of the audit.  **(b)** Audit process. Unless otherwise prohibited by federal requirements or regulations, for any entity conducting a pharmacy audit the following audit items apply:**(1)** The period covered by the audit may not exceed 24 months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law.**(2)** If an entity uses random sampling as a method for selecting a set of claims for examination, the sample size must be appropriate for a statistically reliable sample. The auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit.**(3)** An on-site audit may not take place during the first five business days of the month or on a federal holiday unless consented to by the pharmacy.**(4)** Auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.**(5)** Any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final audit.**(6)** A PBM may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if the required information is not readily available in print or electronic form for the auditor at the time of the audit and one or more of the following conditions applies:**(i)** additional information is required in the provider manual.**(ii)** the information is required by the Food and Drug Administration (FDA).**(iii)** the information is required by the drug manufacturer's product safety program.**(7)** The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:**(i)** the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and**(ii)** a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.  § 3305A  For recoupment or chargeback, the following criteria apply:  **(1)** Audit parameters must consider consumer-oriented parameters based on manufacturer listings.**(2)** The reimbursable cost for a compounded medication shall be reflective of the ingredients, supplies and professional time reasonably required to create the finished product.**(3)** A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.**(4)** The entity conducting the audit shall not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.**(5)** Calculations of overpayments must not include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee.**(6)** An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud, however such errors may be subject to recoupment.**(7)** In the case of errors that have no actual financial harm to the patient or plan, the PBM must not assess any chargebacks. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery.**(8)** Interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.  § 3306A  **(a)** To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual.  **(b)** Any legal prescription that meets the requirements in this subchapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.  § 3307A  The entity conducting the audit must establish a written appeals process which must include appeals of preliminary reports and final reports.  § 3308A  **(a)** A preliminary audit report must be delivered to the pharmacy within 30 days after the conclusion of the audit. The preliminary audit report shall contain claim level information for any discrepancy and an estimated recovery amount.  **(b)** A pharmacy must be allowed at least 45 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.  **(c)** A final audit report must be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, whichever is later.  **(d)** An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 45 days after the appeals process has been exhausted and the final audit report has been issued.  § 3309A  Where contractually required, an auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor.  § 3310A  This subchapter does not apply to any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or any audit completed by the State. |
| **GA** | Ga. Code Ann. §26-4-118 (2021) | DOI | (a) This Code section shall be known and may be cited as “The Pharmacy Audit Bill of Rights.”  (b) Notwithstanding any other law, when an audit of the records of a pharmacy is conducted by a managed care company, insurance company, third-party payor, pharmacy benefits manager, any entity licensed by the Department of Insurance, or any entity that represents such companies, groups, or department, it shall be conducted in accordance with the following bill of rights:  (1) The entity conducting the audit must give the pharmacy notice at least 14 days prior to conducting the audit for each audit cycle and include in such notice a comprehensive list of claims by prescription number to be audited, although the final two digits may be omitted, and the cost of such claims shall not be used as a criterion in determining which claims to audit.  The audit shall not include more than 100 prescriptions per audit and an entity shall not audit more than 200 prescriptions in any 12-month period, provided that a refill shall not constitute a separate prescription;  (2) Any audit which involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;  (3) Any clerical or record-keeping error, including but not limited to a typographical error, scrivener's error, computer error, or omission error, regarding a prescription, front or back label, or other document or record shall not in and of itself constitute fraud.  No such claim shall be subject to criminal penalties without proof of intent to commit fraud.  No recoupment of the cost of drugs or medicinal supplies properly dispensed shall be allowed if such error has occurred;  provided, however, that recoupment shall be allowed to the extent that such error resulted in an overpayment, though recoupment shall be limited to the amount overpaid;  (4) A pharmacy shall be allowed at least 60 days following the receipt of the preliminary audit report in which to correct any error or to address any discrepancy found during an audit which may be subject to recoupment for overpayment as provided for in paragraph (12) of this subsection, including to secure and remit an appropriate copy of the record from a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication if the lack of such a record or an error in such a record is identified in the course of an audit or noticed within the preliminary audit report;  (5) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;  (6) A finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;  however, recoupment of claims must be based on the actual overpayment or underpayment unless the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy;  (7) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;  (8) The period covered by an audit may not exceed two years from the date the claim was submitted to or adjudicated by a managed care company, insurance company, third-party payor, pharmacy benefits manager, any entity licensed by the Department of Insurance, or any entity that represents such companies, groups, or department;  (9) An audit may not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled during that time unless  otherwise consented to by the pharmacy;  (10) The preliminary audit report must be delivered to the pharmacy within 30 days after conclusion of the audit.  A final audit report shall be delivered to the pharmacy within 60 days after receipt of the preliminary audit report or final appeal, as provided for in subsection (c) of this Code section, whichever is later;  (11) A pharmacy shall not be held responsible for any penalty or fee in connection with an audit and there shall be no recoupment of funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements set forth in this Code section;  (12) There shall be no recoupment from a pharmacy except in cases of:  (A) Fraud;  (B) An error that resulted in an overpayment provided that recoupment shall be limited to the amount overpaid;  or  (C) A misfill;  provided, however, that when a patient receives the correct drug in the correct dosage and quantity pursuant to a prescription drug order then no misfill shall be found to have occurred;  and  (13) A pharmacy shall not be audited more than once every six months.  Notwithstanding any other provision in this subsection, the agency conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.  (c) Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process as set forth in subsection (d) of this Code section.  (d) Each entity conducting an audit shall establish an internal appeals process under which a pharmacy shall have at least 30 days from the delivery of the preliminary audit report to appeal an unfavorable preliminary audit report to the entity.  If, following the appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or such portion  without the necessity of any further proceedings.  (e) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor at its request or in an alternate format.  (f) This Code section shall not apply to any investigative audit commenced based upon an articulable suspicion of fraud, willful misrepresentation, or abuse, including without limitation investigative audits under Article 7 of Chapter 4 of Title 49, Code Section 33-1-16 , or any other statutory provision which authorizes investigations relating to insurance fraud.  (g) The provisions of this Code section shall not apply to the Department of Community Health conducting audits under Article 7 of Chapter 4 of Title 49;  provided, however, that the provisions of Code Section 49-4-151.1 shall apply to such audits conducted by the Department of Community Health under Article 7 of Chapter 4 of Title 49.  (h) The entity conducting the audit may not pay the agent or employee who is conducting the audit based on a percentage of the amount recovered.  (i) The Commissioner of Insurance shall have enforcement authority over this Code section and shall promulgate rules and regulations to effectuate the provisions of this Code section.  The Commissioner of Insurance shall have the authority to investigate complaints of alleged violations of this Code section;  to prohibit recoupment;  to order reimbursement of any wrongful recoupment;  to institute fines for violations of the law, rules, or regulations;  and to take any other actions pursuant to any authority granted pursuant to Chapter 64 of Title 33, relating to the regulation and licensure of pharmacy benefits managers. |
| **KY** | [Ky. Rev. Stat. 304.17A-740 (2012)](https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=40126), [Ky. Rev. Stat. 304.17A-741 (2012)](https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=40126), and [Ky. Rev. Stat. 304.17A-743 (2012)](https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=40126) | DOI | **740.**  (1) As used in KRS 304.17A-740 to 304.17A-743, unless the context otherwise requires: (a) "Administrator" has the meaning provided in KRS 304.9-051; (b) "Auditing entity" means an insurer or an administrator that conducts or arranges for the performance of an audit of a pharmacy's records for the purpose of determining compliance with pharmacy benefit requirements; and (c) "Insurer" has the meaning provided in KRS 304.17A-005. (2) A provider agreement or provider contract between a pharmacy and an insurer, an agency of the Commonwealth, a pharmacy benefits administrator, or a pharmacy benefits manager that allows an audit of the pharmacy's records by an auditing entity shall comply with KRS 304.17A-741 and 304.17A-743.  **741.**  When an audit of the records of a pharmacy is conducted by an auditing entity, it shall be subject to the following conditions:  (1) The auditing entity shall give at least thirty (30) days' written notice to the pharmacy  prior to conducting the audit for each audit to be conducted;  (2) An audit performed by the auditing entity that involves clinical or professional  judgment shall be conducted in consultation with a pharmacist;  (3) A pharmacy may use the records of a hospital, physician, or other practitioner as  defined in KRS 217.015(35), or transmitted by any means of communication, for  purposes of validating pharmacy records with respect to orders or refills of a drug;  (4) An auditing entity shall not require a pharmacy to keep records for a period of time  longer than two (2) years, or as required by state or federal law or regulation;  (5) The recoupment of claims shall be based on the actual overpayment or  underpayment of claims unless the pharmacy agrees to a settlement to the contrary;  (6) A pharmacy shall be audited under the same standards and parameters as other  similarly situated pharmacies audited by the auditing entity;  (7) The period covered by the audit shall not exceed two (2) years from the date the  claim was submitted for payment except if a longer period is allowed by federal law  or if there is evidence of fraud;  (8) An audit shall not be scheduled during the first seven (7) calendar days of any  month, unless consented to by the pharmacy;  (9) A preliminary audit report shall be delivered to the pharmacy within one hundred  twenty (120) days after the exit interview;  (10) A final audit report shall be delivered to the pharmacy within six (6) months after  receipt of the preliminary audit report or after all appeals have been exhausted,  whichever is later;  (11) The auditing entity shall allow a pharmacy at least thirty (30) days following receipt  of the preliminary audit report to produce documentation to address any  discrepancies found during an audit;  (12) The final audit report shall provide claim-level detail of the amounts and reasons for  each claim recovery found due. If no amounts have been found due, the final audit  report shall so state;  (13) The auditing entity shall not receive payment based on the amount recovered in an  audit;  (14) The auditing entity shall conduct an exit interview at the close of the audit. The exit interview shall be conducted at a time agreed to by the audited pharmacy. The  interview shall provide the audited pharmacy an opportunity to:  (a) Respond to questions from the auditing entity;  (b) Review and comment on the initial findings of the auditing entity; and  (c) Provide additional documentation to clarify the initial findings of the auditing  entity;  (15) If an audit results in the identification of any clerical or recordkeeping errors such as typographical errors, scrivener's errors, omissions, or computer errors, the pharmacy  shall not be subject to recoupment of funds by the auditing entity unless the auditing  entity can provide proof of intent to commit fraud or the error results in an actual  overpayment to the pharmacy or the wrong medication being dispensed to the  patient. The pharmacy shall have the right to submit amended claims within thirty  (30) days of the discovery of an error to correct clerical or recordkeeping errors in  lieu of recoupment if the prescription was dispensed according to requirements set  forth in state or federal law;  (16) In the case of overpayment, the auditing entity may seek a refund or recoupment of  the overpayment in accordance with KRS 304.17A-712. The amount refunded or  recouped shall be limited to the amount paid to the pharmacy minus the amount that  should have been paid to the pharmacy absent the overpayment and shall not  include the dispensing fee if the correct medication was dispensed to the patient;  and  (17) Claims shall be paid pursuant to KRS 304.17A-702.  **743.**  (1) The auditing entity conducting an audit shall establish an appeals process under which a pharmacy may appeal a final audit report. The auditing entity shall provide to the pharmacy, prior to or at the time of the delivery of the preliminary audit report, a written explanation of the appeals process, including the name, address, and phone number of the person to whom the appeal should be addressed. (2) Following the appeal if it is determined that an audit report or any portion thereof is unsubstantiated, the audit report or unsubstantiated portion shall be dismissed without the necessity of further proceedings. (3) The auditing entity shall not recoup disputed funds or collect interest on disputed funds until the final internal disposition of the audit, including the appeals process set forth in subsection (1) of this section. |
| **MA** | [Mass. Gen. Laws Ann. ch. 175, §226 (2015)](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section226) | DOI | Section 226. (a) For the purposes of this section, the term ''pharmacy benefit manager'' shall mean any person or entity that administers the (i) prescription drug, prescription device or pharmacist services or (ii) prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors, including, but not limited to, self-insured employers, insurance companies and labor unions. A health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this section, unless specifically exempted.  (b) A pharmacy benefit manager shall conduct an audit of the records of a pharmacy in accordance with paragraphs (1) to (13), inclusive.  (1) The contract between a pharmacy and a pharmacy benefit manager shall identify and describe the audit procedures in detail.  (2) With the exception of an investigative fraud audit, the auditor shall give the pharmacy written notice at least 2 weeks prior to conducting the initial on-site audit for each audit cycle.  (3) A pharmacy benefit manager shall not audit claims beyond 2 years prior to the date of audit.  (4) The auditor shall not interfere with the delivery of pharmacist services to a patient and shall make a reasonable effort to minimize the inconvenience and disruption to the pharmacy operations during the audit process.  (5) Any audit that involves clinical or professional judgment shall be conducted by, or in consultation with, a licensed pharmacist from any state.  (6) A finding of an overpayment or underpayment shall be based on the actual overpayment or underpayment. A statistically sound calculation for overpayment or underpayment may be used to determine recoupment as part of a settlement as agreed to by the pharmacy.  (7) The auditor shall audit each pharmacy under the same standards and parameters  with which they audit other similarly situated pharmacies.  (8) An audit shall not be initiated or scheduled during the first 5 calendar days of any month for any pharmacy that averages more than 600 prescriptions per week without the pharmacy's consent.  (9) A preliminary audit report shall be delivered to the pharmacy not later than 30 days after the conclusion of the audit.  (10) The preliminary audit report shall be signed and shall include the signature of any pharmacist participating in the audit.  (11) A pharmacy benefit manager shall not withhold payment to a pharmacy for reimbursement claims as a means to recoup money until after the final internal disposition of an audit, including the appeals process, as provided in subsection (c), unless fraud or misrepresentation is reasonably suspected or the discrepant amount exceeds $15,000.  (12) The auditor shall provide a copy of the final audit report to the pharmacy and plan sponsor within 30 days following the pharmacy's receipt of the signed preliminary audit report or the completion of the appeals process, as provided in subsection (c), whichever is later.  (13) No auditing company or agent shall receive payment based upon a percentage of the amount recovered or other financial incentive tied to the findings of the audit.  (c)(1) Each auditor shall establish an appeals process under which a pharmacy may appeal findings in a preliminary audit.  (2) To appeal a finding, a pharmacy may use the records of a hospital, physician, or other authorized prescriber to validate the record with respect to orders or refills of prescription drugs or devices.  (3) A pharmacy shall have 30 days to appeal any discrepancy found during the preliminary audit.  (4) The National Council for Prescription Drug Programs or any other recognized national industry standard shall be used to evaluate claims submission and product size disputes.  (5) If an audit results in the identification of any clerical or record-keeping errors in a required document or record, the pharmacy shall not be subject to recoupment of funds by the pharmacy benefit manager; provided, that the pharmacy may provide proof that the patient received the medication billed to the plan via patient signature logs or other acceptable methods, unless there is financial harm to the plan or errors that exceed the normal course of business.  (d) This section shall not apply to any audit or investigation of a pharmacy that involves potential fraud, willful misrepresentation or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision which authorizes investigations relating to insurance fraud.  (e) This section shall not apply to a public health care payer, as defined in section 1 of chapter 12C.  (f) The commissioner may promulgate regulations to enforce this section. |
| **MD** | MD. ANN. CODE § 15-1629 | DOI | **(a)** This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.  **(b)** This section does not apply to an audit that involves probable or potential fraud or willful misrepresentation by a pharmacy or pharmacist.  **(c)** A pharmacy benefits manager shall conduct an audit of a pharmacy or pharmacist under contract with the pharmacy benefits manager in accordance with this section.  **(d)** A pharmacy benefits manager may not schedule an onsite audit to begin during the first 5 calendar days of a month unless requested by the pharmacy or pharmacist.  **(e)** When conducting an audit, a pharmacy benefits manager shall:**(1)** if the audit is onsite, provide written notice to the pharmacy or pharmacist at least 2 weeks before conducting the initial onsite audit for each audit cycle;**(2)** employ the services of a pharmacist if the audit requires the clinical or professional judgment of a pharmacist;**(3)** permit its auditors to enter the prescription area of a pharmacy only when accompanied by or authorized by a member of the pharmacy staff;**(4)** allow a pharmacist or pharmacy to use any prescription, or authorized change to a prescription, that meets the requirements of COMAR 10.34.20.02 to validate claims submitted for reimbursement for dispensing of original and refill prescriptions;**(5)** for purposes of validating the pharmacy record with respect to orders or refills of a drug, allow the pharmacy or pharmacist to use records of a hospital or a physician or other prescriber authorized by law that are:**(i)** written; or**(ii)** transmitted electronically or by any other means of communication authorized by contract between the pharmacy and the pharmacy benefits manager;**(6)** audit each pharmacy and pharmacist under the same standards and parameters as other similarly situated pharmacies or pharmacists audited by the pharmacy benefits manager;**(7)** only audit claims submitted or adjudicated within the 2-year period immediately preceding the audit, unless a longer period is authorized under federal or State law;**(8)** deliver the preliminary audit report to the pharmacy or pharmacist within 120 calendar days after the completion of the audit, with reasonable extensions allowed;**(9)** in accordance with subsection (k) of this section, allow a pharmacy or pharmacist to produce documentation to address any discrepancy found during the audit; and**(10)** deliver the final audit report to the pharmacy or pharmacist:**(i)** within 6 months after delivery of the preliminary audit report if the pharmacy or pharmacist does not request an internal appeal under subsection (k) of this section; or**(ii)** within 30 days after the conclusion of the internal appeals process under subsection (k) of this section if the pharmacy or pharmacist requests an internal appeal.  **(f)** If a contract between a pharmacy or pharmacist and a pharmacy benefits manager specifies a period of time in which a pharmacy or pharmacist is allowed to withdraw and resubmit a claim and that period of time expires before the pharmacy benefits manager delivers a preliminary audit report that identifies discrepancies, the pharmacy benefits manager shall allow the pharmacy or pharmacist to withdraw and resubmit a claim within 30 days after:**(1)** the preliminary audit report is delivered if the pharmacy or pharmacist does not request an internal appeal under subsection (k) of this section; or**(2)** the conclusion of the internal appeals process under subsection (k) of this section if the pharmacy or pharmacist requests an internal appeal.  **(g)** During an audit, a pharmacy benefits manager may not disrupt the provision of services to the customers of a pharmacy.  **(h)(1)** A pharmacy benefits manager may not:**(i)** use the accounting practice of extrapolation to calculate overpayments or underpayments; or**(ii)** Except as provided in paragraph (2) of this subsection:**1.** share information from an audit with another pharmacy benefits manager; or**2.** use information from an audit conducted by another pharmacy benefits manager.**(2)** Paragraph (1)(ii) of this subsection does not apply to the sharing of information:**(i)** required by federal or State law;**(ii)** in connection with an acquisition or merger involving the pharmacy benefits manager; or**(iii)** at the payor's request or under the terms of the agreement between the pharmacy benefits manager and the payor.  **(i)** The recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager shall be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist.  **(j)(1)** In this subsection, "overpayment" means a payment by the pharmacy benefits manager to a pharmacy or pharmacist that is greater than the rate or terms specified in the contract between the pharmacy or pharmacist and the pharmacy benefits manager at the time that the payment is made.**(2)** A clerical error, record-keeping error, typographical error, or scrivener's error in a required document or record may not constitute fraud or grounds for recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager if the prescription was otherwise legally dispensed and the claim was otherwise materially correct.**(3)** Notwithstanding paragraph (2) of this subsection, claims remain subject to recoupment of overpayment or payment of any discovered underpayment by the pharmacy benefits manager.  **(k)(1)** A pharmacy benefits manager shall establish an internal appeals process under which a pharmacy or pharmacist may appeal any disputed claim in a preliminary audit report.**(2)** Under the internal appeals process, a pharmacy benefits manager shall allow a pharmacy or pharmacist to request an internal appeal within 30 working days after receipt of the preliminary audit report, with reasonable extensions allowed.**(3)** The pharmacy benefits manager shall include in its preliminary audit report a written explanation of the internal appeals process, including the name, address, and telephone number of the person to whom an internal appeal should be addressed.**(4)** The decision of the pharmacy benefits manager on an appeal of a disputed claim in a preliminary audit report by a pharmacy or pharmacist shall be reflected in the final audit report.**(5)** The pharmacy benefits manager shall deliver the final audit report to the pharmacy or pharmacist within 30 calendar days after conclusion of the internal appeals process.  **(l)(1)** A pharmacy benefits manager may not recoup by setoff any moneys for an overpayment or denial of a claim until:**(i)** the pharmacy or pharmacist has an opportunity to review the pharmacy benefits manager's findings; and**(ii)** if the pharmacy or pharmacist concurs with the pharmacy benefits manager's findings of overpayment or denial, 30 working days have elapsed after the date the final audit report has been delivered to the pharmacy or pharmacist.**(2)** If the pharmacy or pharmacist does not concur with the pharmacy benefits manager's findings of overpayment or denial, the pharmacy benefits manager may not recoup by setoff any money pending the outcome of an appeal under subsection (k) of this section.**(3)** A pharmacy benefits manager shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 30 working days after the final audit report has been delivered to the pharmacy or pharmacist.**(4)** Notwithstanding the provisions of paragraph (1) of this subsection, a pharmacy benefits manager may withhold future payments before the date the final audit report has been delivered to the pharmacy or pharmacist if the identified discrepancy for all disputed claims in a preliminary audit report for an individual audit exceeds $25,000.  **(m)(1)** The Commissioner may adopt regulations regarding:**(i)** the documentation that may be requested during an audit; and**(ii)** the process a pharmacy benefits manager may use to conduct an audit.**(2)** On request of the Commissioner or the Commissioner's designee, a pharmacy benefits manager shall provide a copy of its audit procedures or internal appeals process. |
| **MS** | [Miss. Code Ann. §73-21-183 (2012)](https://codes.findlaw.com/ms/title-73-professions-and-vocations/ms-code-sect-73-21-183.html) | DOI | (1) The entity conducting an audit shall follow these procedures:  (a) The pharmacy contract must identify and describe in detail the audit procedures;  (b) The entity conducting the on-site audit must give the pharmacy written notice at least two (2) weeks before conducting the initial on-site audit for each audit cycle, and the pharmacy shall have at least fourteen (14) days to respond to any desk audit requirements;  (c) The entity conducting the on-site or desk audit shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;  (d) Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;  (e) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not constitute fraud;  however, those claims may be subject to recoupment.  No such claim shall be subject to criminal penalties without proof of intent to commit fraud;  (f) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;  (g) A finding of an overpayment or an underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except that recoupment shall be based on the actual overpayment or underpayment;  (h) A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed;  (i) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;  (j) The period covered by an audit may not exceed two (2) years from the date the claim was submitted to or adjudicated by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department;  (k) An audit may not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;  (l) Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions;  (m) An exit interview that provides a pharmacy with an opportunity to respond to questions and comment on and clarify findings must be conducted at the end of an audit.  The time of the interview must be agreed to by the pharmacy;  (n) Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan or insurer.  An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular  pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan;  (o) The parameters of an audit must comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:  (i) The day supply for eyedrops must be calculated so that the consumer pays only one (1) thirty-day copayment if the bottle of eyedrops is intended by the manufacturer to be a thirty-day supply;  (ii) The day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;  (iii) The day supply for a topical product must be determined by the judgment of the pharmacist based upon the treated area;  (p)(i) Where an audit is for a specifically identified problem that has been disclosed to the pharmacy, the audit shall be limited to claims that are identified by prescription number;  (ii) For an audit other than described in subparagraph (i) of this paragraph (p), an audit shall be limited to one hundred (100) individual prescriptions that have been randomly selected;  (iii) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site;  (iv) Except for audits initiated under paragraph (i) of this subsection, an entity shall not initiate an audit of a pharmacy more than one (1) time in any quarter;  (r) A recoupment shall not be based on:  (i) Documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the State Board of Pharmacy;  or  (ii) A requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the State Board of Pharmacy;  (s) Except for Medicare claims, approval of drug, prescriber or patient eligibility upon  adjudication of a claim shall not be reversed unless the pharmacy or pharmacist obtained the adjudication by fraud or misrepresentation of claim elements;  and  (t) A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.  (2) The entity must provide the pharmacy with a written report of the audit and comply with the following requirements:  (a) The preliminary audit report must be delivered to the pharmacy within one hundred twenty (120) days after conclusion of the audit, with a reasonable extension to be granted upon request;  (b) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request;  (c) A final audit report shall be delivered to the pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, as provided for in Section 73-21-185 , whichever is later;  (d) The audit report must be signed by the auditor;  (e) Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185 .  If the identified discrepancy for an individual audit exceeds Twenty-five Thousand Dollars ($25,000.00), future payments in excess of that amount to the pharmacy may be withheld pending finalization of the audit;  (f) Interest shall not accrue during the audit period;  and  (g) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor. |
| **ND** | [N.D. Cent. Code §§19-03.6-02; 03 (2011)](https://www.legis.nd.gov/cencode/t19c03-6.pdf#nameddest=19-03p6-02) | DOI | 19-03.6-02. Pharmacy benefits manager audit - Rules.  1. An entity conducting an audit of a pharmacy shall:  a. If conducting an onsite audit, give the pharmacy a written notice at least fourteen  business days before conducting an initial audit.  b. If the audit involves clinical or professional judgment, ensure the audit is  conducted by or in consultation with a pharmacist licensed in any state and  employed by or contracted with the pharmacy benefits manager.  c. Limit the audit to no more than twenty-four months from the date that the claim  was submitted to or adjudicated by the entity. A claim may not be reviewed that is  older than twenty-four months from the date of the audit, unless a longer period is  permitted under federal law.  d. Refrain from conducting the audit during the first five business days of the month  unless otherwise consented to by the pharmacy.  e. Refrain from entering the pharmacy area where patient-specific information is  available and remain out of sight and hearing range of the pharmacy customers.  The pharmacy shall designate an area for auditors to conduct their business.  f. Allow the pharmacy to use the records, including a medication administration  record, of a hospital, physician, or other authorized practitioner to validate the  pharmacy record and delivery.  g. Allow the pharmacy to use any legal prescription, including medication  administration records, electronic documents, or documented telephone calls  from the prescriber or the prescriber's agents, to validate claims in connection  with prescriptions and refills or changes in prescriptions.  2. An audit may not allow a recoupment to be assessed for items on the face of a  prescription not required by rules adopted by the state board of pharmacy with respect  to patient hard copy prescription forms for controlled and uncontrolled drugs.  3. A finding of overpayment or underpayment may be based only on the actual  overpayment or underpayment and not on a projection based on the number of  patients served having a similar diagnosis or on the number of similar orders or refills  for similar drugs. A calculation of an overpayment may not include dispensing fees,  Page No. 1  unless a prescription was not dispensed or the prescriber denied authorization. In the  case of an error that has no financial harm to the patient or plan, the pharmacy  benefits manager may not assess any chargeback. The entity conducting the audit  may not use extrapolation in calculating the recoupment or penalties for audits. Any  recoupment may not be deducted against future remittances and must be invoiced to  the pharmacy for payment. An entity performing an audit may not receive payment  based on a percentage of the amount recovered. Interest may not accrue during the  audit period, which begins with the notice of audit and ends with the final audit report.  4. A clerical or recordkeeping error may not be considered fraud, but may be subject to  recoupment. A person is not subject to any criminal penalty for a clerical or  recordkeeping error without proof of intent to commit fraud.  5. The parameters of an audit must comply with consumer-oriented parameters based on  manufacturer listings or recommendations for the following:  a. The day supply for eye drops must be calculated so that the consumer pays only  one 30-day copayment if the bottle of eye drops is intended by the manufacturer  to be a thirty-day supply.  b. The day supply for insulin must be calculated so that the highest dose prescribed  is used to determine the day supply and consumer copayment.  c. The day supply for a topical product must be determined by the judgment of the  pharmacist based upon the treated area.  6. Unless an alternate price is published in a provider contract and signed by both  parties, the usual and customary price charged by a pharmacy for compounded  medications is considered to be the reimbursable cost.  7. An entity conducting an audit shall utilize the same standards and parameters in  auditing a pharmacy the entity uses with other similarly situated pharmacies.  8. An entity conducting an audit shall establish a written appeals process.  19-03.6-03. Audit reports - Disclosure - Distribution of recouped funds - Review of  auditor.  1. A preliminary audit report must be delivered to the pharmacy within one hundred  twenty days after the conclusion of the audit.  2. A pharmacy must be allowed at least sixty days following receipt of the preliminary  audit to provide documentation to address any discrepancy found in the audit.  3. A final audit report must be delivered to the pharmacy within ninety days after receipt of the preliminary audit report or final appeal, whichever is later.  4. No chargeback, recoupment, or other penalty may be assessed until the appeal  process has been exhausted and the final report issued.  5. An entity shall remit any money due to a pharmacy or pharmacist as a result of an  underpayment of a claim within thirty days after the appeals process has been  exhausted and the final audit report has been issued.  6. An auditing entity shall provide a copy of the final report to the plan sponsor for which claims were included in the audit. Any funds recouped must be returned to the plan sponsor. |
| **NE** | Nebraska Revised Statute §44-4603(1) and §44-4607 | DOI | **§44-4603.**  (1) Auditing entity means a pharmacy benefit manager or any person that represents a pharmacy benefit manager in conducting an audit for compliance with a contract between the pharmacy benefit manager and a pharmacy.  **§44-4607**  (1) Unless otherwise prohibited by federal law, an auditing entity conducting a pharmacy audit shall:  (a) Give any pharmacy notice fifteen business days prior to conducting an initial onsite audit;  (b) For any audit that involves clinical or professional judgment, conduct such audit by or in consultation with a pharmacist; and  (c) Audit each pharmacy under the same standards and parameters as other similarly situated pharmacies.  (2) Unless otherwise prohibited by federal law, for any pharmacy audit conducted by an auditing entity:  (a) The period covered by the audit shall not exceed twenty-four months from the date that the claim was submitted to the auditing entity, unless a longer period is required under state or federal law;  (b) If an auditing entity uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample;  (c) The auditing entity shall provide the pharmacy a masked list containing any prescription number or date range that the auditing entity is seeking to audit;  (d) No onsite audit shall take place during the first five business days of the month without the consent of the pharmacy;  (e) No auditor shall enter the area of any pharmacy where patient-specific information is available without being escorted by an employee of the pharmacy and, to the extent possible, each auditor shall remain out of the sight and hearing range of any pharmacy customer;  (f) No recoupment shall be deducted from or applied against a future remittance until after the appeal process is complete and both parties receive the results of the final audit;  (g) No pharmacy benefit manager shall require information to be written on a prescription unless such information is required to be written on the prescription by state or federal law;  (h) Recoupment may be assessed for information not written on a prescription if:  (i)(A) Such information is required in the provider manual; or (B) The information is required by the federal Food and Drug Administration or the drug manufacturer's product safety program; and  (ii) The information required under subdivision (i)(A) or (B) of this subdivision (h) is not readily available for the auditing entity at the time of the audit; and  (i) No auditing entity or agent shall receive payment based on a percentage of any recoupment.  (3) For recoupment under the Pharmacy Benefit Manager Licensure and Regulation Act, the auditing entity shall: (a) Include consumer-oriented parameters based on manufacturer listings in the audit parameters; (b) Consider the pharmacy's usual and customary price for a compounded medication as the reimbursable cost, unless the pricing method is outlined in the pharmacy provider contract; (c) Base a finding of overpayment or underpayment on the actual overpayment or underpayment and not a projection that relies on the number of patients served who have a similar diagnosis, the number of similar orders, or the number of refills for similar drugs; (d) Not use extrapolation to calculate the recoupment or penalties unless required by state or federal law; (e) Not include a dispensing fee in the calculation of an overpayment, unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee; (f) Not consider as fraud any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record. Such error may be subject to recoupment; (g) Not assess any recoupment in the case of an error that has no actual financial harm to the covered person or health benefit plan. An error that is the result of the pharmacy failing to comply with a formal corrective action plan may be subject to recoupment; and (h) Not allow interest to accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.  (4)(a) To validate a pharmacy record and the delivery of a pharmacy service, the pharmacy may use an authentic and verifiable statement or record, including a medication administration record of a nursing home, assisted-living facility, hospital, physician, or other authorized practitioner or an additional audit documentation parameter located in the provider manual.  (b) Any legal prescription that meets the requirements in this section may be used to validate a claim in connection with a prescription, refill, or change in a prescription, including a medication administration record, fax, e-prescription, or documented telephone call from the prescriber to the prescriber's agent.  (5) The auditing entity conducting the audit shall establish a written appeal process which shall include procedures for appealing both a preliminary audit report and a final audit report.  (6)(a) A preliminary audit report shall be delivered to the pharmacy within one hundred twenty days after the conclusion of the audit.  (b) A pharmacy shall be allowed at least thirty days following receipt of a preliminary audit report to provide documentation to address any discrepancy found in the audit.  (c) A final audit report shall be delivered to the pharmacy within one hundred twenty days after receipt of the preliminary audit report or the appeal process has been exhausted, whichever is later.  (d) An auditing entity shall remit any money due to a pharmacy or pharmacist as the result of an underpayment of a claim within forty-five days after the appeal process has been exhausted and the final audit report has been issued.  (7) Where contractually required, an auditing entity shall provide a copy to the plan sponsor of any of the plan sponsor's claims that were included in the audit, and any recouped money shall be returned to the health benefit plan or plan sponsor.  (8) This section does not apply to any investigative audit that involves suspected fraud, willful misrepresentation, or abuse, or any audit completed by a state-funded health care program. |
| **NM** | N.M. Code R. § 13.10.30.18B | DOI | The superintendent may also examine the audits of pharmacies conducted by PBMs to determine whether they are in compliance with Section 61-11-18.2 NMSA 1978. |
| **OH** | Ohio Rev. Code Ann. §3901.81 and [Ohio Rev. Code Ann. §3901.811 (2021)](https://codes.ohio.gov/ohio-revised-code/section-3901.811) | DOI | §3901.81  As used in this section and sections [3901.811](https://codes.ohio.gov/ohio-revised-code/section-3901.811) to [3901.815](https://codes.ohio.gov/ohio-revised-code/section-3901.815) of the Revised Code:  (A) "Auditing entity" means any person or government entity that performs a pharmacy audit, including a payer, a pharmacy benefit manager, or a third-party administrator licensed under Chapter 3959. of the Revised Code.  (B) "Business day" means any day of the week excluding Saturday, Sunday, and a legal holiday, as defined in section [1.14](https://codes.ohio.gov/ohio-revised-code/section-1.14) of the Revised Code.  (C) "Concurrent review" means a claims review within five business days of submission of claims for payment for the provision of dangerous drugs for which the payer or the auditing entity does not impose a penalty or demand to recoup money from the pharmacy in any amount.  (D) "Dangerous drug," "pharmacy," "practice of pharmacy," and "prescription" have the same meanings as in section [4729.01](https://codes.ohio.gov/ohio-revised-code/section-4729.01) of the Revised Code.  (E) "Payer" means any of the following that pays for or processes a claim for payment for the provision of dangerous drugs or pharmacy services:  (1) A health insuring corporation, as defined in section [1751.01](https://codes.ohio.gov/ohio-revised-code/section-1751.01) of the Revised Code;  (2) A person authorized to engage in the business of sickness and accident insurance under Title XXXIX of the Revised Code;  (3) A person or government entity providing coverage of dangerous drugs or pharmacy services to individuals on a self-insurance basis;  (4) A group health plan, as defined in 29 U.S.C. 1167;  (5) A service benefit plan, as referenced in 42 U.S.C. 1396a(a)(25);  (6) A medicaid managed care organization that has entered into a contract with the department of medicaid pursuant to section [5167.10](https://codes.ohio.gov/ohio-revised-code/section-5167.10) of the Revised Code;  (7) Any other person or government entity that is, by law, contract, or agreement, responsible for paying for or processing a claim for payment for the provision of dangerous drugs or pharmacy services.  (F) "Pharmacy audit" means a review of one or more pharmacy records conducted by an auditing entity, one purpose of which is to identify discrepancies in claims for payment for the provision of dangerous drugs or pharmacy services. "Pharmacy audit" does not include concurrent review.  (G) "Pharmacy benefit manager" means a person that provides administrative services related to the processing of claims for payment for the provision of dangerous drugs or pharmacy services, including performing pharmacy audit compliance, negotiating pharmaceutical rebate agreements, developing and managing drug formularies and preferred drug lists, and administering programs for payers' prior authorization of claims for payment for the provision of dangerous drugs or pharmacy services.  (H) "Pharmacy record" means any record stored electronically or as a hard copy by a pharmacy that relates to the provision of dangerous drugs or pharmacy services or any other component of pharmacist care that is included in the practice of pharmacy.  §3901.811  (A) Except as provided in division (B) of this section, an auditing entity is subject to all of the following conditions when performing a pharmacy audit in this state:  (1) If it is necessary that the pharmacy audit be performed on the premises of a pharmacy, the auditing entity shall give the pharmacy that is the subject of the audit written notice of the date or dates on which the audit will be performed and the range of prescription numbers from which the auditing entity will select pharmacy records to audit. Notice of the date or dates on which the audit will be performed shall be given not less than ten business days before the date the audit is to commence. Notice of the range of prescription numbers from which the auditing entity will select pharmacy records to audit shall be received by the pharmacy not less than seven business days before the date the audit is to commence.  (2) The auditing entity shall not include in the pharmacy audit a review of a claim for payment for the provision of dangerous drugs or pharmacy services if the date of the pharmacy's initial submission of the claim for payment occurred more than twenty-four months before the date the audit commences.  (3) Absent an indication that there was an error in the dispensing of a drug, the auditing entity or payer shall not seek to recoup from the pharmacy that is the subject of the audit any amount that the pharmacy audit identifies as being the result of clerical or recordkeeping errors in the absence of financial harm. For purposes of this provision, an error in the dispensing of a drug is any of the following: selecting an incorrect drug, issuing incorrect directions, or dispensing a drug to the incorrect patient.  (4) The auditing entity shall not use the accounting practice of extrapolation when calculating a monetary penalty to be imposed or amount to be recouped as the result of the pharmacy audit.  (B)(1) The condition in division (A)(1) of this section does not apply if, prior to the audit, the auditing entity has evidence, from its review of claims data, statements, or physical evidence or its use of other investigative methods, indicating that fraud or other intentional or willful misrepresentation exists.  (2) The condition in division (A)(3) of this section does not apply if the auditing entity  has evidence, from its review of claims data, statements, or physical evidence or its use of other investigative methods, indicating that fraud or other intentional or willful misrepresentation exists.  (3) Division (A)(4) of this section does not apply when the accounting practice of extrapolation is required by state or federal law. |
| **OR** | OR Rev. Stat. §§ 735.540 through 735.552 | DOI | § 735.540  As used in ORS 735.540 to 735.552:  (1) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity.  (2) "Clerical error" means a minor error:  (a) In the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;  (b) That does not result in financial harm to an entity; and  (c) That does not involve dispensing an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.  (3) "Entity" includes:  (a) A pharmacy benefit manager;  (b) An insurer;  (c) A third party administrator;  (d) A state agency; or  (e) A person that represents or is employed by one of the entities described in this subsection.  (4) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items or services, that uses false or misleading pretenses, representations or promises to obtain any money or property owned by or under the custody or control of any person. [2013 c.570 §4]  § 735.542  An entity that audits claims or an independent third party that contracts with an entity to audit claims:  (1) Must establish, in writing, a procedure for a pharmacy to appeal the entity’s findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy’s claims;  (2) May not conduct an audit of a claim more than 24 months after the date the claim was adjudicated by the entity;  (3) Must give at least 15 days’ advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy;  (4) May not conduct an on-site audit during the first five days of any month without the pharmacy’s consent;  (5) Must conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment;  (6) May not conduct an on-site audit of more than 250 unique prescriptions of a pharmacy in any 12-month period except in cases of alleged fraud;  (7) May not conduct more than one on-site audit of a pharmacy in any 12-month period;  (8) Must audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies;  (9) Must pay any outstanding claims of a pharmacy no more than 45 days after the earlier of the date all appeals are concluded or the date a final report is issued under ORS 735.550 (3);  (10) May not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;  (11) May not recoup costs associated with:  (a) Clerical errors; or  (b) Other errors that do not result in financial harm to the entity or a consumer; and  (12) May not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final.  § 735.544  An entity’s finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs.  § 735.546  An entity that contracts with an independent third party to conduct audits may not:  (1) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or  (2) Disclose information obtained during an audit except to the contracting entity, the pharmacy subject to the audit or the holder of the policy or certificate of insurance that paid the claim.  § 735.548  For purposes of ORS 735.540 to 735.552, an entity, or an independent third party that contracts with an entity to conduct audits, must allow as evidence of validation of a claim:  (1) An electronic or physical copy of a prescription that complies with ORS chapter 689 if the prescribed drug was, within 14 days of the dispensing date:  (a) Picked up by the patient or the patient’s designee;  (b) Delivered by the pharmacy to the patient; or  (c) Sent by the pharmacy to the patient using the United States Postal Service or other common carrier;  (2) Point of sale electronic register data showing purchase of the prescribed drug, medical supply or service by the patient or the patient’s designee; or  (3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy’s central operations and any other reasonably clear and accurate electronic documentation that corresponds to a claim.  § 735.550  (1)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 45 days after the date on which the audit was completed and must be sent:  (A) By mail or common carrier with a return receipt requested; or  (B) Electronically with electronic receipt confirmation.  (b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than 45 days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under ORS 735.542 (1) and to provide additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.  (2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail.  (3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under ORS 735.542 (1). The final report must include a final accounting of all moneys to be recovered by the entity.  (4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under ORS 735.542 (1) are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under ORS 735.542 (1) are final.  § 735.552  ORS 735.540 to 735.552 do not:  (1) Preclude an entity from instituting an action for fraud against a pharmacy;  (2) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data or statements or other investigative methods; or  (3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the state medical assistance program. |
| **PA** | 40 Pa. Stat. §§ 4511-4514 | DOI | § 4511  **(a) Procedure.**--An entity conducting a pharmacy audit under this chapter shall conform to the following rules:**(1)** Except as otherwise provided by federal or state law, an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity.**(2)** Information collected during a pharmacy audit shall be confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the pharmacy benefits manager and the covered entity, for which a pharmacy audit is being conducted.**(3)** The auditing entity conducting a pharmacy audit may not solely compensate an employee or contractor with which an auditing entity contracts to conduct a pharmacy audit, solely based on the amount claimed or the actual amount recouped by the pharmacy being audited.**(4)** The auditing entity shall provide the pharmacy being audited with at least 14 calendar days' prior written notice before conducting a pharmacy audit, unless both parties agree otherwise. if a delay is requested by the pharmacy, the pharmacy shall provide notice to the pbm within 72 hours of receiving notice of the audit.  **(5)** The auditing entity may not initiate or schedule a pharmacy audit during the first five business days of any month for a pharmacy that averages in excess of 600 prescriptions filled per week, without the express consent of the pharmacy.**(6)** The auditing entity shall accept paper or electronic signature logs that document the delivery of prescription or nonproprietary drugs and pharmacist services to a health plan beneficiary or the beneficiary's caregiver or guardian.**(7)** The auditing entity shall provide to the representative of the pharmacy, prior to leaving the pharmacy at the conclusion of the on-site portion of the pharmacy audit, a complete list of pharmacy records reviewed.**(8)** A pharmacy audit that involves clinical judgment shall be conducted by or in consultation with a pharmacist.**(9)**A pharmacy audit may not cover:**(i)** A period of more than 24 months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or covered entity unless a longer period is required by law; or**(ii)** More than 250 prescriptions, provided that a refill does not constitute a separate prescription for the purposes of this subparagraph.**(10)** The auditing entity may not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans.**(11)** The auditing entity may not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this paragraph, "misfill" means a prescription that was not dispensed, a prescription error, a prescription where the prescriber denied the authorization request or a prescription where an extra dispensing fee was charged.**(12)** A pharmacy may do any of the following when a pharmacy audit is performed:**(i)** To validate the pharmacy record and delivery, a pharmacy may use authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital or health care practitioner with prescriptive authority.**(ii)** To validate claims in connection with prescriptions or changes in prescriptions, or refills of prescription or nonproprietary drugs, a pharmacy may use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations or documented telephone calls from the prescribing health care practitioner or practitioner's agent. Documentation of an oral prescription order that has been verified by the prescribing health care practitioner shall meet the provisions of this subparagraph for the initial audit review.  **(b)Written report.**--An auditing entity shall provide the pharmacy with a written report of the pharmacy audit and comply with the following requirements:**(1)** A preliminary pharmacy audit report must be delivered to the pharmacy or its corporate parent within 60 calendar days after the completion of the pharmacy audit. The preliminary report shall include contact information for the auditing entity who conducted the pharmacy audit and an appropriate and accessible point of contact, including telephone number, facsimile number, e-mail, and auditing firm, so that audit results, discrepancies and procedures can be reviewed. The preliminary pharmacy audit report shall include, but not be limited to, claim level information for any discrepancy found and total dollar amount of claims subject to recovery.**(2)** A pharmacy shall be allowed 30 calendar days following receipt of the preliminary audit report to respond to the findings of the preliminary report.**(3)** A final audit report shall be delivered to the pharmacy or its corporate parent not later than 60 calendar days after any responses from the pharmacy or corporate parent are received by the auditing entity. The auditing entity shall issue a final pharmacy audit report that takes into consideration any responses provided to the auditing entity by the pharmacy or corporate parent.**(4)** The final audit report may be delivered electronically.**(5)** A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical error, scrivener's error or computer error, unless the error resulted in overpayment to the pharmacy.**(6)** An auditing entity conducting a pharmacy audit or person acting on behalf of the entity may not charge-back or recoup or collect penalties from a pharmacy until the time period to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later.**(7)** If an identified discrepancy in a pharmacy audit exceeds $25,000, future payments to the pharmacy in excess of that amount may be withheld pending adjudication of an appeal.**(8)** No interest shall accrue for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.  § 4512  A pharmacy may appeal a final audit report in accordance with the procedures established by the entity conducting the pharmacy audit.  § 4513  **(a) General rule.**--The provisions of this chapter do not apply to an investigative audit of pharmacy records when:**(1)** Fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** Other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.  **(b) Federal law.**--This chapter does not supersede any audit requirements established by federal law.  § 4514  The department may promulgate regulations as necessary and appropriate to carry out this chapter. |
| **SC** | S.C. Code §38-71-1810(B) (applies to a health carrier or any entity that represents a responsible party) | DOI | **(A)** For the purposes of this article:**(1)** "Insurer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-670(7) and Section 38-71-840(16).**(2)** "Responsible party" means the entity responsible for payment of claims for health care services other than:**(a)** the individual to whom the health care services were rendered; or**(b)** that individual's guardian or legal representative.**(3)** "Audit" means an evaluation, investigation, or review of claims paid to a pharmacy that takes place at the pharmacy location and does not include review of claims or claims payments that an insurer conducts as a normal course of business.**(4)** "Abuse" means any practice that:**(a)(i)** is inconsistent with sound fiscal or business practices; or**(ii)** fails to meet professionally recognized standards for pharmacy services; and**(b)** directly or indirectly causes financial loss to a responsible party.  **(B)** If a managed care organization, insurer, third-party payor, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, then, with respect to this audit, the pharmacy has a right to:**(1)** have at least fourteen days' advance notice of the initial audit for each audit cycle with no audit to be initiated or scheduled during the first five days of any month without the express consent of the pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days;**(2)** have an audit that involves clinical judgment be conducted with a pharmacist who is licensed and employed by or working under contract with the auditing entity;**(3)** not have clerical or record-keeping errors, including typographical errors, scrivener's errors, and computer errors, on a required document or record considered fraudulent in the absence of any other evidence or serve as the sole basis of rejection of a claim; however, the provisions of this item do not prohibit recoupment of fraudulent payments;**(4)** have the auditing entity to provide the pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media;**(5)** submit records related to the audit in electronic format or by certified mail;**(6)** have the properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication approved by the auditing entity in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug pursuant to federal and state regulations;**(7)** have a projection of an overpayment or underpayment based on either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; however, the provisions of this item do not prohibit recoupments of actual overpayments unless the projection for overpayment or underpayment is part of a settlement by the pharmacy;**(8)** be free of recoupments based on either of the following subitems unless defined within the billing, submission, or audit requirements set forth in the pharmacy provider manual not inconsistent with current State Board of Pharmacy Regulations, except for cases of Food and Drug Administration regulation or drug manufacturer safety programs in accordance with federal or state regulations:**(a)** documentation requirements in addition to, or exceeding requirements for, creating or maintaining documentation prescribed by the State Board of Pharmacy;**(b)** a requirement that a pharmacy or pharmacist perform a professional duty in addition to, or exceeding, professional duties prescribed by the State Board of Pharmacy unless otherwise agreed to by contract with the auditing entity;**(9)** be subject, so long as a claim is made within the contractual claim submission time period, to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim unless a prescription error occurs. For purposes of this subsection, a prescription error includes, but is not limited to, wrong drug, wrong strength, wrong dose, or wrong patient;**(10)** be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements;**(11)** be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity;**(12)** have at least thirty days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit;**(13)** have the option of providing documentation in electronic format or by certified mail;**(14)** have the period covered by an audit limited to twenty-four months from the date a claim was submitted to, or adjudicated by, a managed care organization, an insurer, a third-party payor, or an entity that represents responsible parties, unless a longer period is permitted by or under federal law;**(15)** have the preliminary audit report delivered to the pharmacy within one hundred twenty days after conclusion of the audit;**(16)** have a final audit report delivered to the pharmacy within ninety days after the end of the appeals period; and**(17)** not have the accounting practice of extrapolation used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.  **(C)** Notwithstanding Section 38-71-1840, the auditing entity shall provide the pharmacy, if requested, a masked list that provides a prescription number range the auditing entity is seeking to audit. |
| **SD** | S.D. Codified Laws Ann. §§58-29F-1 - 9 (2013) | DOI | **Section 58-29F-1 - Pharmacy audit integrity program established**  The pharmacy audit integrity program is hereby established to provide standards for an audit of pharmacy records carried out by a pharmacy benefits manager or any entity that represents the pharmacy benefits manager.  **Section 58-29F-2 - Definitions**  Term used in this chapter mean:  **(1)** "Entity," a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations in any capacity;**(2)** "Plan sponsor," the employer in the case of an employee benefit plan established or maintained by a single employer or the employee organization in the case of a plan established or maintained by an employee organization, an association, joint board, trustee, committee, or other similar group that establishes or maintains the plan.  **Section 58-29F-4 - Requirements for conducting pharmacy audit**  Unless otherwise prohibited by federal statutes or regulations, any entity conducting a pharmacy audit shall:  (1) Give a pharmacy a minimum fourteen days written notice before conducting initial on-site audit;(2) Conduct an audit that involves clinical or professional judgment in consultation with a licensed pharmacist; and(3) Audit each pharmacy under the same standards and parameters as other similarly situated pharmacies.  **Section 58-29F-5. Audit terms**  Unless otherwise prohibited by federal statutes or regulations, for any entity conducting a pharmacy audit the following audit items apply:  (1)    The period covered by the audit may not exceed twenty-four months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law;  (2)    If an entity uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample. Notwithstanding any other provision, the auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit;  (3) An on-site audit may not take place during the first five business days of the months of December and January unless the pharmacy consents;  (4) An auditor may not enter any portion of the pharmacy area where patient-specific information is available unless escorted, and to the extent possible shall remain out of sight and hearing range of the pharmacy patients;  (5) Any recoupment may not be deducted against future remittances until final completion of any appeals process and both parties have received the results of the final audit;  (6) A pharmacy benefits manager may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if:  (a) Additional information is required in the provider manual; or  (b) The information is required by the Food and Drug Administration; or  (c) The information is required by the drug manufacturer's product safety program; and  (d) The information in subsections (a), (b), or (c) is not readily available for the auditor at the time of the audit;  (7) The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if:  (a) The plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and  (b) A commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.  **Section 58-29F-6 - Recoupment or chargeback criteria**  For recoupment or chargeback, the following criteria apply:  **(1)** Audit parameters shall consider consumer-oriented parameters based on manufacturer listings;**(2)** A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the provider contract;**(3)** A finding of overpayment or underpayment can only be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;**(4)** The entity conducting the audit may not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulation;**(5)** Calculations of overpayments may not include dispensing fees unless:**(a)** A prescription was not actually dispensed;**(b)** The prescriber denied authorization;**(c)** The prescription dispensed was a medication error by the pharmacy; or**(d)** The identified overpayment is solely based on an extra dispensing fee;**(6)** An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud. However, such errors may be subject to recoupment;**(7)** In the case of errors that have no actual financial harm to the patient or plan, the pharmacy benefits manager may not assess any chargebacks. Errors that are a result of the pharmacy's failing to comply with a formal corrective action plan may be subject to recovery; and**(8)** Interest may not accrue during the audit period for either party. The audit period begins with the notice of the audit and ends with the final audit report.  **Section 58-29F-7 - Validation of pharmacy record and delivery**  To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual. Any legal prescription that meets the requirements in this chapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.  **Section 58-29F-8 - Preliminary and final audit reports**  A preliminary audit report shall be delivered to the pharmacy within sixty days after the conclusion of the audit. A pharmacy shall be allowed at least forty-five days following receipt of the preliminary audit, to provide documentation to address any discrepancy found in the audit. A final audit report shall be delivered to the pharmacy within one hundred twenty days after receipt of the preliminary audit report or final appeal, whichever is later. An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within forty-five days after the appeals process has been exhausted and the final audit report has been issued.  **Section 58-29F-9 - Appeals process**  The entity conducting the audit shall establish a written appeals process which shall include appeals of preliminary reports and final reports. |
| **TX** | Tex. Insurance Code Ann. Subchapter F, §§1369.251- 1369.270 (2013) | DOI | **SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES**  **Sec. 1369.251. DEFINITIONS.** In this subchapter:  (1) "Desk audit" means an audit conducted by a health benefit plan issuer or pharmacy benefit manager at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the offices of the plan issuer or pharmacy benefit manager during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk, or other electronic media. The term does not include a review conducted not later than the third business day after the date a claim is adjudicated provided recoupment is not demanded.  (2) "Extrapolation" means a mathematical process or technique used by a health benefit plan issuer or pharmacy benefit manager that administers pharmacy claims for a health benefit plan issuer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan issuer or pharmacy benefit manager.  (3) "Health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including:  (A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:  (i) an insurance company;  (ii) a group hospital service corporation operating under Chapter [842](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=842);  (iii) a health maintenance organization operating under Chapter [843](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=843);  (iv) an approved nonprofit health corporation that holds a certificate of authority under Chapter [844](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=844);  (v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter [846](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=846);  (vi) a stipulated premium company operating under Chapter [884](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=884);  (vii) a fraternal benefit society operating under Chapter [885](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=885);  (viii) a Lloyd's plan operating under Chapter [941](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=941); or  (ix) an exchange operating under Chapter [942](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=942);  (B) a small employer health benefit plan written under Chapter [1501](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1501); or  (C) a health benefit plan issued under Chapter [1551](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1551), [1575](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1575), [1579](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1579), or [1601](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1601).  (4) "On-site audit" means an audit that is conducted at:  (A) the location of the pharmacist or pharmacy; or  (B) another location at which the records under review are stored.  (5) "Pharmacy benefit manager" has the meaning assigned by Section [4151.151](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=4151.151).  **Sec. 1369.252. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER.** This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:  (1) the state Medicaid program;  (2) the federal Medicare program;  (3) the state child health plan or health benefits plan for children under Chapter [62](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=HS&Value=62) or [63](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=HS&Value=63), Health and Safety Code;  (4) the TRICARE military health system;  (5) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code; or  (6) a self-funded health benefit plan as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).  **Sec. 1369.253. CONFLICT WITH OTHER LAWS.** If there is a conflict between this subchapter and a provision of Chapter [843](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=843) or [1301](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1301) related to a pharmacy benefit manager, this subchapter prevails.  **Sec. 1369.254. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS.** (a) Except as provided by Subsection (d), a health benefit plan issuer or pharmacy benefit manager that performs an on-site audit under this subchapter of a pharmacist or pharmacy shall provide the pharmacist or pharmacy reasonable notice of the audit and accommodate the pharmacist's or pharmacy's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by a means that allows tracking of delivery to the pharmacist or pharmacy not later than the 14th day before the date on which the on-site audit is scheduled to occur.  (b) Not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), the pharmacist or pharmacy may request that an on-site audit be rescheduled to a mutually convenient date. The request must be reasonably granted.  (c) Unless the pharmacist or pharmacy consents in writing, a health benefit plan issuer or pharmacy benefit manager may not schedule or have an on-site audit conducted:  (1) except as provided by Subsection (d), before the 14th day after the date the pharmacist or pharmacy receives notice under Subsection (a), if applicable;  (2) more than twice annually in connection with a particular payor; or  (3) during the first five calendar days of January and December.  (d) A health benefit plan issuer or pharmacy benefit manager is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the pharmacist or pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business. The pharmacist or pharmacy may not request that the audit be rescheduled under Subsection (b).  (e) A pharmacist or pharmacy may be required to submit documents in response to a desk audit not earlier than the 20th day after the date the health benefit plan issuer or pharmacy benefit manager requests the documents.  (f) A contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager must state detailed audit procedures. If a health benefit plan issuer or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, the plan issuer or pharmacy benefit manager must notify the pharmacist or pharmacy in writing of a change in an audit procedure not later than the 60th day before the effective date of the change.  (g) The list of the claims subject to an on-site audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and must identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be omitted.  (h) If the health benefit plan issuer or pharmacy benefit manager in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size may not be greater than 300 individual prescription claims.  **Sec. 1369.255. COMPLETION OF AUDIT.** An audit of a claim under Section [1369.254](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.254) must be completed on or before the one-year anniversary of the date the claim is received by the health benefit plan issuer or pharmacy benefit manager.  **Sec. 1369.256. AUDIT REQUIRING PROFESSIONAL JUDGMENT**. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit or a desk audit involving a pharmacist's clinical or professional judgment must conduct the audit in consultation with a licensed pharmacist.  **Sec. 1369.257. ACCESS TO PHARMACY AREA.** A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit may not enter the pharmacy area unless escorted by an individual authorized by the pharmacist or pharmacy.  **Sec. 1369.258. VALIDATION USING CERTAIN RECORDS AUTHORIZED.**  A pharmacist or pharmacy that is being audited may:  (1) validate a prescription, refill of a prescription, or change in a prescription with a prescription that complies with applicable federal laws and regulations and state laws and rules adopted under Section [554.051](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=OC&Value=554.051), Occupations Code; and  (2) validate the delivery of a prescription with a written record of a hospital, physician, or other authorized practitioner of the healing arts.  **Sec. 1369.2581. AUDIT DISCREPANCIES; WHOLESALE INVOICES.**  (a) A health benefit plan issuer or pharmacy benefit manager that audits wholesale invoices during an audit of a pharmacist or pharmacy may not audit the pharmacy claims of another health benefit plan or pharmacy benefit manager.  (b) A health benefit plan issuer or pharmacy benefit manager shall reverse a finding of a discrepancy if:  (1) the National Drug Code for the dispensed drug is in a quantity that is a subunit or multiple of the drug purchased by the pharmacist or pharmacy as supported by a wholesale invoice;  (2) the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription; and  (3) the drug dispensed by the pharmacist or pharmacy shares all but the last two digits of the National Drug Code of the drug reflected on the supplier invoice.  (c) A health benefit plan issuer or pharmacy benefit manager must accept as evidence to support the validity of a pharmacy claim related to a dispensed drug:  (1) subject to validation, including validation by pharmacy purchase order and payment of a supplier invoice, copies of supplier invoices in the pharmacist's or pharmacy's possession, including:  (A) supplier invoices issued before the date the drug was dispensed and not earlier than 60 days before the first day of the audit period; and  (B) invoices and any supporting documents from any supplier authorized by federal or state law to transfer ownership of the drug acquired by the pharmacist or pharmacy; and  (2) reports required by any state board or agency.  (d) A health benefit plan issuer or pharmacy benefit manager must provide, not later than the fifth business day after the date of a request by the pharmacist or pharmacy, any supporting documents the pharmacist's or pharmacy's suppliers provided to the health benefit plan issuer or pharmacy benefit manager.  **Sec. 1369.259. CALCULATION OF RECOUPMENT; USE OF EXTRAPOLATION PROHIBITED**. (a) A health benefit plan issuer or pharmacy benefit manager may not calculate the amount of a recoupment based on:  (1) an absence of documentation the pharmacist or pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain; or  (2) an error that does not result in actual financial harm to the patient or enrollee, the health benefit plan issuer, or the pharmacy benefit manager.  (b) A health benefit plan issuer or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.  (c) A health benefit plan issuer or pharmacy benefit manager may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.  (d) A health benefit plan issuer or pharmacy benefit manager may not include a dispensing fee amount in the calculation of an overpayment unless:  (1) the fee was a duplicate charge;  (2) the prescription for which the fee was charged:  (A) was not dispensed; or  (B) was dispensed:  (i) without the prescriber's authorization;  (ii) to the wrong patient; or  (iii) with the wrong instructions; or  (3) the wrong drug was dispensed.  **Sec. 1369.260. CLERICAL OR RECORDKEEPING ERROR; FRAUD ALLEGATION.** (a) An unintentional clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error, found during an on-site audit or a desk audit:  (1) is not prima facie evidence of fraud or intentional misrepresentation; and  (2) may not be the basis of a recoupment unless the error results in actual financial harm to a patient or enrollee, health benefit plan issuer, or pharmacy benefit manager.  (b) If the health benefit plan issuer or pharmacy benefit manager alleges that the pharmacist or pharmacy committed fraud or intentional misrepresentation described by Subsection (a), the health benefit plan issuer or pharmacy benefit manager must state the allegation in the final audit report required by Section [1369.264](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.264).  (c) After an audit is initiated, a pharmacist or pharmacy may resubmit a claim described by Subsection (a) if the deadline for submission of a claim under Section [843.337](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=843.337) or [1301.102](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1301.102) has not expired.  **Sec. 1369.261. ACCESS TO PREVIOUS AUDIT REPORTS; UNIFORM AUDIT STANDARDS.** (a) Except as provided by Subsection (b), a health benefit plan issuer or pharmacy benefit manager may have access to an audit report of a pharmacist or pharmacy only if the report was prepared in connection with an audit conducted by the health benefit plan issuer or pharmacy benefit manager.  (b) A health benefit plan issuer or pharmacy benefit manager may have access to audit reports other than the reports described by Subsection (a) if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or the pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.  (c) An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.  **Sec. 1369.262. COMPENSATION OF AUDITOR.**  An individual performing an on-site audit or a desk audit may not directly or indirectly receive compensation based on a percentage of the amount recovered as a result of the audit.  **Sec. 1369.263. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT.** (a) At the conclusion of an on-site audit or a desk audit, the health benefit plan issuer or pharmacy benefit manager shall:  (1) provide to the pharmacist or pharmacy a summary of the audit findings; and  (2) allow the pharmacist or pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings.  (b) Not later than the 60th day after the date the audit is concluded, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a preliminary audit report stating the results of the audit and a list identifying documentation, if any, required to resolve discrepancies, if any, found as a result of the audit.  (c) The pharmacist or pharmacy may, by providing documentation or otherwise, challenge a result or remedy a discrepancy stated in the preliminary audit report not later than the 30th day after the date the pharmacist or pharmacy receives the report.  (d) The pharmacist or pharmacy may request an extension to provide documentation supporting a challenge. The request shall be reasonably granted. A health benefit plan issuer or pharmacy benefit manager that grants an extension is not subject to the deadline to send the final audit report under Section [1369.264](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.264).  **Sec. 1369.264. FINAL AUDIT REPORT.** Not later than the 120th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section [1369.263](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.263), the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report that states:  (1) the audit results after review of the documentation submitted by the pharmacist or pharmacy in response to the preliminary audit report; and  (2) the audit results, including a description of all alleged discrepancies and explanations for and the amount of recoupments claimed after consideration of the pharmacist's or pharmacy's response to the preliminary audit report.  **Sec. 1369.265. CERTAIN AUDITS EXEMPT FROM DEADLINES.** A health benefit plan issuer or pharmacy benefit manager is not subject to the deadlines for sending a report under Sections [1369.263](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.263) and [1369.264](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.264) if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.  **Sec. 1369.266. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT.** (a) If an audit under this subchapter is conducted, the health benefit plan issuer or pharmacy benefit manager:  (1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report; and  (2) may not accrue or assess interest on an amount due until the date the pharmacist or pharmacy receives the final audit report under Section [1369.264](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.264).  (b) The limitations on recoupment and interest accrual or assessment under Subsection (a) do not apply to a health benefit plan issuer or pharmacy benefit manager that, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.  **Sec. 1369.267. WAIVER PROHIBITED.** The provisions of this subchapter may not be waived, voided, or nullified by contract.  **Sec. 1369.268. REMEDIES NOT EXCLUSIVE.**  This subchapter may not be construed to waive a remedy at law available to a pharmacist or pharmacy.  **Sec. 1369.269. ENFORCEMENT; RULES.** The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.  **Sec. 1369.270. LEGISLATIVE DECLARATION.** Except as provided by Section [1369.252](https://statutes.capitol.texas.gov/GetStatute.aspx?Code=IN&Value=1369.252), it is the intent of the legislature that the requirements contained in this subchapter regarding the audit of claims to providers who are pharmacists or pharmacies apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law. |
| **UT** | Utah Code Ann. § 31A-46-303 | DOI | (1) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622. (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless: (a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and (b) the drug is: (i) generally available for purchase in this state from a national or regional wholesaler; and (ii) not obsolete. (3) The maximum allowable cost may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. (4) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall: (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data; (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (4)(a), at least once per week; (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (5); and (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible. (5) (a) The right to appeal in Subsection (4)(c) shall be: (i) limited to 21 days following the initial claim adjudication; and (ii) investigated and resolved by the pharmacy benefit manager within 14 business days. (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager. (6) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract. (7) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the Medicaid program. |
| **WA** | Wash. Rev. Code Ann. §48.200.220 (2020) | DOI | **Auditing of claims—Requirements—Prohibited practices.**  An entity that audits claims or an independent third party that contracts with an entity to audit claims:  (1) Must establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims;  (2) May not conduct an audit of a claim more than twenty-four months after the date the claim was adjudicated by the entity;  (3) Must give at least fifteen days' advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy;  (4) May not conduct an on-site audit during the first five days of any month without the pharmacy's consent;  (5) Must conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment;  (6) May not conduct an on-site audit of more than two hundred fifty unique prescriptions of a pharmacy in any twelve-month period except in cases of alleged fraud;  (7) May not conduct more than one on-site audit of a pharmacy in any twelve-month period;  (8) Must audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies;  (9) Must pay any outstanding claims of a pharmacy no more than forty-five days after the earlier of the date all appeals are concluded or the date a final report is issued under RCW [**48.200.260**](http://app.leg.wa.gov/RCW/default.aspx?cite=48.200.260)(3);  (10) May not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;  (11) May not recoup costs associated with:  (a) Clerical errors; or  (b) Other errors that do not result in financial harm to the entity or a consumer; and  (12) May not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final. |
| **WI** | Wis. Stat. 632.865 (6) | DOI | Audits of pharmacies or pharmacists.  **(a)** Definitions. In this subsection:  **1.** “Audit” means a review of the accounts and records of a pharmacy or pharmacist by or on behalf of an entity that finances or reimburses the cost of health care services or prescription drugs.  **2.** “Entity” means a defined network plan, as defined in s. 609.01 (1b), insurer, self-insured health plan, or pharmacy benefit manager or a person acting on behalf of a defined network plan, insurer, self-insured health plan, or pharmacy benefit manager.  **3.** “Self-insured health plan” has the meaning given in s. 632.85 (1) (c).  **(b)** Procedures. An entity conducting an on-site or desk audit of pharmacist or pharmacy records shall do all of the following:  **1.** If the audit is an audit on the premises of the pharmacist or pharmacy, notify the pharmacist or pharmacy in writing of the audit at least 2 weeks before conducting the audit.  **2.** Refrain from auditing a pharmacist or pharmacy within the first 5 business days of a month unless the pharmacist or pharmacy consents to an audit during that time.  **3.** If the audit involves clinical or professional judgment, conduct the audit by or in consultation with a pharmacist licensed in any state.  **4.** Limit the audit review to no more than 250 separate prescriptions. For purposes of this subdivision, a refill of a prescription is not a separate prescription.  **5.** Limit the audit review to claims submitted no more than 2 years before the date of the audit, unless required otherwise by state or federal law.  **6.** Allow the pharmacist or pharmacy to use authentic and verifiable records of a hospital, physician, or other health care provider to validate the pharmacist's or pharmacy's records relating to delivery of a prescription drug and use any valid prescription that complies with requirements of the pharmacy examining board to validate claims in connection with a prescription, refill of a prescription, or change in prescription.  **7.** Allow the pharmacy or pharmacist to document the delivery of a prescription drug or pharmacist services to an enrollee under a health benefit plan using either paper or electronic signature logs.  **8.** Before leaving the pharmacy after concluding the on-site portion of an audit, provide to the representative of the pharmacy or the pharmacist a complete list of the pharmacy records reviewed.  **(c)** Results of audit. An entity that has conducted an audit of a pharmacist or pharmacy shall do all of the following:  **1.** Deliver to the pharmacist or pharmacy a preliminary report of the audit within 60 days after the date the auditor departs from an on-site audit or the pharmacy or pharmacist submits paperwork for a desk audit. A preliminary report under this subdivision shall include claim-level information for any discrepancy reported, the estimated total amount of claims subject to recovery, and contact information for the entity or person that completed the audit so the pharmacist or pharmacy subject to the audit may review audit results, procedures, and discrepancies.  **2.** Allow a pharmacist or pharmacy that is the subject of an audit to provide documentation to address any discrepancy found in the audit within 30 days after the date the pharmacist or pharmacy receives the preliminary report.  **3.** Deliver to the pharmacist or pharmacy a final audit report, which may be delivered electronically, within 90 days of the date the pharmacist or pharmacy receives the preliminary report or the date of the final appeal of the audit, whichever is later. The final audit report under this subdivision shall include any response provided to the auditor by the pharmacy or pharmacist and consider and address the pharmacy's or pharmacist's response.  **4.** Refrain from assessing a recoupment or other penalty on a pharmacist or pharmacy until the appeal process is exhausted and the final report under subd. 3. is delivered to the pharmacist or pharmacy.  **5.** Refrain from accruing or charging interest between the time the notice of the audit is given under par. (b) 1. and the final report under subd. 3. has been delivered.  **6.** Exclude dispensing fees from calculations of overpayments.  **7.** Establish and follow a written appeals process that allows a pharmacy or pharmacist to appeal the final report of an audit and allow the pharmacy or pharmacist as part of the appeal process to arrange for, at the cost of the pharmacy or pharmacist, an independent audit.  **8.** Refrain from subjecting the pharmacy or pharmacist to a recoupment or recovery for a clerical or record-keeping error in a required document or record, including a typographical or computer error, unless the error resulted in an overpayment to the pharmacy or pharmacist.  **(d)** Confidentiality of audit. Information obtained in an audit under this subsection is confidential and may not be shared unless the information is required to be shared under state or federal law and except that the audit may be shared with the entity on whose behalf the audit is performed. An entity conducting an audit may have access to the previous audit reports on a particular pharmacy only if the audit is conducted by the same entity.  **(e)** Cooperation with audit. If an entity is conducting an audit that is complying with this subsection in auditing a pharmacy or pharmacist, the pharmacy or pharmacist that is the subject of the audit may not interfere with or refuse to participate in the audit.  **(f)** Payment of auditors. A pharmacy benefit manager or entity conducting an audit may not pay an auditor employed by or contracted with the pharmacy benefit manager or entity based on a percentage of the amount recovered in an audit.  **(g)** Applicability.  **1.** This subsection does not apply to an investigative audit that is initiated as a result of a credible allegation of fraud or willful misrepresentation or criminal wrongdoing.  **2.** If an entity conducts an audit to which a federal law applies that is in conflict with all or part of this subsection, the entity shall comply with this subsection only to the extent that it does not conflict with federal law. |
| **WV** | W. Va. Code §§33-51-3 – 33-51-6 (2019) | DOI | **§33-51-3. Definitions.**  For purposes of this article:  “340B entity” means an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. § 256b, including its pharmacy or pharmacies, or any pharmacy or pharmacies, contracted with the participating entity to dispense drugs purchased through such program.  “Affiliate” means a pharmacy, pharmacist, or pharmacy technician which, either directly or indirectly through one or more intermediaries: (A) Has an investment or ownership interest in a pharmacy benefits manager licensed under this chapter; (B) shares common ownership with a pharmacy benefits manager licensed under this chapter; or (C) has an investor or ownership interest holder which is a pharmacy benefits manager licensed under this article.  “Auditing entity” means a person or company that performs a pharmacy audit, including a pharmacy benefits manager, managed care organization, or third-party administrator.  “Business day” means any day of the week excluding Saturday, Sunday, and any legal holiday as set forth in §2-2-1 of this code.  “Claim level information” means data submitted by a pharmacy, required by a payor, or claims processor to adjudicate a claim.  “Covered individual” means a member, participant, enrollee, or beneficiary of a health benefit plan who is provided health care service coverage by a health benefit plan, including a dependent or other person provided health coverage through the policy or contract of a covered individual.  “Extrapolation” means the practice of inferring a frequency of dollar amount of overpayments, underpayments, nonvalid claims, or other errors on any portion of claims submitted, based on the frequency of dollar amount of overpayments, underpayments, nonvalid claims, or other errors actually measured in a sample of claims.  “Defined cost sharing” means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee’s health plan.  “Health benefit plan” or “health plan” means a policy, contract, certificate, or agreement entered into, offered, or issued by a health care payor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.  “Health care payor” or “payor” means a health insurance company, a health maintenance organization, a hospital, medical, or dental corporation, a health care corporation, an entity that provides, administers, or manages a self-funded health benefit plan, including a governmental plan, or any other payor that provides prescription drug coverages, including a workers’ compensation insurer. Health care payor does not include an insurer that provides coverage under a policy of casualty or property insurance.  “Health care provider” has the same meaning as defined in §33-41-2 of this code.  “Health insurance policy” means a policy, subscriber contract, certificate, or plan that provides prescription drug coverage. The term includes both comprehensive and limited benefit health insurance policies.  “Insurance commissioner” or “commissioner” has the same meaning as defined in §33-1-5 of this code.  “Network” means a pharmacy or group of pharmacies that agree to provide prescription services to covered individuals on behalf of a health benefit plan in exchange for payment for its services by a pharmacy benefits manager or pharmacy services administration organization. The term includes a pharmacy that generally dispenses outpatient prescriptions to covered individuals or dispenses particular types of prescriptions, provides pharmacy services to particular types of covered individuals or dispenses prescriptions in particular health care settings, including networks of specialty, institutional or long-term care facilities.  “Maximum allowable cost” means the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.  “National average drug acquisition cost” means the monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services to determine average acquisition cost for Medicaid covered outpatient drugs.  “Nonproprietary drug” means a drug containing any quantity of any controlled substance or any drug which is required by any applicable federal or state law to be dispensed only by prescription.  “Pharmacist” means an individual licensed by the West Virginia Board of Pharmacy to engage in the practice of pharmacy.  “Pharmacy” means any place within this state where drugs are dispensed and pharmacist care is provided.  “Pharmacy audit” means an audit, conducted by or on behalf of an auditing entity of any records of a pharmacy for prescription or nonproprietary drugs dispensed by a pharmacy to a covered individual.  “Pharmacy benefits management” means the performance of any of the following:  (1) The procurement of prescription drugs at a negotiated contracted rate for dispensation within the state of West Virginia to covered individuals;  (2) The administration or management of prescription drug benefits provided by a health benefit plan for the benefit of covered individuals;  (3) The administration of pharmacy benefits, including:  (A) Operating a mail-service pharmacy;  (B) Claims processing;  (C) Managing a retail pharmacy network;  (D) Paying claims to a pharmacy for prescription drugs dispensed to covered individuals via retail or mail-order pharmacy;  (E) Developing and managing a clinical formulary including utilization management and quality assurance programs;  (F) Rebate contracting administration; and  (G) Managing a patient compliance, therapeutic intervention, and generic substitution program.  “Pharmacy benefits manager” means a person, business, or other entity that performs pharmacy benefits management for health benefit plans;  “Pharmacy record” means any record stored electronically or as a hard copy by a pharmacy that relates to the provision of prescription or nonproprietary drugs or pharmacy services or other component of pharmacist care that is included in the practice of pharmacy.  “Pharmacy services administration organization” means any entity that contracts with a pharmacy to assist with payor interactions and that may provide a variety of other administrative services, including contracting with pharmacy benefits managers on behalf of pharmacies and managing pharmacies’ claims payments from payors.  “Point-of-sale fee” means all or a portion of a drug reimbursement to a pharmacy or other dispenser withheld at the time of adjudication of a claim for any reason.  “Rebate” means any and all payments that accrue to a pharmacy benefits manager or its health plan client, directly or indirectly, from a pharmaceutical manufacturer, including, but not limited to, discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered on behalf of a health plan client. The term “rebate” does not include any discount or payment that may be provided to or made to any 340B entity through such program.  “Retroactive fee” means all or a portion of a drug reimbursement to a pharmacy or other dispenser recouped or reduced following adjudication of a claim for any reason, except as otherwise permissible as described in this article.  “Specialty drug” means a drug used to treat chronic and complex, or rare medical conditions and requiring special handling or administration, provider care coordination, or patient education that cannot be provided by a non-specialty pharmacy or pharmacist.  **§33-51-4. Procedures for conducting pharmacy audits.**  (a) An entity conducting a pharmacy audit under this article shall conform to the following rules:  (1) Except as otherwise provided by federal or state law, an auditing entity conducting a pharmacy audit may have access to a pharmacy’s previous audit report only if the report was prepared by that auditing entity.  (2) Information collected during a pharmacy audit is confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the pharmacy benefits manager and with the covered entity for which a pharmacy audit is being conducted and with any regulatory agencies and law-enforcement agencies as required by law.  (3) The auditing entity conducting a pharmacy audit may not compensate an employee or contractor with which an auditing entity contracts to conduct a pharmacy audit solely based on the amount claimed or the actual amount recouped by the pharmacy being audited.  (4) The auditing entity shall provide the pharmacy being audited with at least 14 calendar days" prior written notice before conducting a pharmacy audit unless both parties agree otherwise. If a delay of the audit is requested by the pharmacy, the pharmacy shall provide notice to the pharmacy benefits manager within 72 hours of receiving notice of the audit.  (5) The auditing entity may not initiate or schedule a pharmacy audit without the express consent of the pharmacy during the first five business days of any month for any pharmacy that averages in excess of 600 prescriptions filled per week.  (6) The auditing entity shall accept paper or electronic signature logs that document the delivery of prescription or nonproprietary drugs and pharmacist services to a health plan beneficiary or the beneficiary’s caregiver or guardian.  (7) Prior to leaving the pharmacy after the on-site portion of the pharmacy audit, the auditing entity shall provide to the representative of the pharmacy a complete list of pharmacy records reviewed.  (8) A pharmacy audit that involves clinical judgment shall be conducted by, or in  consultation with, a pharmacist.  (9) A pharmacy audit may not cover:  (A) A period of more than 24 months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or covered entity unless a longer period is required by law; or  (B) More than 250 prescriptions: Provided, That a refill does not constitute a separate prescription for the purposes of this subparagraph.  (10) The auditing entity may not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans.  (11) The auditing entity may not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this subdivision, "misfill" means a prescription that was not dispensed, a prescription error, a prescription where the prescriber denied the authorization request, or a prescription where an extra dispensing fee was charged.  (12) The auditing entity conducting a pharmacy audit or person acting on behalf of the auditing entity may not seek any fee, charge-back, recoupment, or other adjustment for a dispensed product, or any portion of a dispensed product, unless one of the following has occurred:  (A) Fraud or other intentional and willful misrepresentation as evidenced by a review of the claims data, statements, physical review, or other investigative methods;  (B) Dispensing in excess of the benefit design, as established by the plan sponsor;  (C) Prescriptions not filled in accordance with the prescriber’s order; or  (D) Actual overpayment to the pharmacy.  (13) Any fee, charge-back, recoupment, or other adjustment is limited to the actual financial harm associated with the dispensed product, or portion of the dispensed product, or the actual underpayment or overpayment as set forth in the criteria in subdivision (12) of this subsection.  (14) A pharmacy may do any of the following when a pharmacy audit is performed:  (A) A pharmacy may use authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital, or health care provider with prescriptive authority, to validate the pharmacy record and delivery; and  (B) A pharmacy may use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations, or documented telephone calls from the prescribing health care provider or practitioner’s agent, to validate claims in connection with prescriptions or changes in prescriptions or refills of prescription or nonproprietary drugs. Documentation of an oral prescription order that has been verified by the prescribing health care provider shall meet the provisions of this subparagraph for the initial audit review.  (b) An auditing entity shall provide the pharmacy with a written report of the pharmacy audit and comply with the following requirements:  (1) A preliminary pharmacy audit report shall be delivered to the pharmacy or its corporate parent within 60 calendar days after the completion of the pharmacy audit. The preliminary report shall include contact information for the auditing entity that conducted the pharmacy audit and an appropriate and accessible point of contact, including telephone number, facsimile number, e-mail address, and auditing firm name and address so that audit results, procedures and any discrepancies can be reviewed. The preliminary pharmacy audit report shall include, but not be limited to, claim level information for any discrepancy found and total dollar amounts of claims subject to recovery.  (2) A pharmacy is allowed at least 30 calendar days following receipt of the preliminary audit report to respond to the findings of the preliminary report.  (3) A final pharmacy audit report shall be delivered to the pharmacy or its corporate parent no later than 90 calendar days after completion of the pharmacy audit. The final pharmacy audit report shall include any response provided to the auditing entity by the pharmacy or corporate parent and shall consider and address such responses.  (4) The final audit report may be delivered electronically.  (5) A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy.  (6) An auditing entity conducting a pharmacy audit or person acting on behalf of the entity may not charge-back, recoup, or collect penalties from a pharmacy until the time to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later.  (7) If an identified discrepancy in a pharmacy audit exceeds $25,000, future payments to the pharmacy in excess of that amount may be withheld pending adjudication of an appeal.  (8) No interest accrues for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.  (9) Except for Medicare claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim may not be reversed unless the pharmacy or pharmacist obtained adjudication by fraud or misrepresentation of claims elements.  **§33-51-5.  Appeals process.**  A pharmacy may appeal a final audit report in accordance with the procedures established by the entity conducting the pharmacy audit.  **§33-51-6.  Limitations.**  (a) The provisions of this article do not apply to an investigative audit of pharmacy records when:  (1) Fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or  (2) Other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.  (b) This article does not supersede any audit requirements established by federal law. |

PRIOR AUTHORIZATION REQUIREMENTS – NOVEMBER 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **DE** | Del. Code tit. 18, Chapter 33A § 3336A and § 3337A | DOI | § 3336A  A pharmacy benefit manager may not require prior authorization for coverage of a 72 hour supply of medication that is for a non-controlled substance in an emergency situation.  § 3337A  (a) A prior authorization form for a prescription medication shall include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient.  (b) If a prescriber indicates on a prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, the pharmacy benefit manager may not request a reauthorization for the same prescription medication more frequently than every 12 months.  (c) In the same communication in which a pharmacy benefit manager or the pharmacy benefit manager's agent requests a prior authorization for a prescription medication that has therapeutically equivalent medications that do not require a prior authorization from a prescriber, the pharmacy benefit manager or the pharmacy benefit manager's agent shall provide the prescriber with a list of alternative prescription medications of the same class and family as the requested medication.  (d) Prescribers that utilize e-prescribing shall receive alternate medications from the pharmacy benefit manager for prescription medications that do not require a prior authorization before the completion of the e-prescribing transaction.  (e) A pharmacy benefit manager or the pharmacy benefit manager's agent shall provide alternative medications for therapeutically equivalent medications to the pharmacy that require prior authorization on the National Council for Prescription Drug Programs response transaction to a denied claim for prior authorization. |
| **TX** | [Texas Insurance Code § 1369.304](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.304) | DOI | (a) The commissioner by rule shall:  (1) prescribe a single, standard form for requesting prior authorization of prescription drug benefits;  2) require a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits to use the form for any prior authorization of prescription drug benefits required by the plan;  (3) require that the department and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits make the form available electronically on the website of:  (A) the department;  (B) the health benefit plan issuer; and  (C) the agent of the health benefit plan issuer; and  (4) establish penalties for failure to accept the form and acknowledge receipt of the form as required by commissioner rule.  (b) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits shall exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.  (c) In prescribing a form under this section, the commissioner shall:  (1) develop the form with input from the advisory committee on uniform prior authorization forms established under Section 1369.305; and  (2) take into consideration:  (A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by the department;  (B) request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services; and  (C) national standards, or draft standards, pertaining to electronic prior authorization of benefits. |
|  |  |  |  |

PROHIBITED PHARMACY FEES – NOVEMBER 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **NM** | N.M. Stat. § 59A-61-5F and § 59A-61-7 | DOI | N.M. Stat. § 59A-61-5F  **F.** A pharmacy benefits manager or health benefit plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefit plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.  N.M. Stat. § 59A-61-7  **A.** A pharmacy benefits manager shall not charge a pharmacy a fee related to the adjudication of a claim, including:**(1)** the receipt and processing of a pharmacy claim;**(2)** the development or management of a claim processing or adjudication network; or**(3)** participation in a claim processing or claim adjudication network.  **B.** A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract. |
| **TX** | [Texas Insurance Code § 1369.402](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.402) | DOI | A health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including:  (1) the adjudication of a pharmacy benefit claim;  (2) the processing or transmission of a pharmacy benefit claim;  (3) the development or management of a claim processing or adjudication network; or  (4) participation in a claim processing or adjudication network. |
|  |  |  |  |

PROHIBITING CLAWBACKS – NOVEMBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **MD** | MD. ANN. CODE § 15-1628.3 | DOI | **(a)** A pharmacy benefits manager or a carrier may not directly or indirectly charge a contracted pharmacy, or hold a contracted pharmacy responsible for, a fee or performance-based reimbursement related to the adjudication of a claim or an incentive program.**(b)** A pharmacy benefits manager or carrier may not make or allow any reduction in payment for pharmacy services by a pharmacy benefits manager or carrier or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments. |
| **NH** | New Hampshire Rev Stat § 402-N:4 | DOI | **I.** A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less.  **II.** Once it has settled a claim for filling a prescription for an enrollee or insured person and notified the pharmacy of the amount the pharmacy benefits manager or insurer shall pay to the pharmacy for that prescription, the pharmacy benefits manager or insurer shall not lower the amount to be paid to the pharmacy by the pharmacy benefits manager or the insurer for such settled claim; provided, however, that this paragraph shall not apply if the claim was submitted fraudulently or with inaccurate or misrepresented information. |
| **NJ** | N.J.S.A. §17B:27F-7 | DOI | **a.** After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program, or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefits manager shall constitute a final reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefits manager, and the pharmacy services administration organization, or a pharmacy.  **b.** For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection d. of this section, that prevents timely payment from being made on the claim.  **c.** A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:**(1)** otherwise permitted or required by law;**(2)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the pharmacy; or**(3)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the designated pharmacy services administrative organization.  **d.** The provisions of this section shall not apply to an investigative audit of pharmacy records when:**(1)** fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation. |
| **NM** | N.M. Stat. Ann. § 59A-61-6 | DOI | A pharmacy benefits manager shall not reduce or eliminate payment on an adjudicated claim except as permitted by Section 61-11-18.2. |
| **SC** | SC Code § 38-71-2230(C) | DOI | (C) This subsection may not be construed to limit overpayment recovery efforts as set forth in Section 38-59-250.  A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy. |
| **SD** | S.D. Codified Laws Ann. §58-29F-6 (2013) | DOI | 58-29F-6. Recoupment or chargeback criteria.  For recoupment or chargeback, the following criteria apply:  (1) Audit parameters shall consider consumer-oriented parameters based on manufacturer listings;  (2) A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the provider contract;  (3) A finding of overpayment or underpayment can only be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;  (4) The entity conducting the audit may not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulation;  (5) Calculations of overpayments may not include dispensing fees unless:  (a) A prescription was not actually dispensed;  (b) The prescriber denied authorization;  (c) The prescription dispensed was a medication error by the pharmacy; or  (d) The identified overpayment is solely based on an extra dispensing fee;  (6) An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud. However, such errors may be subject to recoupment;  (7) In the case of errors that have no actual financial harm to the patient or plan, the pharmacy benefits manager may not assess any chargebacks. Errors that are a result of the pharmacy's failing to comply with a formal corrective action plan may be subject to recovery; and  (8) Interest may not accrue during the audit period for either party. The audit period begins with the notice of the audit and ends with the final audit report. |
| **TX** | [Texas Insurance Code §1369.553](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.553) | DOI | (a) A health benefit plan issuer or pharmacy benefit manager may not directly or indirectly reduce the amount of a claim payment to a pharmacist or pharmacy after adjudication of the claim through the use of an aggregated effective rate, quality assurance program, other direct or indirect remuneration fee, or otherwise, except in accordance with an audit performed under Subchapter F.  (b) Nothing in this section prohibits a health benefit plan issuer or pharmacy benefit manager from increasing a claim payment amount after adjudication of the claim. |
| **UT** | Utah Code Ann. § 31A-46-304 | DOI | (1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a customer's cost share from any source. (2) A pharmacy benefit manager may not deny or reduce a reimbursement to a pharmacy or a pharmacist after the adjudication of the claim, unless: (a) the pharmacy or pharmacist submitted the original claim fraudulently; (b) the original reimbursement was incorrect because: (i) the pharmacy or pharmacist had already been paid for the pharmacy service; or (ii) an unintentional error resulted in an incorrect reimbursement; or (c) the pharmacy service was not rendered by the pharmacy or pharmacist. (3) Subsection (2) does not apply if: (a) any form of an investigation or audit of pharmacy records for fraud, waste, abuse, or other intentional misrepresentation indicates that the pharmacy or pharmacist engaged in criminal wrongdoing, fraud, or other intentional misrepresentation; or (b) the reimbursement is reduced as the result of the reconciliation of a reimbursement amount under a performance contract if: (i) the performance contract lays out clear performance standards under which the reimbursement for a specific drug may be increased or decreased; and (ii) the agreement between the pharmacy benefit manager and the pharmacy or pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply. |

PROHIBITING GAG CLAUSES AND LIMITING THE AMOUNT CHARGED TO CONSUMERS – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **KS** | K.S.A. § 40-3831 | DOI | (a) This section shall be known and may be cited as the Kansas pharmacy patients fair practices act.  (b) As used in this section:  (1) "Covered person" means the same as defined in K.S.A. 2020 Supp. 40-3822, and amendments thereto.  (2) "Health carrier" means the same as defined in K.S.A. 2020 Supp. 40-2,195, and amendments thereto.(3) "Pharmacy benefits manager" means the same as defined in K.S.A. 2020 Supp. 40-3822, and amendments thereto.  (c)(1) Co-payments applied by a health carrier for a prescription drug may not exceed the total submitted charges by the network pharmacy.  (2) A pharmacy or pharmacist shall have the right to provide a covered person with information regarding the amount of the covered person's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by a pharmacy benefits manager from discussing any such information or for selling a more affordable alternative to the covered person if such an alternative is available.  (d)(1) This section applies to any contract between a pharmacy benefits manager and a pharmacy, a pharmacy services administration organization or a group purchasing organization that is entered into or renewed on and after January 1, 2019.  (2) The provisions of this section shall not apply to any policy or certificate that provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227, and amendments thereto, vision care or any other limited supplemental benefit nor to any Medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis. |
| **KY** | KRS 304.17A-164 | DOI | **304.17A-164** Limitations on insurers and pharmacy benefit managers regarding cost-sharing for prescription drugs -- Exceptions. 1) As used in this section: (a) "Cost sharing" means the cost to an individual insured under a health plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan, which may be subject to annual limitations on cost sharing, including those imposed under 42 U.S.C. secs. 18022(c) and 300gg-6(b), in order for an individual to receive a specifichealth care service covered by the plan; (b) "Generic alternative" means a drug that is designated to be therapeutically equivalent by the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, except that a drug shall not be considered a generic alternative until the drug is nationally available; (c) "Health plan": 1. Means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services; and 2. Includes a health benefit plan as defined in KRS 304.17A-005; (d) "Insured" means any individual who is enrolled in a health plan and on whose behalf the insurer is obligated to pay for or provide health care services; (e) "Insurer" includes: 1. An insurer offering a health plan providing coverage for pharmacy benefits; or 2. (f) Any other administrator of pharmacy benefits under a health plan; "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, government, or governmental subdivision or agency; (g) "Pharmacy" includes: 1. A pharmacy, as defined in KRS Chapter 315; 2. 3. A pharmacist, as defined in KRS Chapter 315; or Any employee of a pharmacy or pharmacist; and (h) "Pharmacy benefit manager" has the same meaning as in KRS 304.17A-161. (2) To the extent permitted under federal law, an insurer issuing or renewing a health plan on or after January 1, 2022, or a pharmacy benefit manager, shall not: (a) Require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage; (b) Exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person for a prescription drug, including any amount paid under paragraph (a) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process; (c) Prohibit a pharmacy from discussing any information under subsection (3) of this section; or (d) Impose a penalty on a pharmacy for complying with this section. (3) A pharmacist shall have the right to provide an insured information regarding the applicable limitations on his or her cost-sharing pursuant to this section for a prescription drug. (4) Subsection (2)(b) of this section shall not apply to any fully insured health benefit plan or self-insured plan provided to an employee under KRS 18A.225. |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4349-3 (applies through a carrier contract with a PBM) and §4349-4 | DOI | **3.  Contract requirements.**A carrier may not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:  A. Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's carrier if the cash price is less than the covered person's cost-sharing amount; or   [  B. Providing information to a state or federal agency, law enforcement agency or the superintendent when such information is required by law.  **4.  Excess payments at point of sale prohibited.**A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:  A. The applicable cost-sharing amount for the prescription drug;  B. The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and  C. The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person. |
| **NE** | Nebraska Revised Statute §44-4606 | DOI | (1) A participation contract between a pharmacy benefit manager and any pharmacist or pharmacy providing prescription drug coverage for a health benefit plan shall not prohibit or restrict any pharmacy or pharmacist from or penalize any pharmacy or pharmacist for disclosing to any covered person any health care information that the pharmacy or pharmacist deems appropriate regarding: (a) The nature of treatment, risks, or an alternative to such treatment; (b) The availability of an alternate therapy, consultation, or test; (c) The decision of a utilization reviewer or similar person to authorize or deny a service; (d) The process that is used to authorize or deny a health care service or benefit; or  (e) Information on any financial incentive or structure used by the health carrier.  (2) A pharmacy benefit manager shall not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for a pharmacist service for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.  (3) A pharmacy benefit manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict, or limit disclosure of information to the director, law enforcement, or a state or federal governmental official, provided that: (a) The recipient of the information represents that such recipient has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and (b) Prior to disclosure of information designated as confidential, the pharmacist or pharmacy:  (i) Marks as confidential any document in which the information appears; or  (ii) Requests confidential treatment for any oral communication of the information.  (4) A pharmacy benefit manager shall not terminate the contract with or penalize a pharmacist or pharmacy due to the pharmacist or pharmacy: (a) Disclosing information about a pharmacy benefit manager practice, except information determined to be a trade secret, as determined by state law or the director; or (b) Sharing any portion of the pharmacy benefit manager contract with the director pursuant to a complaint or a query regarding whether the contract is in compliance with the Pharmacy Benefit Manager Licensure and Regulation Act.  (5)(a) A pharmacy benefit manager shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.  (b) Any amount paid by a covered person under subdivision (5)(a) of this section shall be attributable toward any deductible or, to the extent consistent with section 2707 of the federal Public Health Service Act, 42 U.S.C. 300gg-6, as such section existed on January 1, 2022, the annual out-of-pocket maximum under the covered person's health benefit plan. |
| **OK** | 36 OK Stat § 36-6962C | DOI | The prohibitions under this section shall apply to contracts between pharmacy benefits managers and pharmacists or pharmacies for participation in retail pharmacy networks.  1. A PBM contract shall:  a. Not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, an individual of any differential between the individual's out-of-pocket cost or coverage with respect to acquisition of the drug and the amount an individual would pay to purchase the drug directly, and  b. Ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, a covered individual of any differential between the individual's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.  2. A pharmacy benefits manager's contract with a participating pharmacist or pharmacy shall not prohibit, restrict or limit disclosure of information to the Insurance Commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under the Patient's Right to Pharmacy Choice Act.  3. A pharmacy benefits manager shall establish and maintain an electronic claim inquiry processing system using the National Council for Prescription Drug Programs' current standards to communicate information to pharmacies submitting claim inquiries. |
| **SC** | SC Code § 38-71-2220 (2020) | DOI | (A) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any health care information that the pharmacy or pharmacist deems appropriate within their scope of practice.  (B) A pharmacy or pharmacist must not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available, but a pharmacy benefits manager may proscribe a pharmacy or pharmacist from sharing proprietary or confidential information.  (C) A pharmacy benefits manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the director investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements pursuant to this act. The information or data acquired during an examination or review pursuant to this section is considered proprietary and confidential and is not subject to the South Carolina Freedom of Information Act. |
| **WI** | Wis. Stat. § 632.861 (2) (a); § 632.861 (2) (b); and 632.861(3) | DOI | **(2)** ALLOWING DISCLOSURES.**(a)** A disability insurance policy or self-insured health plan that provides a prescription drug benefit may not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the policy or plan from informing, or penalize such pharmacy for informing, an enrollee of any differential between the out-of-pocket cost to the enrollee under the policy or plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.**(b)** A disability insurance policy or self-insured health plan that provides a prescription drug benefit shall ensure that any pharmacy benefit manager that provides services under a contract with the policy or plan does not, with respect to such policy or plan, restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the policy or plan from informing, or penalize such pharmacy for informing, an enrollee of any differential between the out-of-pocket cost to the enrollee under the policy or plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.  **(3)** COST-SHARING LIMITATION. A disability insurance policy or self-insured health plan that provides a prescription drug benefit or a pharmacy benefit manager that provides services under a contract with a policy or plan may not require an enrollee to pay at the point of sale for a covered prescription drug an amount that is greater than the lowest of all of the following amounts:**(a)** The cost-sharing amount for the prescription drug for the enrollee under the policy or plan.**(b)** The amount a person would pay for the prescription drug if the enrollee purchased the prescription drug at the dispensing pharmacy without using any health plan or health insurance coverage. |
| **WV** | Code of West Virginia § 33-51-9(a) and (l) | DOI | (a) A pharmacy, a pharmacist, and a pharmacy technician shall have the right to provide a covered individual with information related to lower cost alternatives and cost share for the covered individual to assist health care consumers in making informed decisions. Neither a pharmacy, a pharmacist, nor a pharmacy technician may be penalized by a pharmacy benefit manager for discussing information in this section or for selling a lower cost alternative to a covered individual, if one is available, without using a health insurance policy.  (l) A covered individual’s defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.  Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums.   Nothing precludes an insurer from decreasing a covered individual’s defined cost sharing by an amount greater than what is previously stated. The Commissioner may propose a legislative rule or by policy effectuate the provisions of this subsection. Notwithstanding any other effective date to the contrary, the amendments to this article enacted during the 2021 regular legislative session shall apply to all policies, contracts, plans, or agreements subject to this section that are delivered, executed, amended, adjusted, or renewed on or after January 1, 2022. |
|  |  |  |  |

PROHIBITING PBM 340B ENTITY DISCRIMINATION – FEBURARY 2023

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **NE** | Nebraska Revised Statute §44-4609 | DOI | (1) A pharmacy benefit manager that reimburses a 340B entity or a 340B contract pharmacy for a drug that is subject to an agreement under 42 U.S.C. 256b shall not reimburse the 340B entity or the 340B contract pharmacy for the pharmacy-dispensed drug at a rate lower than that paid for the same drug to similarly situated pharmacies that are not 340B entities or 340B contract pharmacies, and shall not assess any fee, chargeback, or other adjustment upon the 340B entity or 340B contract pharmacy on the basis that the 340B entity or 340B contract pharmacy participates in the program set forth in 42 U.S.C. 256b.  (2) A pharmacy benefit manager shall not discriminate against a 340B entity or 340B contract pharmacy in a manner that prevents or interferes with a covered individual's choice to receive such drug from the corresponding 340B entity or 340B contract pharmacy.  (3) For purposes of this section: (a) 340B contract pharmacy means any pharmacy under contract with a 340B entity to dispense drugs on behalf of such 340B entity; and (b) 340B entity means an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. 256b. |
| **WV** | Code of West Virginia § 33-51-9(d) and (e) | DOI | (d) A pharmacy benefit manager, or any other third party, that reimburses a 340B entity for drugs that are subject to an agreement under 42 U.S.C. § 256b shall not reimburse the 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity participates in the program set forth in 42 U.S.C. §256b.  (e) With respect to a patient eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, a pharmacy benefit manager, or any other third party that makes payment for such drugs, shall not discriminate against a 340B entity in a manner that prevents or interferes with the patient’s choice to receive such drugs from the 340B entity: *Provided*, That for purposes of this section, “third party” does not include the state Medicaid program when Medicaid is providing reimbursement for covered outpatient drugs, as that term is defined in 42 U.S.C. §1396r-8(k), on a fee-for-service basis: *Provided, however*, That “third party” does include a Medicaid-managed care organization as described in 42 U.S.C. § 1396b(m). |
|  |  |  |  |

PROHIBITING SPREAD PRICING – NOVEMBER 2022

|  |  |  |  |
| --- | --- | --- | --- |
| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| **AR** | A.C.A. § 23-92-505(c) | DOI | A pharmacy benefits manager is prohibited from conducting spread pricing in this state. |
| **DE** | Del. Code tit. 18, Chapter 33A § 3372A(1) | DOI | A pharmacy benefits manager or representative of a pharmacy benefits manager may not do any of the following:  (1) Engage in spread pricing.  \*\*\*\*\* |
| **KY** | Ky. Rev. Stat. §205.5512(4) (2020) | DOI | “As part of the procurement process to select the state pharmacy benefit manager, the department shall…[p]rohibit…[t]he use of spread pricing.” |
| **LA** | LA Rev Stat § 22:1867 (2021) | DOI | A. A pharmacy benefit manager is prohibited from conducting or participating in spread pricing in this state unless the pharmacy benefit manager provides written notice as provided in Subsection B of this Section.  B. The notice issued by a pharmacy benefit manager, or a health insurance issuer where the health insurance issuer has agreed to issue the notice, that utilizes spread pricing shall be:  (1) Required for each health insurance issuer or plan provider in which the pharmacy benefit manager engaged or participated in spread pricing.  (2) Delivered to the policy holder.  (3) Provided at least biannually.  (4) Indicative of the aggregate amount of spread pricing charged by the pharmacy benefit manager during the period.  (5) Written in plain, simple, and understandable English.  C. Any violation of this Section that is committed or performed with such frequency as to indicate a general business practice shall be subject to the provisions of the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq., as provided in R.S. 40:2870(B). |
| **VA** | Va. Code § 38.2-3467(D)  (applies to the health carrier or through a contract with a PBM) | DOI | No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall conduct spread pricing in the Commonwealth. |
|  |  |  |  |

PROHIBITION ON RETROACTIVE DENIALS OF PHARMACY CLAIMS – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AR** | A.C.A. § 23-92-506(c) | DOI | A claim or aggregate of claims for pharmacist services shall not be directly or indirectly retroactively denied or reduced after adjudication of the claim or aggregate of claims unless: **(1)** The original claim was submitted fraudulently; **(2)** The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; or **(3)** The pharmacist services were not properly rendered by the pharmacy or pharmacist. |
| **CO** | Colo. Rev. Stat. § 10-16-122.3(2) | DOI | **(2)(a)** A contract or agreement, including a performance-based or value-based contract or agreement, between a pharmacy benefit management firm and a pharmacy or a pharmacy services administrative organization with respect to prescription drug benefits administered or managed by the pharmacy benefit management firm must provide that after the date the pharmacy benefit management firm receives a clean claim submitted by a pharmacy, the pharmacy benefit management firm shall not retroactively reduce payment on the claim after the point of sale except as the result of an audit conducted in accordance with section 10-16-122.5.  **(b)** Nothing in this subsection (2) prohibits a pharmacy benefit management firm from retroactively increasing a payment to a pharmacy pursuant to a written agreement between the pharmacy benefit management firm and the pharmacy or making adjustments to claims in the case of a clerical error. |
| **MD** | MD ANN. CODE §15–1631 | DOI | Except for an overpayment as defined in § 15–1629(h) of this subtitle, if a claim has been approved by a pharmacy benefits manager through adjudication, the pharmacy benefits manager may not retroactively deny or modify reimbursement to a pharmacy or pharmacist for the approved claim unless:  (1) the claim was fraudulent;  (2) the pharmacy or pharmacist had been reimbursed for the claim previously; or  (3) the services reimbursed were not rendered by the pharmacy or pharmacist. |
| **ME** | 24-A Maine Rev. Stat. Ann. Chap 56-C §4350-8D | DOI | 8.  Payment.  This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider.  A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost‑sharing amount paid by a covered person.  B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier.  C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection.  D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error. |
| **MN** | Minn. Stat. 62W.13 | DOI | No pharmacy benefit manager shall retroactively adjust a claim for reimbursement submitted by a pharmacy for a prescription drug, unless the adjustment is a result of a:  (1) pharmacy audit conducted in accordance with section [62W.09](https://www.revisor.mn.gov/statutes/2019/cite/62W.09); or  (2) technical billing error. |
| **NJ** | N.J.S.A. §17B:27F-7 | DOI | **a.** After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program, or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefits manager shall constitute a final reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefits manager, and the pharmacy services administration organization, or a pharmacy.  **b.** For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection d. of this section, that prevents timely payment from being made on the claim.  **c.** A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:**(1)** otherwise permitted or required by law;**(2)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the pharmacy; or**(3)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the designated pharmacy services administrative organization.  **d.** The provisions of this section shall not apply to an investigative audit of pharmacy records when:**(1)** fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation. |
| **OR** | Oregon Rev. Stat. § 735.534(2)(i) | DOI | (2)(i) May not retroactively deny or reduce a claim for reimbursement of the cost of services after the claim has been adjudicated by the pharmacy benefit manager unless the:  (A) Adjudicated claim was submitted fraudulently;  (B) Pharmacy benefit manager’s payment on the adjudicated claim was incorrect because the pharmacy or pharmacist had already been paid for the services;  (C) Services were improperly rendered by the pharmacy or pharmacist; or  (D) Pharmacy or pharmacist agrees to the denial or reduction prior to the pharmacy benefit manager notifying the pharmacy or pharmacist that the claim has been denied or reduced.  (3) Subsection (2)(i) of this section may not be construed to limit pharmacy claim audits under ORS 735.540 to 735.552. |
| **SC** | SC Code § 38-71-2230(B) (2020) | DOI | (B) A claim for pharmacist services may not be retroactively denied or reduced after adjudication of the claim unless the:  (1) original claim was submitted fraudulently;  (2) original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services;  (3) pharmacist services were not properly rendered by the pharmacy or pharmacist; or  (4) adjustment was agreed upon by the pharmacy prior to the denial or reduction. |
| **WI** | Wis. Stat. § 632.865(5) | DOI | Unless required otherwise by federal law, a pharmacy benefit manager may not retroactively deny or reduce a pharmacist’s or pharmacy’s claim after adjudication of the claim unless any of the following is true: (a) The original claim was submitted fraudulently. (b) The payment for the original claim was incorrect. Recovery for an incorrect payment under this paragraph is limited to the amount that exceeds the allowable claim. (c) The pharmacy services were not rendered by the pharmacist or pharmacy. (d) In making the claim or performing the service that is the basis for the claim, the pharmacist or pharmacy violated state or federal law. (e) The reduction is permitted in a contract between a pharmacy and a pharmacy benefit manager and is related to a quality program. |
|  |  |  |  |
|  |  |  |  |

PROVIDER CONTRACT STANDARDS – FEBRUARY 2023

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **MD** | MD Ann. Code §15–1628 | DOI | (a) (1) At the time of entering into a contract with a pharmacy or a pharmacist, and at least 30 working days before any contract change, a pharmacy benefits manager shall disclose to the pharmacy or pharmacist: (i) the applicable terms, conditions, and reimbursement rates; (ii) the process and procedures for verifying pharmacy benefits and beneficiary eligibility; (iii) the dispute resolution and audit appeals process; and (iv) the process and procedures for verifying the prescription drugs included on the formularies used by the pharmacy benefits manager.  (2) (i) This paragraph does not apply to a requirement that a specialty pharmacy obtain national certification to be considered a specialty pharmacy in a pharmacy benefits manager’s or carrier’s network.  (ii) For purposes of credentialing a pharmacy or a pharmacist as a condition for participating in a pharmacy benefits manager’s network for a carrier, the pharmacy benefits manager may not: 1. require a pharmacy or pharmacist to renew credentialing more frequently than once every 3 years; or 2. charge a pharmacy or pharmacist a fee for the initial credentialing or renewing credentialing.  (b) (1) Each contract form or an amendment to a contract form between a pharmacy benefits manager and a pharmacy or a pharmacy services administrative organization, as defined in § 15–2001 of this title, acting on behalf of a pharmacy may not become effective unless at least 30 days before the contract form or amendment to the contract form is to become effective, the pharmacy benefits manager files an informational filing with the Commissioner in the manner required by the Commissioner that includes a copy of the contract form or amendment to the contract form.  (2) The Commissioner is not required to review the informational filing to evaluate whether a contract form or amendment to a contract form is in violation of this subtitle at the time the informational filing is made.  (3) The Commissioner may review and disapprove a contract form or amendment to a contract form at any time after the contract form or amendment to the contract form has been submitted as part of an informational filing. |
| **NE** | Nebraska Revised Statute §44-4608 | DOI | (1) With respect to each contract and contract renewal between a pharmacy benefit manager and a pharmacy, the pharmacy benefit manager shall:  (a) Update any maximum allowable cost price list at least every seven business days, noting any price change from the previous list, and provide a means by which a network pharmacy may promptly review a current price in an electronic, print, or telephonic format within one business day of any such change at no cost to the pharmacy; (b) Maintain a procedure to eliminate a product from the maximum allowable cost price list in a timely manner to remain consistent with any change in the marketplace; and (c) Make the maximum allowable cost price list available to each contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy.  (2) A pharmacy benefit manager shall not place a prescription drug on a maximum allowable cost price list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete.  (3) Each contract between a pharmacy benefit manager and a pharmacy shall include a process to appeal, investigate, and resolve disputes regarding any maximum allowable cost price. The process shall include: (a) A fifteen-business-day limit on the right to appeal following submission of an initial claim by a pharmacy; (b) A requirement that any appeal be investigated and resolved within seven business days after the appeal is received by the pharmacy benefit manager; and (c) A requirement that the pharmacy benefit manager provide a reason for any denial of an appeal and identify the national drug code for the drug that may be purchased by the pharmacy at a price at or below the price on the maximum allowable cost price list as determined by the pharmacy benefit manager.  (4) If an appeal is determined to be valid by the pharmacy benefit manager, the pharmacy benefit manager shall: (a) Make an adjustment in the drug price no later than one day after the appeal is resolved; and (b) Permit the appealing pharmacy to reverse and rebill the claim in question, using the date of the original claim. |
| **NH** | New Hampshire Rev Stat [§ 402-N:3](http://www.gencourt.state.nh.us/rsa/html/XXXVII/402-N/402-N-mrg.htm) | DOI | I. All contracts between a carrier or pharmacy benefit manager and a contracted pharmacy shall include:  (a) The sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the carrier or pharmacy benefit manager.  (b) A process to appeal, investigate, and resolve disputes regarding the maximum allowable cost pricing. The process shall include the following provisions:  (1) A provision granting the contracted pharmacy or pharmacist at least 30 business days following the initial claim to file an appeal;  (2) A provision requiring the carrier or pharmacy benefit manager to investigate and resolve the appeal within 30 business days;  (3) A provision requiring that, if the appeal is denied, the carrier or pharmacy benefit manager shall:  (A) Provide the reason for the denial; and (B) Identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost; and  (4) A provision requiring that, if an appeal is granted, the carrier or pharmacy benefits manager shall within 30 business days after granting the appeal: (A) Make the change in the maximum allowable cost; and (B) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question.  II. For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall: (a) Include in the contract with the pharmacy information identifying the national drug pricing compendia or sources used to obtain the drug price data. (b) Make available to a contracted pharmacy the actual maximum allowable cost for each drug. (c) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every 14 days. |
| **NM** | N.M. Stat. § 59A-61-5A, B, C and D | DOI | **A.** A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.  **B.** A pharmacy benefits manager shall provide to a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.  **C.** A contract between a pharmacy benefits manager and a pharmacy shall identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice.  **D.** The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract. |
| **PA** | 40 Pa. Stat. § 4532 | DOI | (a) General rule.--Upon each contract execution or renewal, a PBM shall, with respect to contracts between a PBM and a pharmacy, or  its representative, including a PSAO:  (1) Include in the contract the sources utilized to determine multiple source drug pricing, including, if applicable, the maximum allowable cost or any successive pricing formula of the PBM.(2) Update the pricing information every seven calendar days.(3) Establish a reasonable process by which pharmacies have a method to access relevant or current maximum allowable cost pricing lists in effect and any successive pricing formulas in a timely fashion.  (b) Confidentiality provision.--Nothing in this section may prohibit a PBM from establishing a reasonable confidentiality provision with a pharmacy or its representative , including a PSAO. |
| **TX** | Texas Insurance Code §§ [1369.555](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm#1369.555), 1369.556, 1369.557, 1369.559, 1369.560 | DOI | **Sec. 1369.555. NETWORK CONTRACT FEE SCHEDULE.** A pharmacy benefit network contract must specify or reference a separate fee schedule. Unless otherwise available in the contract, the fee schedule must be provided electronically in an easily accessible and complete spreadsheet format and, on request, in writing to each contracted pharmacist and pharmacy. The fee schedule must describe:  (1) specific services or procedures that the pharmacist or pharmacy may deliver and the amount of the corresponding payment;  (2) a methodology for calculating the amount of the payment based on a published fee schedule; or  (3) any other reasonable manner that provides an ascertainable amount for payment for services.  **Sec. 1369.556. DISCLOSURE OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION CONTRACT.** A pharmacist or pharmacy that is a member of a pharmacy services administrative organization that enters into a contract with a health benefit plan issuer or pharmacy benefit manager on the pharmacist's or pharmacy's behalf is entitled to receive from the pharmacy services administrative organization a copy of the contract provisions applicable to the pharmacist or pharmacy, including each provision relating to the pharmacist's or pharmacy's rights and obligations under the contract.  **Sec. 1369.557. DELIVERY OF DRUGS.** (a) Except in a case in which the health benefit plan issuer or pharmacy benefit manager makes a credible allegation of fraud against the pharmacist or pharmacy and provides reasonable notice of the allegation and the basis of the allegation to the pharmacist or pharmacy, a health benefit plan issuer or pharmacy benefit manager may not as a condition of a contract with a pharmacist or pharmacy prohibit the pharmacist or pharmacy from:  (1) mailing or delivering a drug to a patient on the patient's request, to the extent permitted by law; or  (2) charging a shipping and handling fee to a patient requesting a prescription be mailed or delivered if the pharmacist or pharmacy discloses to the patient before the delivery:  (A) the fee that will be charged; and  (B) that the fee may not be reimbursable by the health benefit plan issuer or pharmacy benefit manager.  (b) A pharmacist or pharmacy may not charge a health benefit plan issuer or pharmacy benefit manager for the delivery of a prescription drug as described by this section unless the charge is specifically agreed to by the health benefit plan issuer or pharmacy benefit manager.  **Sec. 1369.559. RETALIATION PROHIBITED.** (a) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any right or remedy under this chapter. Retaliation prohibited by this section includes:  (1) terminating or refusing to renew a contract with the pharmacist or pharmacy;  (2) subjecting the pharmacist or pharmacy to increased audits; or  (3) failing to promptly pay the pharmacist or pharmacy any money owed by the pharmacy benefit manager to the pharmacist or pharmacy.  (b) For purposes of this section, a pharmacy benefit manager is not considered to have retaliated against a pharmacist or pharmacy if the pharmacy benefit manager:  (1) takes an action in response to a credible allegation of fraud against the pharmacist or pharmacy; and  (2) provides reasonable notice to the pharmacist or pharmacy of the allegation of fraud and the basis of the allegation before taking the action.  **Sec. 1369.560. WAIVER PROHIBITED.** The provisions of this subchapter may not be waived, voided, or nullified by contract. |
|  |  |  |  |

REBATES – JUNE 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **AR** | A.C.A. § 23-92-505(b) | DOI | **(1)** A pharmacy benefits manager shall report to the Insurance Commissioner on a quarterly basis for each healthcare payor the following information:**(A)** The aggregate amount of rebates received by the pharmacy benefits manager;**(B)** The aggregate amount of rebates distributed to the appropriate healthcare payor;**(C)** The aggregate amount of rebates passed on to the enrollees of each healthcare payor at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;**(D)** The individual and aggregate amount paid by the healthcare payor to the pharmacy benefits manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and**(E)** The individual and aggregate amount a pharmacy benefits manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.**(2)** The report required under subdivision (b)(1) of this section is:  **(A)** Proprietary and confidential under § 23-61-107(a)(4) and § 23-61-207; and**(B)** Not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq. |
| **MD** | MD. ANN. CODE § 15-1624 | DOI | **(a)** If a purchaser has a rebate sharing contract, a pharmacy benefits manager shall offer to provide the purchaser a report for each fiscal quarter and each fiscal year that contains the amount of the:**(1)** net revenue of the pharmacy benefits manager from sales of prescription drugs to purchasers made through the pharmacy benefits manager's network of contractually affiliated retail pharmacies or through the pharmacy benefits manager's mail order pharmacies, with respect to the pharmacy benefits manager's entire client base of purchasers;**(2)** total prescription drug expenditures applicable to the purchaser;**(3)** total manufacturer payments earned by the pharmacy benefits manager during the applicable reporting period; and**(4)** total rebates applicable to the purchaser during the applicable reporting period.**(b)** If the exact amount of each item to be reported under subsection (a) of this section is not known by the pharmacy benefits manager at the time of its report, the pharmacy benefits manager shall offer to provide:**(1)** its current best estimate of the amount of each item; and**(2)** an updated report containing the exact amount of each item immediately after it becomes available.**(c)(1)** A pharmacy benefits manager shall provide the information described in subsections (a) and (b) of this section if requested by the purchaser.**(2)** Notwithstanding the provisions of paragraph (1) of this subsection, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information in subsections (a) and (b) of this section is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement. |
| **TX** | Texas Insurance Code § 1369.502 | DOI | (a) Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year:  (1) the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and  (2) the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:  (A) passed to:  (i) health benefit plan issuers; or  (ii) enrollees at the point of sale of a prescription drug; or  (B) retained as revenue by the pharmacy benefit manager.  (b) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.  (c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager. |
| **UT** | Utah Code Ann. § 31A-46-301 | DOI | (1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year:  (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract;  (b) the total value, in the aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and  (c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer.  (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.  (3) (a) The department shall publish the information provided by a pharmacy benefit manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2.  (b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that:  (i) makes a specific submission from a contracting insurer or pharmacy benefit manager identifiable; or  (ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.  (c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with:  (i) a general description of the data that will be published by the department;  (ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:  (A) any correction of errors, with supporting evidence and comments; and  (B) information that demonstrates that the publication of the data will violate Subsection (3)(b), with supporting evidence and comments. |
| **VA** | Section 38.2-3468 B of the Code of Virginia (applies to a health carrier or through a contract for pharmacy benefits) | DOI | Any carrier, on its own or through its contract for pharmacy benefits, shall report to the Commissioner on a quarterly basis for each health benefit plan the following information:  1. The aggregate amount of rebates received by the pharmacy benefits manager;  2. The aggregate amount of rebates distributed to the appropriate health benefit plan;  3. The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;  4. Upon the request of the Commission, the individual and aggregate amount paid by the health benefit plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and services; and  5. Upon the request of the Commission, the individual and aggregate amount a pharmacy benefits manager paid for services itemized by pharmacy, by product, and by goods and services. |
| **WV** | Code of West Virginia § 33-51-9(l) | DOI | (l) A covered individual’s defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.  Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums.   Nothing precludes an insurer from decreasing a covered individual’s defined cost sharing by an amount greater than what is previously stated. The Commissioner may propose a legislative rule or by policy effectuate the provisions of this subsection. Notwithstanding any other effective date to the contrary, the amendments to this article enacted during the 2021 regular legislative session shall apply to all policies, contracts, plans, or agreements subject to this section that are delivered, executed, amended, adjusted, or renewed on or after January 1, 2022. |

REGISTRATION OF PSAOs – MARCH 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **NM** | NM Stat § 59A-61-8 (2020) | DOI | A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent. |
|  |  |  |  |

REPORTING OF HEALTH BENEFIT PLANS ADMINISTERED AND REBATES COLLECTED – MARCH 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **DE** | Del. Code tit. 18, Chapter 33A § 3363A(b) | DOI | (b) A pharmacy benefits manager shall report to the Commissioner on a quarterly basis all of the following information for each insurer:  (1) The itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees, or any other fees.  (2) The aggregate amount of rebates distributed to the appropriate insurer.  (3) The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount.  (4) The individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services.  (5) The individual and aggregate amount a pharmacy benefits manager paid for pharmacy goods or services itemized by all of the following: a. Pharmacy. b.  Product. c. Goods and services. |
| **NH** | N. H. Rev. Stat. § 402-N:6 | DOI | **I.** Each pharmacy benefits manager shall submit an annual report to the commissioner containing a list of health benefit plans it administered, and the aggregate amount of all rebates it collected from pharmaceutical manufacturers that were attributable to patient utilization in the state of New Hampshire during the prior calendar year.  **II.** Information reported to the commissioner pursuant to this section shall be confidential and protected from disclosure under the commissioner's examination authority and shall not be considered a public record subject to disclosure under RSA 91-A. Based on this reporting, the commissioner shall make public aggregated data on the overall amount of rebates collected on behalf of covered persons in the state, but shall not release data that identifies a specific insurer or pharmacy benefit manager. |
| **TX** | Texas Insurance Code § 1369.502 | DOI | (a) Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year:(1) the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and(2) the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:(A) passed to:(i) health benefit plan issuers; or(ii) enrollees at the point of sale of a prescription drug; or(B) retained as revenue by the pharmacy benefit manager.(a-1) Notwithstanding Subsection (a), the report due not later than February 1, 2020, under that subsection must state the required information for the immediately preceding three calendar years in addition to stating the required information for the preceding calendar year. This subsection expires September 1, 2021.(b) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.(c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager. |
| **UT** | Utah Code Ann. § 31A-46-307 | DOI | (1) A pharmacy benefit manager may not enter into or renew a contract with an insurer on or after January 1, 2021, to administer or manage rebate contracting or rebate administration unless the pharmacy benefit manager agrees to regularly report to the insurer information regarding pharmaceutical manufacturer rebates received by the pharmacy benefit manager under the contract. (2) The quality and type of information required under Subsection (1) shall be detailed, claims level information unless the pharmacy benefit manager and insurer agree to waive this requirement in a separate written agreement. |
| **WI** | Wis. Stat. 632.865 (7) | DOI | **(a)** Beginning on June 1, 2021, and annually thereafter, every pharmacy benefit manager shall submit to the commissioner a report that contains, from the previous calendar year, the aggregate rebate amount that the pharmacy benefit manager received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors and the percentage of the aggregate rebate amount that is retained rebates. Information required under this paragraph is limited to contracts held with pharmacies located in this state.  **(b)** Reports under this subsection shall be considered a trade secret under the uniform trade secret act under s. 134.90.  **(c)** The commissioner may not expand upon the reporting requirement under this subsection, except that the commissioner may effectuate this subsection. |
|  |  |  |  |

TRANSPARENCY PROVISIONS – NOVEMBER 2022

| **STATE** | **CITATION** | **WHO** | **LANGUAGE** |
| --- | --- | --- | --- |
| **NM** | N.M. Code R. § 13.10.30.20 and § 13.10.30.21 | DOI | § 13.10.30.20. **A. Oversight required.** If a health insurance carrier utilizes the services of a PBM, the carrier shall ensure an adequate pharmaceutical network, timely and fair claims payment to pharmacies, appropriate appeals procedures, lack of retaliation against pharmacies and appropriate formulary development and tier structures. Assignment of the responsibilities of the carrier to a PBM as to any of these matters shall be set forth in the written agreement between the PBM and the carrier.  **B. Program administration.** The ultimate responsibility for competent administration of a health insurance carrier's programs lies with the carrier.  **C. Records maintenance.** A health insurance carrier shall maintain for a minimum of five years reviews conducted of the operations of its PBM(s). A carrier shall produce such records at the superintendent's request.  § 13.10.30.21. Every PBM shall maintain at its principal administrative office for the duration of the written agreement referred to in Section 59A-12A-4 NMSA 1978 and five years thereafter adequate books and records of all transactions between it, health insurance carriers and pharmacies. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The superintendent shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein shall be deemed confidential, except that the superintendent may use such information in any proceedings instituted against the PBM. The health insurance carrier shall retain the right to continuing access to such books and records to permit the carrier to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurance carrier and the PBM regarding the proprietary rights of the parties in such books and records. |
| **TX** | Texas Insurance Code §§ [4151.103](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.103), [4151.112,](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.112) [4151.113](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4151.htm#4151.113) | DOI | **Sec. 4151.001. DEFINITIONS**. In this chapter:  (1) "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term includes a delegated entity under Chapter [1272](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1272) and a workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305) that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. The term does not include a person described by Section [4151.002](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=4151.002).  (2) "Insurer" means a person who engages in the business of life, health, accident, or workers' compensation insurance under the law of this state. For purposes of this chapter only, the term also includes an "insurance carrier," as defined by Section [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(27), Labor Code, other than a governmental entity or a workers' compensation self-insurance group subject to regulation under Chapter [407A](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407A), Labor Code.  (3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.  (4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.  (5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.  (6) "Workers' compensation benefits" means benefits provided under Title 5, Labor Code, or services provided through a certified workers' compensation health care network authorized under Chapter [1305](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=IN&Value=1305).  (7) "Workers' compensation insurance coverage" means coverage subject to Subtitle E, Title 10. The term includes coverage described by Sections [401.011](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=401.011)(44)(A) and (B), Labor Code.  (8) "Workers' compensation self-insurer" means a legal entity subject to regulation under Chapter [407](http://www.statutes.legis.state.tx.us/GetStatute.aspx?Code=LA&Value=407), Labor Code.  **Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION BY COMMISSIONER.** (a) The administrator and the insurer, plan, or plan sponsor shall retain a copy of the written agreement as part of their official records:  (1) during the term of the agreement; and  (2) until the fifth anniversary of the date on which the agreement expires.  (b) On written request by the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or the commissioner's designee.  (c) Information the commissioner or the commissioner's designee obtains from the written agreement is confidential and may not be made available to the public. An employee of the department may examine the information in exercising powers and performing duties under this chapter.  (d) The commissioner shall adopt rules to address the transfer of records from one administrator to another.  **Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS.** (a) An administrator shall maintain at the administrator's principal administrative office adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant.  (b) The administrator shall maintain the books and records:  (1) until the fifth anniversary of the end of the term of the written agreement to which the  (2) in accordance with prudent standards of insurance recordkeeping.  **Sec. 4151.113. ACCESS TO BOOKS AND RECORDS.** (a) For the purpose of examination, audit, and inspection, the administrator shall provide to the commissioner and the commissioner's designee access to the books and records maintained as required by Section 4151.112.  (b) A trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, is confidential, except the commissioner may use that information in a proceeding against the administrator.  (c) An insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. The right provided by this subsection is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records. |
| **UT** | Utah Code Ann. § 31A-46-301 and § 31A-46-302 | DOI | § 31A-46-301. (1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year:  (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract;  (b) the total value, in the aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and  (c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer.  (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.  (3) (a) The department shall publish the information provided by a pharmacy benefit manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2.  (b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that:  (i) makes a specific submission from a contracting insurer or pharmacy benefit manager identifiable; or  ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.  (c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with:  (i) a general description of the data that will be published by the department;  (ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:  (A) any correction of errors, with supporting evidence and comments; and  (B) information that demonstrates that the publication of the data will violate Subsection (3)(b), with supporting evidence and comments.  § 31A-46-302. (1) If a pharmacy service entity engages in direct or indirect remuneration with a pharmacy, the pharmacy service entity shall make a reimbursement report available to the pharmacy upon the pharmacy's request.  (2) For the reimbursement report described in Subsection (1), the pharmacy service entity shall:  (a) include the adjusted compensation amount related to a claim and the reason for the adjusted compensation; and  (b) provide the reimbursement report:  (i) in accordance with the contract between the pharmacy and the pharmacy service entity;  (ii) in an electronic format that is easily accessible; and  (iii) within 120 days after the day on which the pharmacy benefit manager receives a report of a sale of a product or service by the pharmacy.  (3) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy with:  (a) the reasons for any adjustments contained in a reimbursement report; and  (b) an explanation of the reasons provided in Subsection (3)(a).  (4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a pharmacist of:  (i) an insured customer's cost share for a covered prescription drug or prescription device;  (ii) the availability of any therapeutically equivalent alternative medications; or  (iii) alternative methods of paying for the prescription medication or prescription device, including paying the cash price, that are less expensive than the cost share of the prescription drug.  (b) Penalties that are prohibited under Subsection (4)(a) include increased utilization review, reduced payments, and other financial disincentives.  (5) A pharmacy benefit manager may not require an insured customer to pay, for a covered prescription drug or prescription device, more than the lesser of:  (a) the applicable cost share of the prescription drug or prescription device being dispensed;  (b) the applicable allowable claim amount of the prescription drug or prescription device being dispensed;  (c) the applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or  (d) the retail price of the prescription drug or prescription device without prescription drug coverage.  (6) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit manager may not engage in direct or indirect remuneration that results in a reduction in total compensation received by a pharmacy from the pharmacy benefit manager for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice of the direct or indirect remuneration. |
| **WI** | Wis. Stat. § 632.865(7) | DOI | (7) Transparency reports. (a) Beginning on June 1, 2021, and annually thereafter, every pharmacy benefit manager shall submit to the commissioner a report that contains, from the previous calendar year, the aggregate rebate amount that the pharmacy benefit manager received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors and the percentage of the aggregate rebate amount that is retained rebates. Information required under this paragraph is limited to contracts held with pharmacies located in this state.  (b) Reports under this subsection shall be considered a trade secret under the uniform trade secret act under s. 134.90.  (c) The commissioner may not expand upon the reporting requirement under this subsection, except that the commissioner may effectuate this subsection. |
| **WV** | Code of West Virginia § 33-51-12 | DOI | (a) A pharmacy benefits manager shall report to the commissioner on an annual basis, or more often as the commissioner deems necessary, for each health plan or covered entity the following information:  (1) The aggregate amount of rebates received by the pharmacy benefits manager;  (2) The aggregate amount of rebates distributed to each health plan or covered entity contracted with the pharmacy benefits manager;  (3) The aggregate amount of rebates passed on to the enrollees of each health plan or covered entity at the point of sale that reduced the enrollees applicable deductible, copayment, coinsurance, or other cost-sharing amount;  (4) The individual and aggregate amount paid by the health plan or covered entity to the pharmacy benefits manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and  (5) The individual and aggregate amount a pharmacy benefits manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.  (b) A pharmacy benefits manager shall annually report in the aggregate to the commissioner and to a health plan or covered entity the difference between the amount the pharmacy benefits manager reimbursed a pharmacy and the amount the pharmacy benefits manager charged a health plan.  (c) A health benefit plan or covered entity shall annually report to the commissioner the aggregate amount of credits, rebates, discounts, or other such payments received by the health benefit plan or covered entity from a pharmacy benefits manager or drug manufacturer and disclose whether or not those credits, rebates, discounts or other such payments were passed on to reduce insurance premiums or rates. The commissioner shall consider the information in this report in reviewing any premium rates charged for any individual or group accident and health insurance policy as set forth in [**§33-6-9**](https://code.wvlegislature.gov/33-6-9)(e), [**§33-24-6**](https://code.wvlegislature.gov/33-24-6)(c), and [**§33-25A-8**](https://code.wvlegislature.gov/33-25A-8) of this code.  (d) A pharmacy benefits manager shall produce a quarterly report to the commissioner of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and above the national average drug acquisition cost.  For each drug in the report, a pharmacy benefits manager shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed, whether the dispensing pharmacy was an affiliate of the pharmacy benefits manager, whether the drug was dispensed pursuant to a government health plan, and the average national drug acquisition cost for the month the drug was dispensed. The report shall exclude drugs dispensed pursuant to 42 U.S.C. § 256b. A copy of this report shall also be published on the pharmacy benefits manager’s publicly available website for a period of at least 24 months. This report is exempt from the confidentiality provisions of subsection (f).  (e) The reports shall be filed electronically on a form and manner as prescribed by the commissioner pursuant to a legitimate rule promulgated by the commissioner.  (f) With the exception of the quarterly report noted in subsection (d) of this section all data and information provided by the pharmacy benefits manager, health plan, or covered entity pursuant to these established reporting requirements shall be considered proprietary and confidential and exempt from disclosure under the West Virginia Freedom of Information Act **[§29B-1-4](https://code.wvlegislature.gov/29B-1-4)**(a)(1) of this code. |