December 22, 2020

The Honorable Michael Conway
Chair, Regulatory Framework (B) Task Force
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001

**RE: EXPLANATION OF AMENDMENTS TO "[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT"**

Dear Chair Conway,

The National Community Pharmacists Association and the 65 signatories below appreciate the opportunity to provide written comments on the proposed "[State] Pharmacy Benefit Manager Licensure and Regulation Model Act" ("Draft"), which would empower state insurance commissioners to regulate and license pharmacy benefit managers (PBMs) doing business in their states. This model act is a step towards greater oversight of a massive, largely unregulated industry.

NAIC's efforts to regulate those PBM practices and conflicts of interest that PBMs use to enrich themselves to the detriment of patients, payers, and community pharmacies are particularly timely in light of the U.S. Supreme Court's recent ruling in *Rutledge v. PCMA*. In that case, the Court unanimously ruled that the federal ERISA statute does not prohibit the state of Arkansas from enforcing its regulations against PBMs that serve ERISA plans, thus freeing state to enact PBM regulations in the best interest of their residents. The implications of this case regarding a state's authority to regulate PBMs reach far beyond Arkansas, as shown by the fact that the U.S. federal government and 45 states and D.C. submitted briefs in support of Arkansas's position.

Given this ruling, legislatures will be pursuing legislation to increase PBM oversight in their states, and they will be looking to NAIC's model to determine how best to accomplish this. Therefore, we request you add the amendments in the attached document so states are better prepared to address those PBM practices that limit patient access to community pharmacy services and increase prescription drug costs. An explanation of the suggested amendments is below.

**Section 3. Definitions**

Amendment #1 adds a definition of "pharmacy benefit manager affiliate."

**Section 5. Licensing Requirement**

Amendment #2 adds a provision requiring the insurance commissioner to adopt a PBM license application fee that is based on the department's reasonable costs in administering the laws. This provision will ensure that the department can enforce the Draft's provisions in the public's best interest while minimizing the cost to the public.


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**Section 6. Prohibited PBM Practices**

Amendments #3 and #4 adds provisions protecting patient choice from PBM conflicts of interest. Specifically, the provisions would prohibit a PBM from preventing an enrollee from utilizing the network pharmacy of his/her choice, refusing to contract with a pharmacy that is willing to meet the terms and conditions of network participation, mandating that an enrollee use a mail-order pharmacy, and steering an enrollee to a pharmacy that is a PBM-affiliated pharmacy. Too often, a PBM will usurp a patient's ability to make his/her own healthcare decisions by mandating or steering a patient to a specific pharmacy, often one owned or otherwise affiliated with the PBM. Not only do such practices remove a patient's autonomy, but they also often cost the patient and plan more. One study in Florida found PBMs steer patients with high-cost, high-profit prescriptions to affiliated pharmacies, and "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy." [1] This amendment would ensure patients are free to make healthcare decisions that are in their best interest, instead of the PBM's best interest. Provisions such as these have been implemented in states nationwide; twenty-eight states currently have laws protecting patients from mandated mail-order provisions, and twenty-seven states protect a patient's right to utilize any pharmacy that is willing to meet the terms and conditions for network participation.

Amendment #5 would protect payers by requiring PBMs to be fiduciaries of the health carriers they serve. The conflicts of interest mentioned above that serve PBM interests at patients' expense also cost payers significant amounts. Although PBMs claim to cut costs for payers, they are typically under no legal or contractual obligation to do so. And practices such as spread pricing and patient-steering force payers to hand additional dollars to PBMs. Requiring PBMs to act as fiduciaries would prevent these costly conflicts of interest.

Amendment #6 would ensure pharmacies have the opportunity to correct errors found during the course of a pharmacy audit. Pharmacists understand that audits are a necessary practice to identify fraud, abuse, and wasteful spending, and they are not opposed to appropriate audits to identify such issues. Current PBM audits of pharmacies, however, are often used as an additional revenue source for the PBM. PBMs routinely target community pharmacies and recoup vast sums of money for nothing more than technical clerical errors where the correct medication was appropriately dispensed, and no financial harm was incurred. One issue is that pharmacy audits often occur after the period during which a pharmacy can reverse and rebill a claim. In that scenario, if an audit turns up an error, the pharmacy does not have the opportunity to correct the mistake. Allowing the PBM to reach back into the distant past to challenge previously adjudicated claims places the pharmacy at a distinct financial disadvantage, and this amendment would ensure the pharmacy has the opportunity to correct any mistakes that are found. Forty-two states

[1] 3 Axis Advisors, *Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis* 126 (Jan. 27, 2020).

currently have laws addressing pharmacy audit procedures, and this provision, modeled on a Maryland statute,[2] would further strengthen those laws.

**Section 8. Regulations**

Amendment #7 would add wording to the Drafting Note to bring attention to the recent U.S Supreme Court's ruling in *Rutledge v. PCMA*, in which the Court ruled that ERISA does not preempt Arkansas from enforcing its PBM regulations against PBMs that serve ERISA plans. State legislatures across the country have been hesitant to pass PBM regulations over concerns that those laws would be struck down in court due to ERISA, thereby denying insurance commissioners the necessary authority to protect patients from harmful and costly PBM practices. The Drafting Note is an appropriate place to add a sentence informing state legislatures about the Supreme Court's ruling on this issue.

Amendment #8 would extend the commissioner's rulemaking authority to include reconciliations and remittance procedures, as well as rebates. PBMs derive revenue from almost every player in the drug supply chain, including pharmacies and manufacturers. This revenue is often, but not exclusively, in the form of rebates. This amendment would allow the commissioner to address more PBM revenue streams and bring more transparency to the flow of prescription drug dollars.

Amendment #9 would reinforce the idea that healthcare decisions should be made by healthcare professionals and not PBMs or insurance companies.

Amendment #10 would add retroactive adjudication/transaction fees to the list of prohibited "clawbacks." This provision prohibiting clawbacks will lower patient out-of-pocket costs. When a PBM has reimbursed a pharmacy for filling a prescription, it is not uncommon for the PBM to claw back a portion of the reimbursement days, weeks, or even months later. However, a patient's cost share amount is tied to the initial reimbursement. Therefore, when there is a retroactive clawback, the true reimbursement amount is lower than the initial reimbursement. This means that a patient's cost share is based on an arbitrarily inflated figure. By prohibiting retroactive clawbacks, the Draft will ensure a patient's cost share reflects the true cost of their healthcare services. Over 17 states have already taken action to save patients money by addressing these retroactive clawbacks.

**Conclusion**

We commend the Task Force's efforts to promote, preserve, and protect the public health, safety, and welfare by establishing common sense standards and criteria for the regulation and licensure of PBMs. We thank you for the opportunity to provide these comments. If you have any questions about the information provided in this letter, please contact Matthew Magner at (703) 600-1186 or matthew.magner@ncpa.org.

Sincerely,

[2] H.B. 1273 (Md. 2020).

National Community Pharmacists Association
AIDS Healthcare Foundation
Alabama Pharmacy Association
Alaska Pharmacists Association
AlliantRx
American Associated Pharmacies
American Pharmacies
American Pharmacy Cooperative, Inc.
American Pharmacy Services Corporation
Arete Pharmacy Network
Arizona Pharmacy Association
Colegio de Farmacéuticos de Puerto Rico
Colorado Pharmacists Society
Connecticut Pharmacists Association
Dakota Drug, Inc
Delaware Pharmacists Society
Federation of Pharmacy Networks
Florida Pharmacy Association
Georgia Pharmacy Association
Good Neighbor Pharmacy/Elevate Provider Network
Idaho State Pharmacy Association
Illinois Pharmacists Association
Independent Pharmacy Alliance
Independent Pharmacy Cooperative
Iowa Pharmacy Association
Kansas Pharmacists Association
Kentucky Pharmacists Association
Louisiana Independent Pharmacies Association
Louisiana Pharmacists Association
Louisiana Wholesale Drug Co., Inc.
Massachusetts Independent Pharmacists Association
Minnesota Pharmacists Association
Mississippi Pharmacists Association
Montana Pharmacy Association
National Alliance of State Pharmacy Associations
New Jersey Pharmacists Association
New Mexico Pharmacists Association
New Mexico Pharmacy Business Council
North Carolina Association of Pharmacists
North Dakota Pharmacists Association
North Dakota Pharmacy Service Corporation
Northeast Pharmacy Service Corp.
Ohio Pharmacists Association
Oklahoma Pharmacists Association
Omega Pharmacy Group
Osborn Drugs
PARD, an Association of Community Pharmacies
Pennsylvania Pharmacists Association
Pharmacists Society of the State of New York
Pharmacists United for Truth and Transparency
Pharmacy Providers of Oklahoma (PPOk)
Pharmacy Society of Wisconsin
PPSC
QualityCare Pharmacies
Restore Rx Specialty Pharmacy
Sav-Mor Drug Stores, Inc
Smith Drug Company
South Carolina Pharmacy Association
South Dakota Pharmacists Association
Texas Pharmacy Association
Texas Pharmacy Business Council
Value Drug Company
Value Specialty Pharmacy
Virginia Pharmacists Association
Washington State Pharmacy Association
WSPC “Well-Served Pharmacy Community”

*Adopted by the Health Insurance and Managed Care (B) Committee - TBD*
*Adopted by the Regulatory Framework (B) Task Force – TBD*
*Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup – Oct. 29, 2020*

Draft: 10/29/20
*A new model*

Comments are being requested on this draft on or before Dec. 22, 2020. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

# [STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

**Table of Contents**



## Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

## Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

(2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;

(3) Provide for powers and duties of the commissioner; and

(4) Prescribe penalties and fines for violations of this Act.

## Section 3. Definitions

For purposes of this Act:

A. "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both paragraphs (1) and (2).

B. "Commissioner" means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

C. "Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

E. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

F. "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

(1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing and maintaining formularies;

(6) Designing prescription benefit programs; or

(7) Advertising or promoting services.

G. "Pharmacist" means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. "Pharmacist services" means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. "Pharmacy" means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) "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, to covered persons who are residents of this state, for health benefit plans.

(2) "Pharmacy benefit manager" does not include:

(a) A health care facility licensed in this state;

(b) A health care professional licensed in this state;

(c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or

(d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

K. "Pharmacy benefit 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 benefit manager.

**Section 4. Applicability**

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

**Drafting Note:** States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

**Section 5. Licensing Requirement**

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

**Drafting Note:** States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

**Drafting Note:** States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee ~~of $[X]~~ established through regulation by the commissioner. Any fee adopted by the commissioner under this section must be based on the department's reasonable costs in administering this Act.

E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of $[X] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

**Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices**

A. In any participation contracts between a pharmacy benefit manager 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 healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;

(2) The availability of alternate therapies, consultations, or tests;

(3) The decision of utilization reviewers or similar persons to authorize or deny services;

(4) The process that is used to authorize or deny healthcare services or benefits; or

(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

(1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and

(2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:

(a) Marks as confidential any document in which the information appears; or

(b) Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:

(1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or

(2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.

E. (1) A pharmacy benefit manager may 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.

(2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

F. Patient choice: a pharmacy benefit manager may not:

(1) Prohibit or limit any person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of his 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 any other 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, incentive or penalty under a health benefit plan that would affect or influence 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.

(5) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or pharmacy benefit manager affiliate; or

(6) 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, restriction, limitation, 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, a pharmacy benefit manager affiliate 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.

G. Patient steering and data privacy protection:

(1) A pharmacy benefits manager or any pharmacy benefits manager affiliate shall not:

- Refer a covered person to a mail order pharmacy or any other pharmacy benefit manager affiliate.
- Utilize a covered person's pharmacy service data collected pursuant to the provision of claims processing services for the purpose referring the covered person to a mail order pharmacy or any other pharmacy benefit manager affiliate.

(2) For purposes of this subsection 'refer' means:

- Ordering a covered person to a pharmacy either orally or in writing, including online messaging;
- Offering or implementing plan designs that require covered persons to utilize pharmacy benefit manager affiliate, or that increase plan or patient costs, including requiring covered persons to pay the full cost for a prescription when covered persons choose not to use a pharmacy benefit manager affiliate; or
- Person-specific advertising, marketing, direct written, electronic or verbal

communication, promotion or other solicitation of a pharmacy by an affiliate or pharmacy benefit manager as a result of an arrangement or agreement with the pharmacy's affiliate.

H. Fiduciary responsibility: A pharmacy benefits manager is a fiduciary to a health carrier and shall:

(3) Discharge that duty in accordance with the provisions of federal and/or state law.

(4) Notify the covered entity in writing of any activity, policy or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of interest and inability to comply with the duties imposed by this subsection; but in no event does such notification exempt the pharmacy benefits manager from compliance with all other sections of this chapter.

(5) Disclose all direct or indirect payments related to the dispensation of prescription drugs or classes or brands of drugs to the covered entity.

I. Audit procedures:

(6) A contract between a pharmacy or pharmacist and a pharmacy benefits manager must contain a provision allowing, during the course of a pharmacy audit conducted by or on behalf of a pharmacy benefit manager, a pharmacy or pharmacist to withdraw and resubmit a claim within 30 days after:

- The preliminary written audit report is delivered if the pharmacy or pharmacist does not request an internal appeal; or
- The conclusion of the internal audit appeals process if the pharmacy or pharmacist requests an internal audit appeal.

(7) To the extent that an audit results in the identification of any clerical or record-keeping errors (such as typographical errors, scrivener's errors, or computer errors) in a required document or record, the pharmacy shall not be subject to recoupment of funds by the PBM unless—the PBM can provide proof of intent to commit fraud or such error results in actual financial harm to the PBM, a health plan managed by the PBM, or a consumer.

(8) For purposes of this subsection, "audit" means any physical on site, remote electronic or concurrent review of a pharmacist service submitted to the pharmacy benefit manager or pharmacy benefit manager affiliate by a pharmacists or pharmacy for payment.

**Section 7. Enforcement**

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

**Drafting Note:** States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

**Drafting Note:** States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

(2) The information or data acquired during an examination under paragraph (1) is:

(a) Considered proprietary and confidential;

(b) Not subject to the [Freedom of Information Act] of this state;

(c) Not subject to subpoena; and

(d) Not subject to discovery or admissible in evidence in any private civil action.

C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner's duties to determine compliance with this Act.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

**Drafting Note:** If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

**Section 8. Regulations**

The commissioner ~~may~~ shall adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

**Drafting Note:** This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes or made suggestions that extend into the regulation of pharmacy benefit manager business practices. In light of the U.S. Supreme Court's ruling in *Rutledge v. PCMA*, which clarifies the state's authority to regulate PBM pricing and reimbursement practices, states should consider addressing the following PBM practices. The provisions below, which are followed by citations to state law where applicable, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation:

(1) PBM network adequacy (Ark. Code 23-92-505 and Okla. Stat. 36-6961) (Also, see provisions in the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74));

(2) Prohibited market conduct practices (Ark. Code 23-92-506; MD. ANN. CODE § 15-1642; N.M. Stat. 59A-61-5 and 59A-61-7; Oregon Rev. Stat. §§ 735.534 through 735.552; and South Carolina Code §38-71-2230(A)(1));

(3) Data reporting requirements under state price-gouging laws;

(4) Rebates, reconciliation, and remittance procedures (MD. ANN. CODE § 15-1624 and Texas Insurance Code §1369.502);

(5) ~~Prohibitions~~ Coverage and formulary determinations that implicate prohibitions and limitations on the corporate practice of medicine (CPOM);

(6) Compensation (Ark. Code 23-92-506(b)(5)(A) and N.J.S.A. 17B:27F-8 (New Jersey));

(7) Procedures for pharmacy audits conducted by or on behalf of a PBM (Del. Ins. Code Chapter 33A §§ 3301A – 3310A; MD. ANN. CODE § 15-1629; Oregon Rev. Stat. §§ 735.540 through 735.552; and 40 PA. CONS. STAT. §§ 4511-4514);

(8) Medical loss ratio (MLR) compliance;

(9) Affiliate information-sharing (Ga. Code § 26-4-119 and § 33-64-11(a)(8);

(10) Lists of health benefit plans administered by a PBM in this state (New Hampshire Rev Stat § 402-N:6)

(11) Reimbursement lists or payment methodology used by PBMs (Ark. Code § 17-92-507; Del. Ins. Code Chapter 33A §§ 3321A – 3324A; Kansas Rev Stat §§ 40-3829 - 40-3830; 24-A Maine Rev. Stat. Ann. Chapter 56-C; Colo. Rev Stat. § 25-37-103.5; MD. ANN. CODE § 15-1628.1 and §15-1628.2; N.J.S.A. §17B:27F-2 (New Jersey); and Oregon Rev. Stat. § 735.534 and § 735.536);

(12) Prohibiting clawbacks, transaction, and adjudication fees (Ala. Code § 27-45A-5; MD. ANN. CODE § 15-1628.3; Minn. Stat. 62W.13; N.J.S.A. 17B:27-7 (New Jersey); and Oregon Rev. Stat. § 735.534);

(13) Affiliate compensation (Colo. Rev. Stat. § 10-16-122.3 and Ga. Code § 26-4-119 and § 33-64-11(a)(7));

(14) Prohibiting spread pricing (LA. REV. STAT. ANN § 22:1867 and Va. Code § 38.2-3467(D)); and

(15) Transparency provisions (24-A Maine Rev. Stat. Ann. Chapter 56-C and Texas Insurance Code § 1369.502).

**Section 9. Severability**

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 10. Effective Date**

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

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