**[State] Pharmacy Benefit Manager Licensure and Regulation Model Act**

Suggested Revisions to Draft Dated July 6, 2020

Sept. 1, 2020 Comment Deadline

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| **Section 1. Title** |
| **This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.** |
| ***No comments received*** |  |
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| **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.** |
| **HIV+HEP Policy Institute (HIV+HEP)** | \*\*\*\*\*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, transparency, 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. |
| **NAIC consumer representatives** | \*\*\*\*\*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);(3) e Provide for consumer savings, transparency 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. |
| **Pharmaceutical Care Management Association (PCMA)** | 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 and prevents pharmacy benefit managers from requiring gag clauses in pharmacy contracts.  |
| **Vermont Department of Insurance (VT DOI)** | 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 additional powers and duties to the commissioner; and(4) Prescribe penalties and fines for violations of this Act. |
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| **Section 3. Definitions** |
| **A. Claims processing services** | “**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).** |
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| **B. Commissioner** | **“Commissioner” means the insurance commissioner of this state.****Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.  |
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| **C. Covered entity** | **(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 a state in the capacity of a provider of health coverage; or****(c) An employer, a 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:****(a) A self-funded plan that is exempt from state regulation pursuant to federal law;****(b) A plan issued for coverage for federal employees; or****(c) A health benefit 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.** |
| **American Association of Payers, Administrators and Networks (AAPAN)** | Does the model apply to workers compensation insurance? |
| **America’s Health Insurance Plans (AHIP)** | (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 a state in the capacity of a provider of health coverage; or(c) An employer, a labor union or other group of persons organized in the state that provides health coverage to covered individuals who reside in the state.\*\*\*\*\* |
| **HIV+HEP; NAIC consumer representatives** | (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 a state in the capacity of a provider of health coverage; or(c) An employer, a 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. |
| **National Association of Chain Drug Stores (NACDS)** | \*\*\*\*\*(2) “Covered entity” does not include:(a) A plan issued for coverage for federal employees; or(b) A health benefit 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. |
| **National Community Pharmacists Association (NCPA)** | \*\*\*\*\*(2) “Covered entity” does not include a health benefit 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. |
| **VT DOI** | (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 a state in the capacity of a provider of health coverage; or(c) An employer, a 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.**Moved to Section 3E, definition of “health benefit plan”.** |
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| **D. Covered person** | **“Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.** |
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| **E. Health benefit plan** | **“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.** |
| **HIV+HEP** | “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a covered entity to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services. |
| **VT DOI** | “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. “Health benefit plan” includes standalone prescription drug plans.(2) ”Health benefit plan” does not include:(a) A self-funded plan that is exempt from state regulation pursuant to federal law;(b) A plan issued for coverage for federal employees; or(c) A health benefit 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. |
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| **F. Other prescription drug or device services** | **“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.** |
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| **G. Pharmacist** | **“Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.** |
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| **H. Pharmacist services** | **“Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.** |
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| **I. Pharmacy** | **“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.** |
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| **J. Pharmacy benefit manager** | **(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; or (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager.** |
| **AHIP** | \*\*\*\*\*(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 a covered entity that performs any claims processing or other prescription drug or device services for its enrollees. |
| **BlueCross and BlueShield Association (BCBSA)** | \*\*\*\*\*(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 nonprofit hospital or medical service organization that does not administer and/or contracts with another entity to administer the pharmacy benefit or (d)) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager. |
| **HIV+HEP** | (1) “Pharmacy benefit manager” means a person, business or entity that, pursuant to a contract or under an employment relationship with a carrier, a self-insurance plan or other third-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, self-insurance plan or other third-party payer, including, but not limited to, processing and paying claims for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudicating appeals or grievances related to prescription drug coverage, contracting with network pharmacies, controlling the cost of covered prescription drugs or other prescription drug or devices services.(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; or (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager. |
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| **Suggested Additional Definitions** |
| **HIV+HEP** | “Cost-sharing” means any expenditure required by or on behalf of a covered person with respect to essential health benefits; such term includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending on non-covered services.“Rebate” means any and all payments that accrue to a pharmacy benefit manager or its covered entity 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 such claims administered on behalf of a covered entity client.“Aggregate Retained Rebate Percentage” means the percentage of all rebates received from a manufacturer or other entity to a Pharmacy Benefit Manager for prescription drug utilization which is not passed on to Pharmacy Benefit Mangers’ health carrier clients. The percentage shall be calculated for each health carrier for rebates in the prior calendar years as follows: a) the sum total dollar amount of rebates received from all pharmaceutical manufacturers for all utilization of covered persons of a health carrier that was not passed through to the health carrier; and b) divided by the sum total dollar amount of all rebates received from all pharmaceutical manufacturers for covered persons of a health carrier.  |
| **NAIC consumer representatives** | “Cost-sharing” means the amount paid by a covered person as required under the covered person’s health benefit plan at the point of sale.“Rebates” means all price concessions paid by a manufacturer to a pharmacy benefit manager or health carrier, including rebates, discounts, and other price concessions that are based on actual or estimated utilization of a prescription drug. |
| **NCPA** | “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. |
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| **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 covered entity that offers pharmacy benefits 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.**  |
| **AHIP** | A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended in this state, twelve (12) months after the effective date of this Act, including any covered entity that offers pharmacy benefits 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.\*\*\*\*\* |
| **HIV+HEP** | A. This Act shall apply to pharmacy benefit managers that manage prescription drug benefits for a health benefit plan issued, renewed, recredentialed, amended or extended by a covered entity on or after the effective date of this Act. **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 the pharmacy benefit manager’s licensure, any contract it holds with a covered entity 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.  |
| **NACDS** | 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. **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. |
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| **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 obtaining a license from the commissioner under this Act.** |
| **NAIC consumer representatives** | 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. |
| **New Mexico Department of Insurance (NM DOI)** | A. A person may not establish or operate as a pharmacy benefit manager in this state without obtaining a license from the commissioner under this Act. |
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| **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.  |
| **BCBSA** | B. The commissioner may adopt regulations establishing the licensing application 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.  |
| **HIV+HEP** | B. The commissioner shall 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.  |
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| **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.  |
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| **D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $[X].** |
| **NCPA** | D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee established through regulation by the commissioner. Any fee adopted by the commissioner under this section shall be based on the department’s reasonable costs in administering the Act. |
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| **E. The commissioner may refuse to issue 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 had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.** |
| **AHIP** | E. The commissioner may refuse to issue a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not financially responsible , or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction. |
| **BCBSA** | Add language providing an appeal process for a PBM denied licensure.  |
| **NAIC consumer representatives** | E. The commissioner may refuse to issue 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, has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction, or has been subject to penalties under another state’s pharmacy benefit manager statute or regulation. |
| **VT DOI** | 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 or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction. |
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| **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.** |
| **HIV+HEP** | F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid for one (1) year 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. |
| **VT DOI** | Add specific language authorizing the commissioner to revoke or suspend a license, including specific grounds for suspending or revoking a license. Also, add specific monetary penalties with possibly enhanced penalties for intentional or willful violations. |
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| **Additional Suggested Subsections** |
| **American Medical Association (AMA)** | G. The Commissioner may suspend, revoke, or place on probation a Pharmacy Benefit Manager license under any of the following circumstances:(1) The Pharmacy Benefit Manager has engaged in fraudulent activity that constitutes a violation of state or federal law:(2) The Commissions received consumer complains that justify an action under this section to protect the safety and interests of consumers;(3) The Pharmacy Benefit Manager fails to pay an application fee for the license; or(4) The Pharmacy Benefit Manager fails to comply with a requirement set forth in this section. H. If a pharmacy benefits manager acts without obtaining a license pursuant to this section, the pharmacy benefits manager is subject to a fine of $5,000 per day for the period the pharmacy benefits manager is found to be in violation.I. A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated formulary services to any unlicensed nonaffiliated business entity. |
| **BCBSA** | Require a PBM to notify the commissioner of any changes in its application within 90 days of the change and disclose the list of health benefit plans it administers in this state. |
| **HIV+HEP** | G. The Commissioner may suspend, revoke, or place on probation a Pharmacy Benefit Manager license under any of the following circumstances: (1) The Pharmacy Benefit Manager has engaged in fraudulent activity that constitutes a violation of state or federal law: (2) The Commissions received consumer complains that justify an action under this section to protect the safety and interests of consumers; (3) The Pharmacy Benefit Manager fails to pay an application fee for the license; or (4) The Pharmacy Benefit Manager fails to comply with a requirement set forth in this section. H. If a Pharmacy Benefit Manager, acts without obtaining a license pursuant to this section, it will be subject to a fine of $5,000 per day for the period they are found to be in violation. I. A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its services to any unlicensed nonaffiliated business entity.  |
| **NAIC consumer representatives** | G. If a pharmacy benefit manager acts without obtaining a license pursuant to this section, the pharmacy benefit manager is subject to a fine of $5,000 per day for the period the pharmacy benefit manager is found to be in violation. |
| **URAC** | C. A pharmacy benefit manager that is accredited by a nationally recognized private accrediting entity that the commissioner has approved shall be deemed as having met the requirements of the relevant sections of this Act. 1. The commissioner shall approve nationally recognized private accrediting entities that the commissioner has determined has accreditation standards that adequately and appropriately validate the operations of pharmacy benefit managers. 2. The private accrediting entity shall file or provide the state with documentation that the pharmacy benefit manager has been accredited by the entity. 3. The commissioner may adopt regulations establishing the process to approve pharmacy benefit manager accrediting entities.  |
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| **Section 6. Gag Clauses Prohibited** |
| **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 or pharmacist may provide to a covered person information regarding the covered person’s total cost for pharmacist services for a prescription drug.** **C. 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.** **D. 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 investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act.**  |
| **AHIP** | A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies , no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any differential between the enrollee’s out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount the individual would pay for acquisition of the drug without using any health insurance coverage:B. A covered entity shall ensure that any contracted pharmacy benefit manager does not prohibit, restrict or penalize a pharmacy that dispenses a prescription drug from informing an enrollee of any differential between the enrollee’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 insurance coverage.  |
| **AMA** | \*\*\*\*\*E. A pharmacy benefit manager many not require a covered person 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 under a health benefit plan.F. Any amount paid by a covered person under subsection (E) of this section shall be attributable toward any deductible or annual out-of-pocket maximums under the covered person’s health benefit plan |
| **BCBSA** | Conform to the federal requirements and remove Section 6A(4)-(5). |
| **Citizens Against Government Waste (CAGW)** | Remove provisions that pharmacists probably would not have the requisite knowledge, such as in Section 6A(4)-(5). |
| **HIV+HEP** | A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for a covered entity, 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. \*\*\*\*\* |
| **NAIC consumer representatives** | 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 or pharmacist may provide to a covered person information regarding the covered person’s total cost for pharmacist services for a prescription drug. C. 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. D. 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 investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act. E. A pharmacy benefit manager may not require a covered person 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 under a health benefit plan. F. Any amount paid by a covered person under subsection (E) of this section shall be attributable toward any deductible or annual out-of-pocket maximums under the covered person’s health benefit plan. |
| **NCPA** | **Section 6. Prohibited PBM 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 or pharmacist may provide to a covered person information regarding the covered person’s total cost for pharmacist services for a prescription drug. C. 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. D. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, penalize, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint, conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act, or gathering information for public policy purposes.E. 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. F. Patient steering and data privacy protection. (1) A pharmacy benefit manager or any pharmacy benefit manager affiliate shall not: (a) Refer a covered person to a mail order pharmacy or any other pharmacy benefit manager affiliate; or (b) 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: (a) Ordering a covered person to a pharmacy either orally or in writing, including online messaging; (b) 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 (c) 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. G. Fiduciary responsibility. A pharmacy benefit manager is a fiduciary to a covered entity and shall: (1) Discharge that duty in accordance with the provisions of federal and/or state law. (2) Notify the covered entity in writing of any activity, policy or practice of the pharmacy benefit 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 benefit manager from compliance with all other sections of this chapter. (3) Disclose all direct or indirect payments related to the dispensation of prescription drugs or classes or brands of drugs to the covered entity. H. Audit procedures. (1) A contract between a pharmacy or pharmacist and a pharmacy benefit manager shall 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: (a) The preliminary written audit report is delivered if the pharmacy or pharmacist does not request an internal appeal; or (b) The conclusion of the internal audit appeals process if the pharmacy or pharmacist requests an internal audit appeal. (2) 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. (3) 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 pharmacist or a pharmacy for payment. |
| **NM DOI** | A. In any contract between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage, 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. **\*\*\*\*\*** |
| **PCMA** | A. In any participation contracts between a pharmacy benefit manager and a pharmacy providing prescription drug coverage for health benefit plans, no pharmacy may be prohibited, restricted or penalized from disclosing to a covered person  (1) Information regarding the covered person’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) information regarding a more affordable alternative to the covered person if a more affordable alternative is available. B. A pharmacy benefit manager contract with a participating pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act.  |
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| **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).**(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.** |
| **AMA** | \*\*\*\*\*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).(2) All pharmacy benefit files and records shall be subject to examination by the Commissioner or by duly appointed designees. The Commissioner, authorized employees and examiners shall have access to any of a pharmacy benefit manager’s files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.(3) Every officer, director, employee or agent of the pharmacy benefit manager, 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. (4) When making an examination under this section, the 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.C. The commissioner shall require a pharmacy benefit manager to submit a report for the preceding calendar year stating that the pharmacy benefit manager is in compliance with the requirements of the act.D. The commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefits manager for each violation of this law.E. The Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the provisions of this Act.(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. |
| **BCBSA** | Add language clarifying the parameters of any examination or audit such as a substantial complaint and that the scope of the investigation be limited to the triggering event.  |
| **Coalition of State Rheumatology Organizations (CSRO)** | \*\*\*\*\*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).(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; and (c) Not subject to discovery or admissible in evidence in any private civil action.Also:Add language establishing the commissioner’s right to assess monetary penalties in addition to any other noncompliance penalties. Add language establishing the commissioner’s right to revoke or suspend a PBM’s license under the PBM brings itself into compliance.  |
| **HIV+HEP** | 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 covered entity 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).(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 shall require a pharmacy benefit manager to submit a report for the preceding calendar year stating that the pharmacy benefit manager is in compliance with the requirements of the Act. D. Investigate complaints of alleged violations of this Act. E. The commissioner may impose a penalty of not more than $7,500 on a pharmacy benefits manager for each violation of this law. |
| **NAIC consumer representatives** | 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).(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 shall require a pharmacy benefit manager to submit a report for the preceding calendar year stating that the pharmacy benefit manager is in compliance with the requirements of the Act. D. The commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefit manager for each violation of this law. |
| **NCPA** | A. The commissioner shall enforce compliance with the requirements of this Act. The commissioner may assess fines, impose civil penalties, and suspend or revoke a license for a violation of the requirements of this Act.\*\*\*\*\* |
| **VT DOI** | 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).(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.**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.  |
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| **Section 8. Regulations** |
| **A. The commissioner may adopt regulations regulating pharmacy benefit managers that not inconsistent with this Act.** |
| **AHIP** | A. The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations]. |
| **AMA; NCPA** | A. The commissioner shall adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act. |
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| **The Subgroup adopted a motion Sept. 14 to move this provision to the end of the draft model as a drafting note and other changes TBD.****B. The regulations adopted pursuant to Subsection A may include but are not limited to the following:****(1) Pharmacy benefit manager network adequacy;****(2) Prohibited market conduct practices;****(3) Data reporting requirements under state price-gouging laws;****(4) Rebates;****(5) Prohibitions and limitations on the corporate practice of medicine (CPOM);****(6) Compensation;****(7) Procedures for pharmacy audits conducted by or on behalf of a pharmacy benefit manager;****(8) Medical loss ratio (MLR) compliance;****(9) Affiliate information-sharing;****(10) Lists of health benefit plans administered by a pharmacy benefit manager in this state;****(11) Reimbursement lists or payment methodology used by pharmacy benefit managers;** **(12) Clawbacks prohibited. A pharmacy benefit manager or representative of a pharmacy benefit manager may not make or permit any reduction of payment for pharmacist services by a pharmacy benefit manager or a covered entity directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including but not limited to, generic effective rates, brand effective rates, direct and indirect remuneration fees or any other reduction or aggregate reduction of payment;****(13) Affiliate compensation.** **(a) “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.** **(b) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services; and****(14) Spread pricing prohibited.** **(a) “Spread pricing" means the model of prescription drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.****(b) A pharmacy benefit manager is prohibited from conducting spread pricing in this state.****Drafting Note:** Subsection B lists options for a state to consider in adopting regulations to implement the provisions of this Act. Not every option listed will be appropriate for every state. |
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| **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.** |
| ***No comments received*** |  |
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| **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.** |
| **AHIP** | 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 [twelve (12)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act. |
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| **Suggested New Sections** |
| **AMA** | **New Section. Prohibition against Interference with the Patient-Physician Relationship.**1. A pharmacy benefit manager shall be prohibited from implementing or carrying out any policy that interferes with a pharmacist licensed in this state from carrying out his or her corresponding responsibility under the federal Controlled Substances Act.
2. A pharmacy benefit manager shall, prior to implementing a policy that limits or otherwise places a restriction on the quantity or dosage of a prescription for a controlled substance, or the means of dispensing a prescription for a controlled substance, shall be required to submit the policy to the [state medical board, state pharmacy board and any other appropriate regulatory board charged with regulating health care professionals] for review prior to implementation.
	1. The [regulatory board(s)] shall cooperatively review the policy to determine whether it comports with state law and regulation.
	2. The [regulatory board(s)] shall publish a coordinated opinion as to its findings within six months of the date that the policy was submitted for review.
	3. The pharmacy, pharmacy benefit manager or covered entity shall not be permitted to implement, continue or enforce its policy prior to the issuance of the findings as required under this section.
	4. Any policy that the [regulatory board] determines interferes with the practice of medicine, pharmacy, or other licensed health care profession shall be declared null and void.
3. A pharmacy benefit manager that has its own, or acts to carry out, a policy that limits or otherwise places a restriction on the quantity or dosage of a prescription for a controlled substance, or the means of dispensing a prescription for a controlled substance, shall immediately suspend the policy, and within 30 days of this Act going into effect, be required to submit the policy to the state medical board, state pharmacy board [and any other appropriate regulatory board charged with regulating health care professionals] for review as required under Section B of this Act.
4. Unless the U.S. Drug Enforcement Administration, state medical, nursing or other health care professional licensing board has rendered a final decision limiting, suspending or terminating a duly licensed health care professional’s authority to prescribe controlled substances, a pharmacy benefit manager shall be prohibited from limiting, suspending or terminating the health care professional’s authority to prescribe controlled substances.
5. Nothing in this Act shall be construed as preventing an individually licensed pharmacist from exercising his or her corresponding responsibility as required under state and federal law.

**New Section. Transparency**1. Annually, a pharmacy benefit manager must provide the commissioner the following information from the previous calendar year:
2. the aggregate dollar amount of all discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for each drug on the pharmacy benefit manager’s formularies;
3. the aggregate dollar amount of all discounts and rebates that are retained by the pharmacy benefit manager for each drug on the PBM's formularies;
4. actual total reimbursement amounts for each drug the pharmacy benefit manager pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied;
5. the negotiated price health plans pay the pharmacy benefit manager for each drug on the pharmacy benefit manager’s formularies;
6. the amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan;
7. any ownership interest the pharmacy benefit manager has in a pharmacy or health plan with which it conducts business;
8. Report from the commissioner
	1. All information submitted to the commissioner pursuant to this section shall be exempt from disclosure under the Freedom of Information Act, except to the extent such information is included on an aggregated basis in the report required by subsection (b) of this section. The commissioner shall not disclose information submitted pursuant to this section in a manner that (1) is likely to compromise the financial, competitive or proprietary nature of such information, or (2) would enable a third party to identify a health care plan, health carrier, pharmacy benefits manager, pharmaceutical manufacturer, or the value of a rebate provided for a particular outpatient prescription drug or therapeutic class of outpatient prescription drugs.
	2. Not later than March 1, 202[], and annually thereafter, the commissioner shall submit a report to the committee(s) of jurisdiction within General Assembly having cognizance of matters relating to insurance. The report shall contain (1) an aggregation of the information submitted to the commissioner pursuant to this section for the immediately preceding calendar year, and (2) such other information as the commissioner, in the commissioner's discretion, deems relevant for the purposes of this section. Not later than February 1, 202[], and annually thereafter, the commissioner shall provide each pharmacy benefits manager and any third party affected by submission of a report required by this subsection with a written notice describing the content of the report.
	3. The commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefits manager for each violation of this section.

**New section. Business Practices** 1. A pharmacy benefit manager has a fiduciary duty to a to a third party with which the pharmacy benefit manager has entered into a contract to manage the pharmacy benefits plan of the third party client and shall discharge that duty in accordance with the provisions of state and federal law.
2. A pharmacy benefit manager shall perform its duties with care, skill, prudence, diligence, and professionalism.
3. A pharmacy benefit manager shall notify a health carrier client in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the duties imposed in this section.

**Drafting note:** States may want to consider inserting specific reference to the state law governing prescription drug benefit management. The NAIC *Health Carrier Prescription Drug Benefit Management Model Act* (#22) includes provisions governing plan benefit design, pharmacy and therapeutics committees and other activities that are often carried out by pharmacy benefit managers acting as thedesignee of the issuer. States should consider cross-referencing the state’s prescription drug management law with specific reference to any additional legal requirements pharmacy benefits managers have with regard to any activity covered by the prescription drug management law carried out by the pharmacy benefit manager on behalf of an issuer. |
| **HIV+HEP** | **Section 8. Transparency**A. Beginning X, 20XX, and annually thereafter, each licensed Pharmacy Benefit Manager shall submit a transparency report containing data from the prior calendar year to the [State Agency]. The transparency report shall contain the following information: (1) The aggregate amount of all rebates that the Pharmacy Benefit Manager received from all pharmaceutical manufacturers for all covered entities that are clients of the Pharmacy Benefit Manager and for each covered entity of the Pharmacy Benefit Manager; (2) The aggregate administrative fees that the Pharmacy Benefit Manager received from all manufacturers for all covered entities that are clients of the Pharmacy Benefit Manager and for each covered entity that is a client of the of the Pharmacy Benefit Manager; (3) The aggregate retained rebates that the Pharmacy Benefit Manager received from all pharmaceutical manufacturers and did not pass through to covered entities; (4) The aggregate retained rebate percentage as defined in Section 3; and (5) The highest, lowest, and mean aggregate retained rebate percentage for all covered entity clients and for each covered entity client. B. . A Pharmacy Benefit Manager providing information under this section may designate that material as confidential and proprietary information. Disclosure, however, may be ordered by a court of this State for good cause shown or made in a court filing. C. Within sixty (60) days of receipt, the [State Agency] shall publish the transparency report of each Pharmacy Benefit Manager on the agency’s website in a way that does not violate State trade secrets law. D. The state Attorney General may impose civil fines and penalties of not more than $1,000 per day per violation of this section.**Section 9. Business Practices** 1. A. A pharmacy benefit manager has a fiduciary duty to a health carrier client and shall discharge that duty in accordance with the provisions of state and federal law.
2. B. A pharmacy benefit manager shall perform its duties with care, skill, prudence, diligence, and professionalism.
3. C. A pharmacy benefit manager shall notify a health carrier in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the duties imposed in this section.
4. D. A pharmacy benefit manager may not require a cover person 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 under a health benefit plan.
5. E. Any cost-sharing amount shall be attributable toward any deductible or annual out-of-pocket maximums under the covered person’s health benefit plan.
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| **NAIC consumer representatives** | **Section 8. Transparency** 1. A. Annually, a pharmacy benefit manager must provide the commissioner the following information from the previous calendar year:

(1) the aggregate dollar amount of all discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for drugs on the pharmacy benefit manager’s formularies; (2) the aggregate dollar amount of all discounts and rebates that are retained by the PBM for drugs on the PBM's formularies; (3) actual total reimbursement amounts the pharmacy benefit manager pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied; (4) the negotiated price health plans pay the pharmacy benefit manager for drugs on the pharmacy benefit manager’s formularies; (5) the amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan; (6) any ownership interest the pharmacy benefit manager has in a pharmacy or health plan with which it conducts business; B. All information submitted to the commissioner pursuant to this section shall be exempt from disclosure under the Freedom of Information Act, except to the extent such information is included on an aggregated basis in the report required by subsection (C) of this section. The commissioner shall not disclose information submitted pursuant to this section in a manner that is likely to compromise the financial, competitive or proprietary nature of such information. 1. C. The commissioner shall submit an annual report to the committee(s) of jurisdiction within General Assembly having cognizance of matters relating to insurance. The report shall contain (1) an aggregation of the information submitted to the commissioner pursuant to this section for the immediately preceding calendar year, and (2) such other information as the commissioner, in the commissioner’s discretion, deems relevant for the purposes of this section.

**Section 9. Business Practices** 1. A. A pharmacy benefit manager has a fiduciary duty to a to a third party with which the pharmacy benefit manager has entered into a contract to manage the pharmacy benefits plan of the third party client and shall discharge that duty in accordance with the provisions of state and federal law.
2. B. A pharmacy benefit manager shall perform its duties with care, skill, prudence, diligence, and professionalism.
3. C. A pharmacy benefit manager shall notify a health carrier client in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the duties imposed in this section.

**Section 10 Prescription Drug Benefit Management** 1. A. As “designees” of health plans, pharmacy benefit managers must comply with state laws governing prescription drug management, including formulary design, non-discrimination, transparency, and notice requirements.
2. **Drafting Note:** States may want to consider inserting specific reference to the state law governing prescription drug benefit management. The NAIC *Health Carrier Prescription Drug Benefit Management Model Law* (#22) includes provisions governing plan benefit design, pharmacy and therapeutics committees, formulary change notice requirements, and other activities that are often carried out by pharmacy benefit managers acting as the designee of the issuer. States should consider cross-referencing the state’s prescription drug management law with specific reference to any additional legal requirements pharmacy benefits managers have with regard to any activity covered by the prescription drug management law carried out by the pharmacy benefit manager on behalf of an issuer.
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| **NACDS** | **Section 9. Clawbacks Prohibited.** A pharmacy benefit manager or representative of a pharmacy benefit manager is prohibited from retroactively making or permitting any reduction of payment for pharmacist services directly or indirectly to a pharmacy during a reconciliation process. The previous sentence shall not prohibit any retroactive increase in payment for pharmacist services to a pharmacy during a reconciliation process pursuant to a written agreement with the pharmacy.  |