SENATE BILL NO. 38

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATORS ELTON, French

Introduced: 1/21/09
Referred: Health and Social Services, Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance; removing references, definitions, and confidentiality of information provisions relating to managed care entities, substituting health care insurers in the former role of managed care entities, and amending the definitions of 'covered person,' 'managed care plan,' and 'utilization review,' as those terms relate to the administration of managed care insurance plans; authorizing persons to act as pharmacy benefits managers subject to oversight by the division of insurance; and amending the definition of 'health care insurer' as it relates to health care insurance."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.07.010 is amended to read:

Sec. 21.07.010. Patient and health care provider protection. (a) A contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY] that offers a managed care plan must contain a provision that

(1) provides for a reasonable mechanism to identify all medical care

services to be provided by the **health care insurer** [MANAGED CARE ENTITY];

(2) clearly states or references an attachment that states the health care provider's rate of compensation;

(3) clearly states all ways in which the contract between the health care provider and **the health care insurer** [MANAGED CARE ENTITY] may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;

(4) provides that, in the event of a dispute between the parties to the contract, a fair, prompt, and mutual dispute resolution process must be used; at a minimum, the process must provide

(A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 10 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;

(B) that if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;

(C) that if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;

(D) that the parties shall agree to negotiate in good faith in the initial meeting and in mediation;

(5) states that a health care provider may not be penalized or the health care provider's contract terminated by the **health care insurer** [MANAGED CARE ENTITY] because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary medical care services;

(6) protects the ability of a health care provider to communicate openly

with a covered person about all appropriate diagnostic testing and treatment options; and

(7) defines words in a clear and concise manner.

(b) A contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY] that offers a managed care plan may not contain a provision that

(1) has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered medical care services that are medically necessary; nothing in this paragraph shall be construed to prohibit a contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY] from containing incentives for efficient management of the utilization and cost of covered medical care services;

(2) requires the provider to contract for all products that are currently offered or that may be offered in the future by the **health care insurer** [MANAGED CARE ENTITY]; or

(3) requires the health care provider to be compensated for medical care services performed at the same rate as the health care provider has contracted with another **health care insurer** [MANAGED CARE ENTITY].

(c) A **health care insurer** [MANAGED CARE ENTITY] may not enter into a contract with a health care provider that requires the provider to indemnify or hold harmless the **health care insurer** [MANAGED CARE ENTITY] for the acts or conduct of the **health care insurer** [MANAGED CARE ENTITY]. An indemnification or hold harmless clause entered into in violation of this subsection is void.

*** Sec. 2.** AS 21.07.020 is amended to read:

Sec. 21.07.020. Required contract provisions for managed care plans. A managed care plan must contain

(1) a provision that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider;

(2) a provision for emergency room services if any coverage is provided for treatment of a medical emergency;

(3) a provision that covered medical care services be reasonably available in the community in which a covered person resides or that, if referrals are required by the plan, adequate referrals outside the community be available if the medical care service is not available in the community;

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, utilization review decisions for care following emergency services must be made as soon as is practicable but in any event not later than 24 hours after receiving the request for preapproval or for coverage determination; and

(B) to deny, reduce, or terminate a health care benefit or to deny payment for a medical care service because that service is not medically necessary shall be made by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who is a licensed health care provider;

(5) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY]; except as provided under (6) of this section, this appeal mechanism must provide for a written decision

(A) from the **health care insurer** [MANAGED CARE ENTITY] within 18 working days after the date written notice of an appeal is received; and

(B) on the appeal by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who holds the same professional license as the health care provider who is treating the covered person;

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY] in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the **health care insurer**

[MANAGED CARE ENTITY] shall

(A) decide an appeal described in this paragraph within 72 hours after receiving the appeal; and

(B) provide for a written decision on the appeal by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who holds the same professional license as the health care provider who is treating the covered person;

(7) a provision that discloses the existence of the right to an external appeal of a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY]; the external appeal shall be as conducted in accordance with AS 21.07.050;

(8) a provision that discloses covered benefits, optional supplemental benefits, and benefits relating to and restrictions on nonparticipating provider services;

(9) a provision that describes the preapproval requirements and whether clinical trials or experimental or investigational treatment are covered;

(10) a provision describing a mechanism for assignment of benefits for health care providers and payment of benefits;

(11) a provision describing availability of prescription medications or a formulary guide, and whether medications not listed are excluded; if a formulary guide is made available, the guide must be updated annually; and

(12) a provision describing available translation or interpreter services, including audiotape or braille information.

*** Sec. 3.** AS 21.07.030(a) is amended to read:

(a) If a **health care insurer** [MANAGED CARE ENTITY] offers a managed care plan that provides for coverage of medical care services only if the services are furnished through a network of health care providers that have entered into a contract with the **health care insurer** [MANAGED CARE ENTITY], the **health care insurer** [MANAGED CARE ENTITY] shall also offer a non-network option to covered persons at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from

increased costs caused by the use of a non-network provider. The **health care insurer** [MANAGED CARE ENTITY] shall provide an actuarial demonstration of the increased costs to the director at the director's request. If the increased costs are not justified, the director shall require the **health care insurer** [MANAGED CARE ENTITY] to recalculate the appropriate costs allowed and resubmit the appropriate deductible, copayment, or premium to the director. This subsection does not apply to a covered person who is offered non-network coverage through another managed care plan or through another **health care insurer** [MANAGED CARE ENTITY].

*** Sec. 4.** AS 21.07.030(b) is amended to read:

(b) The amount of any additional premium charged by the **health care insurer** [MANAGED CARE ENTITY] for the additional cost of the creation and maintenance of the option described in (a) of this section and the amount of any additional cost sharing imposed under this option shall be paid by the covered person unless it is paid by an employer or other person through agreement with the **health care insurer** [MANAGED CARE ENTITY].

*** Sec. 5.** AS 21.07.030(c) is amended to read:

(c) A covered person may make a change to the medical care coverage option provided under this section only during a time period determined by the **health care insurer** [MANAGED CARE ENTITY]. The time period described in this subsection must occur at least annually and last for at least 15 working days.

*** Sec. 6.** AS 21.07.030(d) is amended to read:

(d) If a **health care insurer** [MANAGED CARE ENTITY] that offers a managed care plan requires or provides for a designation by a covered person of a participating primary care provider, the **health care insurer** [MANAGED CARE ENTITY] shall permit the covered person to designate any participating primary care provider that is available to accept the covered person.

*** Sec. 7.** AS 21.07.030(e) is amended to read:

(e) Except as provided in this subsection, a **health care insurer** [MANAGED CARE ENTITY] that offers a managed care plan shall permit a covered person to receive medically necessary or appropriate specialty care, subject to appropriate referral procedures, from any qualified participating health care provider that is

available to accept the individual for medical care. This subsection does not apply to specialty care if the **health care insurer** [MANAGED CARE ENTITY] clearly informs covered persons of the limitations on choice of participating health care providers with respect to medical care. In this subsection,

(1) "appropriate referral procedures" means procedures for referring patients to other health care providers as set out in the applicable member contract and as described under (a) of this section;

(2) "specialty care" means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

*** Sec. 8.** AS 21.07.030(f) is amended to read:

(f) If a contract between a health care provider and a **health care insurer** [MANAGED CARE ENTITY] is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the **health care insurer** [MANAGED CARE ENTITY], the covered person may continue to receive medical care services from that provider as provided in this subsection, and the contract between the **health care insurer** [MANAGED CARE ENTITY] and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the **health care insurer** [MANAGED CARE ENTITY]. However, treatment is required to continue only while the managed care plan remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment;

(C) through completion of postpartum care, if the covered person is pregnant on the date of termination; or

(2) until the end of the medically necessary treatment for the condition,

disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, "terminal" means a life expectancy of less than one year.

*** Sec. 9.** AS 21.07.050(a) is amended to read:

(a) A **health care insurer** [MANAGED CARE ENTITY] offering a managed care plan shall provide for an external appeal process that meets the requirements of this section in the case of an externally appealable decision for which a timely appeal is made in writing either by the **health care insurer** [MANAGED CARE ENTITY] or by the covered person.

*** Sec. 10.** AS 21.07.050(b) is amended to read:

(b) A **health care insurer** [MANAGED CARE ENTITY] may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal appeal under AS 21.07.020, but only if the decision is made in a timely basis consistent with the deadlines provided under this chapter.

*** Sec. 11.** AS 21.07.050(c) is amended to read:

(c) Except as provided in this subsection, the external appeal process shall be conducted under a contract between the **health care insurer** [MANAGED CARE ENTITY] and one or more external appeal agencies that have qualified under AS 21.07.060. The **health care insurer** [MANAGED CARE ENTITY] shall provide

(1) that the selection process among external appeal agencies qualifying under AS 21.07.060 does not create any incentives for external appeal agencies to make a decision in a biased manner;

(2) for auditing a sample of decisions by external appeal agencies to ensure that decisions are not made in a biased manner; and

(3) that all costs of the process, except those incurred by the covered person or treating professional in support of the appeal, shall be paid by the **health care insurer** [MANAGED CARE ENTITY] and not by the covered person.

*** Sec. 12.** AS 21.07.050(d) is amended to read:

(d) An external appeal process must include at least the following:

(1) a fair, de novo determination based on coverage provided by the plan and by applying terms as defined by the plan; however, nothing in this paragraph may be construed as providing for coverage of items and services for which benefits

are excluded under the plan or coverage;

(2) an external appeal agency shall determine whether the **health care insurer's** [MANAGED CARE ENTITY'S] decision is (A) in accordance with the medical needs of the patient involved, as determined by the **health care insurer** [MANAGED CARE ENTITY], taking into account, as of the time of the **health care insurer's** [MANAGED CARE ENTITY'S] decision, the patient's medical needs and any relevant and reliable evidence the agency obtains under (3) of this subsection, and (B) in accordance with the scope of the covered benefits under the plan; if the agency determines the decision complies with this paragraph, the agency shall affirm the decision, and, to the extent that the agency determines the decision is not in accordance with this paragraph, the agency shall reverse or modify the decision;

(3) the external appeal agency shall include among the evidence taken into consideration

(A) the decision made by the **health care insurer** [MANAGED CARE ENTITY] upon internal appeal under AS 21.07.020 and any guidelines or standards used by the **health care insurer** [MANAGED CARE ENTITY] in reaching a decision;

(B) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed;

(C) the opinion of the individual's treating physician or health care provider; and

(D) the managed care plan;

(4) the external appeal agency may also take into consideration the following evidence:

(A) the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals;

(B) the results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies;

(C) practice and treatment guidelines prepared or financed in

whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

(F) to the extent that the agency determines **them** [IT] to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care that are directly related to the matters under appeal;

(G) to the extent that the agency determines **them** [IT] to be free of any conflict of interest, the results of peer reviews conducted by the **health care insurer** [MANAGED CARE ENTITY] involved;

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

(A) whether a denial of a claim for benefits is an externally appealable decision;

(B) whether an externally appealable decision involves an expedited appeal; and

(C) for purposes of initiating an external review, whether the internal appeal process has been completed;

(6) a party to an externally appealable decision may submit evidence related to the issues in dispute;

(7) the **health care insurer** [MANAGED CARE ENTITY] involved shall provide the external appeal agency with access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the external appeal agency; and

(8) a determination by the external appeal agency on the decision must

(A) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(B) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is

filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the **health care insurer's** [MANAGED CARE ENTITY'S] decision;

(C) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(D) inform the covered person of the individual's rights, including any time limits, to seek further review by the courts of the external appeal determination.

*** Sec. 13.** AS 21.07.050(e) is amended to read:

(e) If the external appeal agency reverses or modifies the denial of a claim for benefits, the **health care insurer** [MANAGED CARE ENTITY] shall

(1) upon receipt of the determination, authorize benefits in accordance with that determination;

(2) take action as may be necessary to provide benefits, including items or services, in a timely manner consistent with the determination; and

(3) submit information to the external appeal agency documenting compliance with the agency's determination.

*** Sec. 14.** AS 21.07.060(b) is amended to read:

(b) An external appeal agency is qualified to consider appeals of managed care plan health care decisions if the agency meets the following requirements:

(1) the agency meets the independence requirements of this section;

(2) the agency conducts external appeal activities through a panel of two clinical peers, unless otherwise agreed to by both parties; and

(3) the agency has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the **health care insurer** [MANAGED CARE ENTITY] on a timely basis consistent with this chapter.

*** Sec. 15.** AS 21.07.070 is amended to read:

Sec. 21.07.070. Limitation on liability of reviewers. An external appeal agency qualifying under AS 21.07.060 and having a contract with a **health care insurer** [MANAGED CARE ENTITY], and a person who is employed by the agency

or who furnishes professional services to the agency, may not be held by reason of the performance of any duty, function, or activity required or authorized under this chapter to have violated any criminal law [,] or to be civilly liable if due care was exercised in the performance of the duty, function**,** or activity and there was no actual malice or gross misconduct in the performance of the duty, function, or activity.

*** Sec. 16.** AS 21.07.080 is amended to read:

Sec. 21.07.080. Religious nonmedical providers. This chapter may not be construed to

(1) restrict or limit the right of a **health care insurer** [MANAGED CARE ENTITY] to include services provided by a religious nonmedical provider as medical care services covered by the managed care plan;

(2) require a **health care insurer** [MANAGED CARE ENTITY], when determining coverage for services provided by a religious nonmedical provider, to

(A) apply medically based eligibility standards;

(B) use health care providers to determine access by a covered person;

(C) use health care providers in making a decision on an internal or external appeal; or

(D) require a covered person to be examined by a health care provider as a condition of coverage; or

(3) require a managed care plan to exclude coverage for services provided by a religious nonmedical provider because the religious nonmedical provider is not providing medical or other data required from a health care provider if the medical or other data is inconsistent with the religious nonmedical treatment or nursing care being provided.

*** Sec. 17.** AS 21.07 is amended by adding new sections to read:

Article 2. Pharmacy Benefits Management.

Sec. 21.07.100. Agreements; prohibited provisions; approval. (a) A pharmacy benefits manager may only act under the terms of a written agreement between the pharmacy benefits manager and a health care insurer, a pharmacist, a

pharmacy, or a covered person that is approved by the director. The director shall establish, by regulation, the permitted and prohibited terms of an agreement consistent with AS 21.07.100 - 21.07.160 and the process by which the agreement may be submitted for review and approval.

(b) Pharmacy benefits that may be managed by a pharmacy benefits manager include

(1) mail service pharmacy programs;

(2) claims processing services;

(3) retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered persons;

(4) clinical formulary development and management services;

(5) rebate contracting and administration services;

(6) patient compliance, therapeutic intervention, and generic substitution programs; and

(7) disease management programs involving prescription drug use.

(c) An agreement between a health care insurer and a pharmacy benefits manager may not

(1) provide that a pharmacist or pharmacy is responsible for the actions of the health care insurer or the pharmacy benefits manager;

(2) require a pharmacist or pharmacy to participate in one contract in order to participate in another contract;

(3) exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network solely because the pharmacist or pharmacy declined to participate in another plan or network managed by the pharmacy benefits manager; or

(4) require a pharmacist or pharmacy to change a covered person's prescription unless the prescribing physician and the covered person authorize the pharmacist or pharmacy to make the change.

(d) An agreement must apply the same coinsurance, copayment, and deductible terms to all covered drug prescriptions filled by a pharmacy, including a mail order pharmacist or pharmacy that participates in a network.

(e) If an agreement provides that the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager acts as a fiduciary of the pharmacist or pharmacy that provided the services.

(f) A pharmacy benefits manager shall file with the division a copy of each agreement under which it operates for approval by the division not less than 30 days before the execution of the agreement. The agreement shall be considered approved unless the division disapproves it within 30 days after it is filed.

Sec. 21.07.105. Prohibited practices. (a) A pharmacy benefits manager may not

(1) intervene in the delivery or transmission of prescriptions from the prescriber to the pharmacist or pharmacy for the purpose of influencing the prescriber's choice of therapy, influencing the patient's choice of pharmacist or pharmacy, or altering the prescription information;

(2) switch a prescribed drug without the express authorization of the prescriber;

(3) transfer a health benefit plan to another payment network unless the pharmacy benefits manager receives written authorization from the insurer;

(4) unfairly discriminate when advertising which pharmacists or pharmacies are participating pharmacists or pharmacies;

(5) require record keeping by a pharmacist or pharmacy that is more stringent than required by state or federal laws or regulations; or

(6) unfairly discriminate when contracting with pharmacists or pharmacies based on copayments or days of supply.

(b) A health care insurer and a pharmacy benefits manager may not unfairly discriminate against a pharmacist or pharmacy that is acting within the scope of a license or certification with respect to participation in a network or reimbursement plan.

Sec. 21.07.110. Agreement termination. (a) An agreement between a pharmacy benefits manager and a pharmacist or pharmacy may not be terminated, and a pharmacy benefits manager may not penalize a pharmacist or pharmacy, because a pharmacist or pharmacy

(1) has filed a complaint, grievance, or appeal;

(2) expresses disagreement with a pharmacy benefits manager's decision to deny or limit benefits to a covered person;

(3) assists a covered person to seek reconsideration of the pharmacy benefits manager's decision; or

(4) discusses alternative medications with a covered person.

(b) Before terminating an agreement with a pharmacist or pharmacy that results in the exclusion of a pharmacist or pharmacy from a network, the pharmacy benefits manager shall give the pharmacist or pharmacy a written explanation of the reason for the termination at least 30 days before the termination date. However, the agreement may be terminated immediately if the termination is based on

(1) the loss of the pharmacist's or pharmacy's license; or

(2) a licensee's conviction of fraud.

(c) Termination of an agreement between a pharmacy benefits manager and a pharmacist or pharmacy does not release a pharmacy benefits manager from the obligation to make a payment due to the pharmacist or pharmacy for services rendered.

Sec. 21.07.115. Medication reimbursement costs. (a) A pharmacy benefits manager shall use a current and nationally recognized benchmark as a basis to establish the reimbursement paid to network pharmacists or pharmacies for medications and products. The reimbursement must be determined as follows:

(1) for a brand name or single source product, the index is the First DataBank or the Facts and Comparisons average wholesale price effective on the date of service;

(2) for a generic drug or multisource product, the maximum allowable cost is established by reference to the First DataBank or Facts and Comparisons baseline price.

(b) Only products that comply with pharmacy laws as equivalent and generically interchangeable with a federal Food and Drug Administration Orange Book rating of "A-B" may be reimbursed using a maximum allowable cost price method.

(c) If a multisource product does not have a baseline price, the multisource product shall be treated as a single-source branded drug for the purpose of determining reimbursement.

Sec. 21.07.120. Payments; audits. (a) If a pharmacy benefits manager or health care insurer processes a claim electronically, the pharmacy benefits manager or health care insurer shall electronically transmit payments to the pharmacist or pharmacy not later than seven calendar days after the claim is transmitted to the pharmacist or pharmacy.

(b) If a pharmacy benefits manager or health care insurer processes claims nonelectronically, the time limits for payment to a pharmacist or pharmacy must be set out in the agreement between the pharmacy benefits manager or health care insurer and the pharmacist or pharmacy.

(c) A pharmacy benefits manager or health care insurer shall adjust the price charged to a pharmacist or pharmacy within 24 hours after a price increase notification received from a manufacturer or supplier.

(d) Except as provided in (f) of this section, claims paid by a pharmacy benefits manager or a health care insurer may not be retroactively denied or adjusted after seven days after adjudication of the claims.

(e) A pharmacy benefits manager or a health care insurer may not retroactively reverse a determination of eligibility.

(f) A pharmacy benefits manager or health care insurer may retroactively deny or adjust a claim if

(1) the original claim was submitted fraudulently;

(2) the original claim payment was incorrect because the pharmacist or pharmacy was already paid for services rendered; or

(3) the services were not rendered by the pharmacist or pharmacy.

(g) A pharmacy benefits manager or a health care insurer may not require an extrapolation audit as a condition of participating in a contract, network, or program.

(h) A pharmacy benefits manager or a health care insurer may not recoup money the pharmacy benefits manager believes to be owed as a result of an audit by setoff until the pharmacist or pharmacy has the opportunity to review the pharmacy

benefits manager's or the health care insurer's findings and concurs with the results. If the parties disagree, the results of the audit are subject to review by the director.

Sec. 21.07.125. Disclosures to covered persons. (a) If a health care insurer uses the services of a pharmacy benefits manager, the pharmacy benefits manager shall provide a written notice to a covered person that is approved by the health care insurer. The notice must advise the covered person of the identity of, and relationship among, the pharmacy benefits manager, the health care insurer, and the covered person.

(b) The notice required in (a) of this section must contain

(1) a statement advising the covered person that the pharmacy benefits manager is regulated by the insurance laws that are enforced by the director;

(2) a statement that the covered person has the right to file a complaint, appeal, or grievance with the division concerning the pharmacy benefits manager or health care insurer; and

(3) the telephone number, mailing address, and electronic mail address of the director.

(c) The notice required in (a) of this section must be written in plain English, using terms that are generally understood by a layperson, and a copy must be provided to the division and to each pharmacist or pharmacy participating in a network.

Sec. 21.07.130. Authorized substitutions. (a) If a pharmacy benefits manager requests a substitute prescription for a drug prescribed to a covered person and obtains the approval of the prescribing health professional or the prescribing health professional's authorized representative for a prescription drug substitution, the pharmacy benefits manager may substitute a lower-priced generic and therapeutically equivalent drug for a higher-priced prescribed drug.

(b) If the substitute drug costs more than the prescribed drug, the substitution must be made for medical reasons that benefit the covered person.

(c) A pharmacy benefits manager shall disclose to the covered person the cost of the original drug and the cost of the substitute drug, any benefit or payment accruing to the pharmacy benefits manager as a result of the substitution, any potential effects on a patient's health that may occur as a result of the substitution, the safety of

the substitution, and the side effects of the original drug compared to the side effects of the substitute drug.

(d) The pharmacy benefits manager shall compensate the health care insurer for any benefit or payment received by the pharmacy benefits manager as a result of a prescription drug substitution under this section.

Sec. 21.07.135. Complaint process. (a) The director shall adopt regulations establishing procedures for the investigation of complaints concerning the activity of a pharmacy benefits manager.

(b) The division shall refer to the Board of Pharmacy a complaint involving an issue that is under the jurisdiction of the Board of Pharmacy under AS 08.80.030.

Sec. 21.07.140. Compensation for claim adjustment. (a) Compensation to a pharmacy benefits manager for claims adjusted or settled on behalf of a health care insurer may not be based on claims experience.

(b) This section does not prohibit the compensation of a pharmacy benefits manager based on the total number of claims paid or processed.

Sec. 21.07.145. Duty to the covered entity and health care insurer. (a) A pharmacy benefits manager shall provide to a health care insurer the financial and use information requested by the health care insurer relating to providing pharmacy benefits to a covered person for the health care insurer.

(b) A pharmacy benefits manager providing information under this section may designate the information provided under (a) of this section as confidential. Information designated as confidential by a pharmacy benefits manager and provided to a health care insurer under this section may not be disclosed by the covered entity to a person without the consent of the pharmacy benefits manager, except that disclosure may be made when authorized or required by a court.

(c) A pharmacy benefits manager shall disclose to the health care insurer all financial terms and arrangements for remuneration that apply between the pharmacy benefits manager and a prescription drug manufacturer or labeler, including rebates, formulary management and drug-switching or drug-substitution programs, educational support, claims processing and pharmacy network fees charged by retail pharmacies, and data sales fees.

(d) A pharmacy benefits manager shall disclose to the health care insurer whether there is a difference between the price paid to a retail pharmacy and the amount billed to the health care insurer.

(e) A health care insurer may audit the pharmacy benefits manager's records related to the rebates or other information provided in this section.

Sec. 21.07.150. Pharmacy benefits manager registration. A pharmacy benefits manager shall be registered as a third-party administrator under AS 21.27.630 - 21.27.660.

Sec. 21.07.155. Fees; penalty. (a) The division may, by regulation,

(1) assess reasonable fees from a pharmacy benefits manager for the costs of administration of AS 21.07.100 - 21.07.160; and

(2) establish reasonable penalties, including suspending the registration of a pharmacy benefits manager that fails to pay the appropriate fees.

(b) If the director determines, after a hearing under AS 21.06.170 - 21.06.230, that a person has acted as a pharmacy benefits manager without registering authority to act as a pharmacy benefits manager under AS 21.07.150, the person is subject to a civil penalty of not less than $5,000 and not more than $10,000 for each violation.

Sec. 21.07.160. Applicability to the state and a bargaining unit. AS 21.07.100 - 21.07.160 apply to a pharmacy benefits manager providing services to

(1) the state when it provides group insurance by means of self insurance under AS 39.30.091; and

(2) a bargaining unit that is exempted under AS 39.30.090(a)(2) and an implementing regulation or regulations and that provides health care benefits for eligible state employees and their dependents.

*** Sec. 18.** AS 21.07.250(11) is amended to read:

(11) "managed care plan" or "plan" means an individual or group health insurance **policy that complies with AS 21.07.020** [PLAN OPERATED BY A MANAGED CARE ENTITY];

*** Sec. 19.** AS 21.07.250(14) is amended to read:

(14) "participating health care provider" means a health care provider who has entered into an agreement with a **health care insurer** [MANAGED CARE

ENTITY] to provide services or supplies to a patient covered by a managed care plan;

*** Sec. 20.** AS 21.07.250(18) is amended to read:

(18) "utilization review" means a system of **monitoring the use of , or evaluating the clinical necessity, appropriateness, efficacy, or efficiency of, medical care services, procedures, settings or supplies including ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review** [REVIEWING THE MEDICAL NECESSITY, APPROPRIATENESS, OR QUALITY OF MEDICAL CARE SERVICES AND SUPPLIES PROVIDED UNDER A MANAGED CARE PLAN USING SPECIFIED GUIDELINES, INCLUDING PREADMISSION CERTIFICATION, THE APPLICATION OF PRACTICE GUIDELINES, CONTINUED STAY REVIEW, DISCHARGE PLANNING, PREAUTHORIZATION OF AMBULATORY PROCEDURES, AND RETROSPECTIVE REVIEW];

*** Sec. 21.** AS 21.07.250 is amended by adding new paragraphs to read:

(20) "Board of Pharmacy" or "board" means the Board of Pharmacy established under AS 08.80.010;

(21) "covered person" means a member, policy holder, subscriber, enrollee, beneficiary, or dependent participating in a health care plan;

(22) "health care insurer" has the meaning given in AS 21.54.500;

(23) "pharmacist" has the meaning given in AS 08.80.480;

(24) "pharmacy" has the meaning given in AS 08.80.480.

*** Sec. 22.** AS 21.54.500(17) is amended to read:

(17) "health care insurer" means a person **that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of medical care** [TRANSACTING THE BUSINESS OF HEALTH CARE INSURANCE], including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a **self-funded** multiple employer welfare arrangement **under AS 21.85, or a person subject to this title who provides coverage for the cost of medical care** [, A

CHURCH PLAN, AND A GOVERNMENTAL PLAN, EXCEPT FOR A NONFEDERAL GOVERNMENTAL PLAN THAT ELECTS TO BE EXCLUDED UNDER 42 U.S.C. 300gg-21(b)(2) (HEALTH CARE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)];

*** Sec. 23.** AS 21.90.900 is amended by adding a new paragraph to read:

(46) "pharmacy benefits manager" means a person that, acting under the terms of an agreement, procures prescription drugs at a negotiated rate and dispenses the prescription drugs to a covered person or administers prescription drug benefits provided by a covered entity for the benefit of a covered person, including claims processing services and prescription drug and medical device services.

*** Sec. 24.** AS 21.07.040, 21.07.250(8), 21.07.250(9), and 21.07.250(10) are repealed.