House Bill 1128

By: Representatives Park of the 101st, Dreyer of the 59th, Drenner of the 85th, Hugley of the 136th, Smyre of the 135th, and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 64 of Title 33 of the Official Code of Georgia Annotated, relating to regulation and licensure of pharmacy benefits managers, so as to revise provisions relating to rules and regulations; to provide for audits; to revise provisions relating to reimbursement requirements; to require reasonably adequate and accessible pharmacy benefits manager networks; to provide for a fiduciary duty by pharmacy benefits managers; to provide for protections for 340B entities; to provide for definitions; to amend Part 1 of Article 1 of Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to the state employees' health insurance plan, so as to require that all contracts for pharmacy benefits management under the state health benefit plan include collection of data on pharmacy claims; to provide for related matters; to provide for an effective date and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 64 of Title 33 of the Official Code of Georgia Annotated, relating to regulation and licensure of pharmacy benefits managers, is amended by revising Code Section 33-64-7, relating to a prohibition on the extension of rules and regulations and the enforcement of specific provisions of the chapter and rules and regulations, as follows:

"33-64-7.

(a) The Commissioner ~~may not enlarge upon or extend the specific provisions of this chapter through any act, rule, or regulation; provided, however, that the Commissioner~~ is authorized to enforce any specific provision of this chapter and may promulgate rules and regulations to effectuate the specific provisions of this chapter. Such rules shall include penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure, for violations of this chapter and the rules and regulations adopted pursuant to this chapter.

(b) The Commissioner may examine or audit the books and records of a pharmacy benefits manager to determine if the pharmacy benefits manager is in compliance with this chapter; provided, however, that any information or data acquired during the examination or audit is considered proprietary and confidential and exempt from disclosure under Article 4 of Chapter 18 of Title 50, relating to open records."

SECTION 2.

Said chapter is further amended by revising Code Section 33-64-9, relating to requirements for the use of maximum allowable cost pricing by pharmacy benefits managers, as follows:

"33-64-9.

~~(a) Upon each contract execution or renewal between a pharmacy benefits manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:~~

~~(1) Include in such contract or renewal the sources utilized to determine multi-source generic drug pricing, such as maximum allowable cost or any successive benchmark pricing formula, and update such pricing information at least every five business days, provided that such pricing information update shall be at least every 14 business days for those contracts pursuant to Article 7 of Chapter 4 of Title 49; and~~

~~(2) Maintain a procedure to eliminate products from the multi-source generic list of drugs subject to such pricing or modify multi-source generic drug pricing within five business days when such drugs do not meet the standards and requirements of this Code section in order to remain consistent with pricing changes in the marketplace.~~

~~(b) A pharmacy benefits manager shall reimburse pharmacies for drugs subject to multi-source generic drug pricing based upon pricing information which has been updated within five business days as set forth in paragraph (1) of subsection (a) of this Code section.~~

~~(c) A pharmacy benefits manager may not place a drug on a multi-source generic list unless there are at least two therapeutically equivalent, multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.~~

(a)(1) A pharmacy benefits manager may not reimburse a pharmacy or pharmacist for a prescription drug in an amount less than the lowest of:

(A) The National Average Drug Acquisition Cost (NADAC) for the prescription drug, plus a dispensing fee of $10.49;

(B) The pharmacy or pharmacist's acquisition cost for the prescription drug, plus a dispensing fee of $10.49; or

(C) The pharmacy or pharmacist's usual and customary charge to the general public for the prescription drug.

(2) A pharmacy benefits manager may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.

~~(d)~~(b) All contracts between a pharmacy benefits manager and a contracted pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, shall include a process to internally appeal, investigate, and resolve disputes regarding ~~multi-source generic~~ prescription drug pricing. The process shall include the following:

(1) The right to appeal shall be limited to 14 calendar days following reimbursement of the initial claim; and

(2) A requirement that the health benefit plan issuer or pharmacy benefits manager shall respond to an appeal ~~described in subsection (a) of this Code section~~ no later than 14 calendar days after the date the appeal was received by such health benefit plan issuer or pharmacy benefits manager.

~~(e)~~(c) For appeals that are denied, the pharmacy benefits manager shall provide the reason for the denial ~~and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost~~.

~~(f)~~(d) If the appeal is successful, the health benefit plan issuer or pharmacy benefits manager shall~~:~~

~~(1) Adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;~~

~~(2) Apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health plan issuer or pharmacy benefits manager; and~~

~~(3) Allow~~ allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal.

~~(g)~~(e) Appeals shall be upheld if~~:~~

~~(1) The~~ the pharmacy being reimbursed for the drug ~~subject to the multi-source generic drug pricing~~ in question was not reimbursed as required in subsection ~~(b)~~(a) of this Code section~~; or~~

~~(2) The drug subject to the multi-source generic drug pricing in question does not meet the requirements set forth in subsection (c) of this Code section~~.

~~(h)~~(f) The Commissioner shall have enforcement authority over this Code section.″

SECTION 3.

Said chapter is further amended by adding new Code sections to read as follows:

"33-64-12.

(a) A pharmacy benefits manager shall provide a reasonably adequate and accessible pharmacy benefits manager network, as determined by the Commissioner, for the provision of prescription drugs that shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

(b) A mail-order pharmacy may not be included in the calculations determining pharmacy benefits manager network adequacy.

(c) A pharmacy benefits manager shall provide a pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this state in a time and manner required by rule issued by the Commissioner pursuant to this Code section.

(d) Failure to provide a reasonably adequate and accessible pharmacy benefits manager network shall result in the suspension or revocation of a pharmacy benefits manager license by the Commissioner.

33-64-13.

A pharmacy benefits manager licensed to do business in the State of Georgia has a fiduciary duty to a covered entity with which the pharmacy benefits manager has entered into a contract to manage the pharmacy benefits plan of the covered entity and shall notify the covered entity in writing of any activity, policy, or practice of the pharmacy benefits manager that presents a conflict of interest that interferes with the ability of the pharmacy benefits manager to discharge that fiduciary duty.

33-64-14.

(a) As used in this Code section, the term:

(1) '340B entity' means an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. Section 256b, including the entity's pharmacy or pharmacies, or any pharmacy or pharmacies contracted with the entity to dispense drugs purchased through the program.

(2) 'Third party' means care management organizations as described in Chapter 21A of this title. Such term shall not include Medicaid when providing reimbursement for covered outpatient drugs on a fee-for-service basis.

(b) With respect to a patient eligible to receive prescription drugs subject to an agreement under 42 U.S.C. Section 256b, a pharmacy benefits manager, or any third party that makes payment for those prescription drugs, shall not discriminate against:

(1) A 340B entity in a manner that prevents or interferes with the patient's choice to receive those prescription drugs from the 340B entity;

(2) A pharmacy participating in a health plan as an entity authorized to participate under 42 U.S.C. Section 256b in a manner that prevents or interferes with the patient's choice to receive those prescription drugs from the pharmacy; or

(3) A 340B entity by reimbursing for pharmacy dispensed prescription drugs at a rate lower than that paid for the same prescription drug to pharmacies that are not 340B entities and shall not assess any fee or other adjustment upon the 340B entity nor exclude a 340B pharmacy from the pharmacy benefits manager's or third party's pharmacy network or otherwise discriminate against any 340B entity on the basis that the 340B entity participates in the program described in 42 U.S.C. Section 256b.

(c) This Code section creates a private cause of action for a pharmacy or 340B entity against a pharmacy benefits manager or third party who violates this Code section."

SECTION 4.

Part 1 of Article 1 of Chapter 18 of Title 45 of the Official Code of Georgia Annotated, relating to the state employees' health insurance plan, is amended by adding a new Code section to read as follows:

"45-18-6.2.

(a) As used in this Code section, the term 'state health benefit plan' means the health insurance plan or plans established pursuant to this article and Part 6 of Article 17 of Chapter 2 of Title 20 for state and public employees, dependents, and retirees.

(b) On and after July 1, 2020, any contracts entered into or renewed by the board for health care coverage for enrollees under the state health benefit plan shall include language for pharmacy benefits management requiring a pharmacy benefits manager to report to the board quarterly, for all quarters through the one ending June 30, 2022, for all pharmacy claims:

(1) The amount paid to the pharmacy provider per claim, including, but not limited to, costs of drug reimbursement;

(2) Dispensing fees;

(3) Copayments; and

(4) The amount charged to the plan sponsor for each claim by the pharmacy benefits manager.

(c) If there is a difference between the reported amounts in subsection (b) of this Code section, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim.

(d) All data and information provided by the plan sponsor shall be kept secure, and notwithstanding any other provision of law, the board shall maintain the confidentiality of the proprietary information and shall not share or disclose the proprietary information contained in the report or data collected with persons not on the board. Only those board employees involved in collecting, securing, and analyzing the data for the purpose of preparing the report provided for in this Code section may have access to the proprietary data.

(e) The board shall provide a report using aggregated data to the Governor and the General Assembly on the implementation of the provisions of this Code section and its impact on program expenditures by December 1, 2020. Such report shall not contain confidential or proprietary information.

(f) If the information required by this Code section is not provided by the pharmacy benefits manager, the board shall terminate the contract with the pharmacy benefits manager.″

SECTION 5.

(a) This Act shall become effective on July 1, 2020, and shall apply to all contracts issued, delivered, or issued for delivery in this state on and after such date.

(b) This Act shall not apply to any self-funded, employer sponsored health insurance plan regulated under the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. Section 1001, et seq.

SECTION 6.

All laws and parts of laws in conflict with this Act are repealed.