LEGISLATURE OF THE STATE OF IDAHO

Sixty-fourth Legislature Second Regular Session - 2018

IN THE SENATE

SENATE BILL NO. 1336

BY STATE AFFAIRS COMMITTEE

AN ACT

RELATING TO PHARMACIES; AMENDING TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 65, TITLE 41, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO DEFINE TERMS, TO PROVIDE FOR APPLICABILITY, TO PROVIDE FOR REQUIRED PRACTICES FOR PHARMACY BENEFIT MANAGERS, TO PROHIBIT CERTAIN WAIVERS, TO PROVIDE FOR ENFORCEMENT, TO PROVIDE FOR RULEMAKING AND TO PROVIDE MAXIMUM ALLOWABLE COST TRANSPARENCY REQUIREMENTS FOR PHARMACY BENEFIT MANAGERS; AND PROVIDING SEVERABILITY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 65, Title 41, Idaho Code, and to read as follows:

CHAPTER 65

PHARMACY BENEFIT MANAGER TRANSPARENCY ACT

41-6501. SHORT TITLE. This chapter shall be known and may be cited as the "Pharmacy Benefit Manager Transparency Act."

41-6502. DEFINITIONS. For purposes of this chapter:

(1) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(2) "Entity" means a managed care organization, insurance company, administrator, third-party payor, plan sponsor or self-funded health plan trust fund.

(3) "Generic exclusivity period" means the period, designated by the United States food and drug administration (FDA), following a successful challenge of the original manufacturer's patent on an innovator drug, during which a second manufacturer of a pharmaceutically and therapeutically equivalent multiple source drug may market its version without competition from other multiple source manufacturers.

(4) "MAC list" means the list of drugs for which maximum allowable costs have been established.

(5) "Maximum allowable cost" (MAC) means a maximum reimbursement amount for a multiple source drug or a drug for which only two (2) products are available during a generic exclusivity period as defined by 21 U.S.C. 355.

(6) "Multiple source drug" means a drug in which there are three (3) or more drug products that are:

(a) Rated by the FDA as therapeutically equivalent under the FDA's most recent publication of approved drug products with therapeutic equivalence evaluations;

(b) Determined by the FDA to be pharmaceutically equivalent or bioequivalent; and

(c) Separately sold or marketed in the United States during the same calendar quarter.

(7) "Nationally available" means that such products are available for purchase by retail pharmacies in sufficient supply from national pharmaceutical wholesalers and are not obsolete or temporarily unavailable.

(8) "Network pharmacy" means a retail pharmacy that contracts with a pharmacy benefit manager.

(9) "Obsolete" means that such products may be listed in national pricing compendia but are no longer actively marketed by the manufacturer.

(10) "Pharmacy benefit manager" or "PBM" means an organization that contracts with retail pharmacies on behalf of an entity to provide pharmacy services to such entities.

(11) "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by the state of Idaho and that dispenses medications to the general public. Such term does not include a nursing home pharmacy, long-term care pharmacy, hospital pharmacy, clinics, charitable or nonprofit pharmacy, government pharmacy or pharmacy benefit managers.

(12) "Temporarily unavailable" means that such products are experiencing short-term supply interruptions for which only inconsistent or intermittent supply is available in the current marketplace.

(13) "Therapeutically equivalent" means drugs that are approved by the FDA and that the FDA has determined will provide essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen.

41-6503. APPLICABILITY. (1) All pharmacy benefit managers that conduct any of the following pharmacy-related activities for entities in the state of Idaho must comply with the provisions of this chapter:

(a) Claims processing;

(b) Retail pharmacy network management;

(c) Pharmacy discount card programs;

(d) Employer worker's compensation benefits management;

(e) Payment of claims to retail pharmacies for prescription drugs dispensed to covered persons;

(f) Clinical formulary development and management services, including but not limited to utilization management and quality assurance programs;

(g) Rebate contracting and administration;

(h) Conducting audits of contracted retail pharmacies;

(i) Setting pharmacy reimbursement prices and methodologies; or

(j) Establishing a "spread" or differential between what is received from entities as reimbursement for prescription drugs and what is paid to retail pharmacies by the PBM for such drugs.

(2) The provisions of this chapter shall not apply to Idaho medicaid or medical assistance as defined in chapter 2, title 56, Idaho Code.

41-6504. REQUIRED PRACTICES FOR PHARMACY BENEFIT MANAGERS. (1) The business of pharmacy benefit managers is one affected by the public interest, and, as such, pharmacy benefit managers shall act in good faith, abstain from deception, and practice honesty and equity in all pharmacy benefit management activities.

(2) As of January 1, 2020, all pharmacy benefit managers shall obtain a PBM license from the director of the Idaho department of insurance before providing services to entities. Licenses shall be effective for one (1) year and may be renewed for additional annual periods. The director of the Idaho department of insurance may revoke, suspend, deny, or restrict a license of a PBM for violation of this act or on the grounds of violations of state or federal laws or regulations as determined necessary or appropriate by the director. In the event that a license is revoked, suspended or denied, the director may permit such further operation of the PBM for a limited time not to exceed sixty (60) days under conditions and restrictions as determined by the director for a period as necessary for the beneficial interests of the entities and pharmacy providers with whom the pharmacy benefit manager contracts.

(a) The director may renew the license of any PBM, subject to any restrictions considered necessary or appropriate by the director.

(b) The director shall provide written notice to the PBM of any revocation, denial, suspension or restriction, including the specific reasons. The PBM shall have the same rights to notice, hearings and other provisions as provided to licensees under state law.

(c) The director shall provide the board of pharmacy, upon request, with copies of applications, correspondences and any other documents provided by the PBM to the director, and with notices, findings, determinations and other documents provided by the director to the PBM.

(3) When applying for a license, pharmacy benefit managers shall include, at a minimum, the following on or with a form prescribed by the director:

(a) All organizational documents including, but not limited to, articles of incorporations, bylaws and other similar documents and any amendments;

(b) The names, addresses, titles, and qualifications of the members of the board of directors and officers or the partners or owners in the case of a partnership or association, as well as a report of the details of any suspension, sanction, penalty or other disciplinary action relating to the PBM and its officers, directors, partners or owners;

(c) A detailed description of the claims processing services, pharmacy services, insurance services, other prescription drug or device services or other administrative services provided;

(d) Audited financial statements for the current year and the preceding year showing the assets, liabilities, direct or indirect income, and any other sources of financial support sufficient as deemed by the director to show financial stability and viability to meet its obligations to participants and participating pharmacies. If audited financial statements are unavailable, the director may allow a recent unaudited financial statement prepared by an independent certified public accountant combined with a surety bond in the amount of one million dol-

lars ($1,000,000) payable to an aggrieved party on a form acceptable to the director to meet this requirement, including at least thirty (30) days' prior notice to the director before any cancellation of the bond shall be effective;

(e) The payment of a registration or licensure fee upon application and for every renewal period in an amount set forth by rule, and in no event less than three hundred dollars ($300) nor more than seven hundred dollars ($700); and

(f) Such other information as the director may require.

(4) A pharmacy benefit manager license shall be effective for one (1) year and may be renewed by providing information on a form prescribed by the director that shall include any updated or current information set forth in subsection (3) of this section and shall also include updated financial statements and bond information set forth in subsection (3)(d) of this section and the payment of a license renewal fee in the amount set forth in subsection (3)(e) of this section.

(5) A pharmacy benefit manager shall take no action that would restrict a covered person's choice of pharmacy from which to receive prescription medications.

(a) A PBM shall not require that a covered person use a specific retail pharmacy, mail-order pharmacy, specialty pharmacy or a pharmacy in which the PBM has ownership interest. The PBM shall not provide incentives to covered persons to encourage the use of a pharmacy in which the PBM has ownership interest.

(b) A PBM may not require that a pharmacist or retail pharmacy participate in a network managed by such PBM as a condition for the retail pharmacy to participate in another network managed by the same PBM.

(c) A PBM may not exclude an otherwise qualified pharmacist or retail pharmacy from participation in a particular network provided that the pharmacist or pharmacy accepts industry-standard terms, conditions and reimbursement rates of the PBM. The pharmacy must meet all applicable federal and state licensure and permit requirements and must not have been excluded from participation in any federal or state program.

41-6505. WAIVERS. Any waiver by a pharmacy benefit manager or entity of any provisions of this chapter is unenforceable and void.

41-6506. ENFORCEMENT. (1) The practices covered by the provisions of this chapter are matters vitally affecting the public interest for the purpose of applying chapter 13, title 41, Idaho Code. A violation of this chapter is not reasonable in relation to the development and preservation of business and is an unfair or deceptive act in trade or commerce and an unfair method of competition for the purpose of applying chapter 13, title 41, Idaho Code.

(2) The director may impose an administrative penalty in the amount as set forth in section 41-117, Idaho Code, and may deny, suspend, revoke, refuse to issue or refuse to continue any license issued under this chapter upon a finding that any licensee or applicant has committed any violation of this chapter or finds that the applicant or licensee is unfit to be licensed.

(3) The enforcement provision of subsection (1) of this section relates to state law only and is not intended to create an alternative enforcement mechanism under the federal employee retirement income security act of 1974 or any other federal law.

41-6507. RULEMAKING AUTHORITY. The director of the Idaho department of insurance is authorized to promulgate, adopt and enforce rules and fees necessary to implement the provisions of this chapter.

41-6508. MAXIMUM ALLOWABLE COST TRANSPARENCY REQUIREMENTS FOR PHARMACY BENEFIT MANAGERS. (1) A maximum allowable cost shall be:

(a) Established only for a multiple source drug or when only two (2) products are available during a generic exclusivity period as defined by 21 U.S.C. 355;

(b) Determined using comparable drug prices obtained from multiple nationally recognized comprehensive data sources including wholesalers, drug file vendors and pharmaceutical manufacturers for drugs that are nationally available and available for purchase by retail pharmacies in the state of Idaho; and

(c) Established for a product using only equivalent drugs as determined by the FDA.

(2) For the setting of prescription drug reimbursement benchmarks, including MAC lists, the PBM shall:

(a) Disclose upon request by a retail pharmacy which of the compendia or wholesaler data is used to obtain pricing data used in the calculation of the reimbursement amount;

(b) Make price adjustments at least twice a month and shall provide pharmacies with prompt notification of any changes or additions made to reimbursement MAC lists and rates at that time, except when a price for a drug changes by more than one hundred percent (100%), in which case the price adjustment for that drug shall be made within three (3) business days of the change in price;

(c) Make all applicable price MAC lists, including all changes in the price of drugs, available to network pharmacies upon request in a readily accessible and usable format that contains a complete list of the drug name, national drug code (NDC), package size, per unit price, strength of drug, generic product identifier (GPI) and generic code number (GCN). In the event there are multiple reimbursement MAC lists under the same contract, the contract shall identify which MAC lists are appropriately applicable; and

(d) Provide a process for a pharmacy provider to comment on, contest or appeal the prescription drug reimbursement amount, including a process to allow pharmacy providers to submit two hundred (200) claims per appeal containing all NDCs within the GPI. The process shall include response to the retail pharmacy in a timely manner.

(i) If the challenge is unsuccessful, the PBM shall notify the retail pharmacy of the compendia used in the determination and the wholesaler and NDC that supports the current MAC price. Any obsolete or temporarily unavailable products are not allowed in the determination of MAC.

(ii) If the challenge is successful, the PBM shall make an adjustment in the drug price to the date of the originally challenged claim and make the adjustment applicable to all similarly situated network pharmacies.

(iii) A network pharmacy retains the right to collect or not collect additional appropriate copayments from a patient after adjustments in the drug price after a successful challenge.

(3) A PBM may not charge a transaction fee, or any fees associated with processing or adjudicating a claim transaction that are not specified in the contract, for claims submissions provided in an electronic format by a retail pharmacy.

SECTION 2. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.