February 19, 2021

SENATE BILL No. 143

DIGEST OF SB 143 (Updated February 18, 2021 1:07 pm - DI 120)

Citations Affected: IC 27-1.

Synopsis: Pharmacy benefit managers. Adds requirements of pharmacy benefit managers when denying an appeal of the maximum allowable cost pricing of a prescription drug. Requires the department of insurance to develop a process for complaints regarding pharmacy benefit managers, including: (1) denied appeals of maximum allowable cost pricing; and (2) unfair, unjust, or unlawful contract provisions.

Effective: July 1, 2021.

Zay, Grooms, Charbonneau, Doriot, Freeman

January 4, 2021, read first time and referred to Committee on Rules and Legislative Procedure.
January 28, 2021, amended; reassigned to Committee on Insurance and Financial Institutions.
February 15, 2021, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.
February 18, 2021, amended, reported favorably — Do Pass.

February 19, 2021

First Regular Session of the 122nd General Assembly (2021)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

SENATE BILL No. 143

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-24.5-19, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2021 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 19. (a) A pharmacy benefit manager shall provide equal access and incentives to all pharmacies within the pharmacy benefit **manager's** network.

(b) A pharmacy benefit manager may not do any of the following:

(1) Condition participation in any network on accreditation, credentialing, or licensing of a pharmacy, ~~provider that,~~ other than a license or permit required by the Indiana board of pharmacy or other state or federal regulatory authority for the services provided by the pharmacy. However, nothing in this subdivision precludes the department from providing credentialing or accreditation standards for pharmacies.

(2) Discriminate against any pharmacy. ~~provider.~~

(3) Directly or indirectly retroactively deny a claim or aggregate of claims after the claim or aggregate of claims has been

adjudicated, unless any of the following apply:

(A) The original claim was submitted fraudulently.

(B) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the drug.

(C) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

(4) Reduce, directly or indirectly, payment to a pharmacy for pharmacist services to an effective rate of reimbursement, including permitting an insurer or plan sponsor to make such a reduction.

(5) Reimburse a pharmacy that is affiliated with the pharmacy benefit manager, other than solely being included in the pharmacy benefit manager's network, at a greater reimbursement rate than other pharmacies in the same network.

(6) Impose limits, including quantity limits or refill frequency limits, on a pharmacy's access to medication that differ from those existing for a pharmacy benefit manager affiliate.

(7) Share any covered individual's information, including de-identified covered individual information, received from a pharmacy or pharmacy benefit manager affiliate.

A violation of this subsection by a pharmacy benefit manager constitutes an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 2. IC 27-1-24.5-22, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2021 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 22. (a) A pharmacy benefit manager shall do the following:

(1) Identify to contracted:

(A) pharmacy ~~service administration~~ **services administrative** organizations; or

(B) pharmacies if the pharmacy benefit manager contracts directly with pharmacies;

the sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health ~~benefit~~ plan administered by the pharmacy benefit manager.

(2) Establish an appeal process for contracted pharmacies, pharmacy services administrative organizations, or group purchasing organizations to appeal and resolve disputes concerning the maximum allowable cost pricing.

(3) Update and make available to pharmacies:

(A) at least every ~~forty-five (45)~~ **seven (7)** days; or

(B) in a different time frame if contracted between a pharmacy benefit manager and a pharmacy;

the pharmacy benefit manager's maximum allowable cost list.

(4) Determine that a prescription drug:

(A) is not obsolete;

(B) is generally available for purchase by pharmacies in Indiana from a national or regional wholesaler licensed in Indiana; and

(C) is not:

(i) temporarily unavailable;

(ii) listed on a drug shortage list; or

(iii) unable to be lawfully substituted;

before the prescription drug is placed or continued on a maximum allowable cost list.

(b) The appeal process required by subsection (a)(2) must include the following:

(1) The right to appeal a claim not to exceed sixty (60) days following the initial filing of the claim.

(2) The investigation and resolution of a filed appeal by the pharmacy benefit manager in a time frame determined by the commissioner.

(3) If an appeal is denied, a requirement that the pharmacy benefit manager ~~provide the reason for the denial.~~ **do the following:**

(A) Provide the reason for the denial.

(B) Identify the national drug code of the prescription drug in a reasonable quantity size that is commercially available and the source where it may be purchased from a licensed wholesaler, without any minimum purchase requirements, at a price at or below the stated maximum allowable cost. If the appealing contracted pharmacy, pharmacy services administrative organization, or group purchasing organization provides reasonable evidence that it is unable to source the prescription drug from the licensed wholesaler at or below the maximum allowable cost, the pharmacy benefit manager must continue to identify the national drug code of the prescription drug in a reasonable quantity size that is currently commercially available and the source where it may be purchased from a licensed wholesaler until the contracted pharmacy, pharmacy services administrative organization, or group purchasing organization is able to source the prescription drug at or

below the maximum allowable cost.

(4) If an appeal is approved, a requirement that the pharmacy benefit manager do the following:

(A) Change the maximum allowable cost of the drug for the pharmacy that filed the appeal as of the initial date of service that the appealed drug was dispensed.

(B) Adjust the maximum allowable cost of the drug for the appealing pharmacy and for all other contracted pharmacies in the same network of the pharmacy benefit manager that filled a prescription for patients covered under the same health ~~benefit~~ plan beginning on the initial date of service the appealed drug was dispensed.

(C) Notify each pharmacy in the pharmacy benefit manager's network that:

(i) the maximum allowable cost for the drug was adjusted as a result of an approved appeal; and

(ii) the adjustment is retroactive to the initial date of service the appealed drug was dispensed.

~~(C)~~ **(D)** Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable.

~~(D)~~ **(E)** Allow the appealing pharmacy and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health ~~benefit~~ plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed.

~~(E)~~ **(F)** Make retroactive price adjustments in the next payment cycle unless otherwise agreed to by the pharmacy.

(5) The establishment of procedures for auditing submitted claims by a ~~contract~~ **contracted** pharmacy in a manner established by administrative rules under IC 4-22-2 by the department. The auditing procedures:

(A) may not use extrapolation or any similar methodology;

(B) may not allow for recovery by a pharmacy benefit manager of a submitted claim due to clerical or other error where the patient has received the drug for which the claim was submitted;

(C) must allow for recovery by a ~~contract~~ **contracted** pharmacy for underpayments by the pharmacy benefit manager; and

(D) may only allow for the pharmacy benefit manager to

recover overpayments on claims that are actually audited and discovered to include a recoverable error.

(c) The department must approve the manner in which a pharmacy benefit manager may respond to an appeal filed under this section. The department shall establish a process for a pharmacy benefit manager to obtain approval from the department under this section.

SECTION 3. IC 27-1-24.5-22.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 22.6. (a) If a pharmacy benefit manager denies an appeal under section 22(a)(2) of this chapter, the appealing contracted pharmacy, pharmacy services administrative organization, or group purchasing organization may file a complaint with the department not later than thirty (30) days from the date of the denial. The department may request additional information from either party as necessary to resolve a complaint.**

(b) If a contracted pharmacy or pharmacy services administrative organization believes that its contract with a pharmacy benefit manager contains an unfair, unjust, or unlawful contractual provision regarding reimbursement rates, the contracted pharmacy or pharmacy services administrative organization may file a complaint with the department.

(c) The department shall establish a process for complaints filed under this section.

COMMITTEE REPORT

Madam President: The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill No. 143, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill be reassigned to the Senate Committee on Insurance and Financial Institutions.

(Reference is to SB 143 as introduced.)

BRAY, Chairperson

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 143, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-5-5, AS AMENDED BY P.L.152-2017, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 5. (a) The office may provide a prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program **through:**

(1) until December 31, 2021, the use of a managed care organization that has contracted with the office to provide services under the risk based managed care organization; and

(2) beginning January 1, 2022, a contract entered into with a postsecondary educational institution that has entered into a contract with the office as described in this section.

(b) If the office provides a prescription drug benefit to a Medicaid

recipient in a Medicaid risk based managed care program:

(1) the office shall develop a procedure and provide:

(A) until December 31, 2021, the recipient's risk based managed care provider with information concerning the recipient's prescription drug utilization for the risk based managed care provider's case management program; **and**

(B) beginning January 1, 2022, the postsecondary educational institution that has contracted with the office to administer the program described in subsection (c) with information necessary to administer the program; and

(2) the provisions of IC 12-15-35.5 apply.

(c) ~~If the office does not provide a prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program, a managed care organization shall provide coverage and reimbursement for outpatient single source legend drugs subject to IC 12-15-35-46, IC 12-15-35-47, and IC 12-15-35.5.~~ **The office shall contract with an in state postsecondary educational institution that has a pharmacy school to provide, beginning January 1, 2022, a prescription drug benefit to Medicaid recipients in a Medicaid risk based managed care program. However, if the office is unable to enter into a contract with a postsecondary educational institution under this subsection to provide the prescription drug benefit, the office shall provide the prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program.**

(d) The office shall apply to the United States Department of Health and Human Services for any Medicaid state plan amendment or Medicaid waiver necessary to implement this section.

SECTION 2. IC 12-15-5-8, AS ADDED BY P.L.246-2005, SECTION 105, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 8. (a) As used in this section, "maintenance drug" means a medication that is dispensed under a single prescription for a period of not less than one hundred eighty (180) days, excluding authorized refills, for the ongoing treatment of a chronic medical condition or disease or congenital condition or disorder.

(b) The office may designate:

(1) a mail order pharmacy;

(2) an Internet based pharmacy (as defined in IC 25-26-18-1);

(3) a pharmacy that agrees to sell a maintenance drug at the same price as a mail order or an Internet based pharmacy; or

(4) all the pharmacies listed in subdivisions (1) through (3);

through which a recipient may obtain a maintenance drug.

(c) If the office makes a designation under subsection (b), a managed care organization that has a contract with the office under IC 12-15-12 **or a postsecondary educational institution that has a contract with the office under section (5)(c) of this chapter** is not required to use a pharmacy that is designated under subsection (b).

(d) If a Medicaid recipient's physician prescribes a maintenance prescription drug, the Medicaid recipient may purchase the maintenance prescription drug from a pharmacy that is designated under subsection (b).

(e) The office shall apply to amend the state Medicaid plan if the office determines that an amendment is necessary to carry out this section.

(f) The office may require a recipient to pay the maximum copayment allowable under federal law if the recipient obtains a maintenance drug from a pharmacy other than a pharmacy described in subsection (b).

SECTION 3. IC 12-15-12-4.5, AS ADDED BY P.L.101-2005, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4.5. A managed care ~~provider's~~ **organization's** contract or provider agreement with the office may, **until December 31, 2021,** include a prescription drug program, subject to IC 12-15-5-5, IC 12-15-35, and IC 12-15-35.5. **Beginning January 1, 2022, the office may not contract with a managed care organization to include a prescription drug program for Medicaid recipients.**

SECTION 4. IC 12-15-12-22, AS AMENDED BY P.L.152-2017, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 22. A:

(1) managed care organization that has a contract with the office to provide Medicaid services under a risk based managed care program; ~~or~~

(2) behavioral health managed care organization that has contracted with a managed care organization described in subdivision (1); **or**

(3) postsecondary educational institution that has a contract with the office to provide a prescription drug benefit as described in IC 12-15-5-5(c);

shall accept, receive, and process claims for payment that are filed electronically by a Medicaid provider.".

Page 1, line 6, delete "auditor of state;" and insert "**state board of accounts;**".

Page 1, line 8, delete "auditor of" and insert "**state board of**

accounts;".

Page 1, delete line 9.

Page 2, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 6. IC 12-15-35-45, AS AMENDED BY P.L.152-2017, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, may appoint an advisory committee to make recommendations to the board on the development of a Medicaid outpatient drug formulary.

(b) If the office decides to establish a Medicaid outpatient drug formulary, the formulary shall be developed by the board.

(c) A formulary, preferred drug list, or prescription drug benefit used by:

(1) a managed care organization; **or**

(2) a postsecondary educational institution that has contracted with the office under IC 12-15-5-5(c);

is subject to IC 12-15-5-5, IC 12-15-35.5, and sections 46 and 47 of this chapter.

SECTION 7. IC 12-15-35-48, AS AMENDED BY P.L.130-2018, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 48. (a) The board shall review the prescription drug program of a managed care organization **until December 31, 2021,** that participates in a risk based managed care program, **and beginning January 1, 2022, a postsecondary educational institution that has entered into a contract with the office under IC 12-15-5-5(c) to provide a prescription drug benefit in the risk based managed care program** at least one (1) time per year. The board's review of a prescription drug program must include the following:

(1) An analysis of the single source drugs requiring prior authorization, including **for a managed care organization,** the number of drugs requiring prior authorization in comparison to other managed care organizations' prescription drug programs that participate in the state's Medicaid program.

(2) A determination and analysis of the number and the type of drugs subject to a restriction.

(3) A review of the rationale for:

(A) the prior authorization of a drug described in subdivision (1); and

(B) a restriction on a drug.

(4) A review of the number of requests a managed care organization **or postsecondary educational institution** received

for prior authorization, including the number of times prior authorization was approved and the number of times prior authorization was disapproved.

(5) A review of:

(A) patient and provider satisfaction survey reports; and

(B) pharmacy-related grievance data for a twelve (12) month period.

(b) A managed care organization **and a postsecondary educational institution** described in subsection (a) shall provide the board with the information necessary for the board to conduct its review under subsection (a).".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 143 as printed January 29, 2021.)

ZAY, Chairperson

Committee Vote: Yeas 6, Nays 1.

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 143, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 17.

Delete pages 2 through 4.

Page 5, delete lines 1 through 21.

Page 9, delete lines 21 through 32.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 143 as printed February 16, 2021.)

MISHLER, Chairperson

Committee Vote: Yeas 12, Nays 0.