

**HOUSE BILL No. 2598**

By Committee on Insurance

2-10

1 AN ACT concerning insurance; relating to the oversight and regulation of  
2 pharmacy benefits managers; the pharmacy benefits managers licensure  
3 act; amending K.S.A. 65-16,123, 65-16,124, 65-16,125 and 65-16,126  
4 and K.S.A. 2019 Supp. 40-3821, 40-3822, 40-3823, 40-3824, 40-3825,  
5 40-3826, 40-3827, 40-3829 and 40-3830 and repealing the existing  
6 sections.

7

8 *Be it enacted by the Legislature of the State of Kansas:*

9 New Section 1. (a) A pharmacy benefits manager's license may be  
10 revoked, suspended or limited, or the licensee may be censured or placed  
11 under probationary conditions, or an application for a license or for  
12 reinstatement of a license may be denied upon a finding of the existence of  
13 any the following grounds:

14 (1) The applicant or licensee committed fraud or misrepresentation in  
15 applying for or securing an original, renewal or reinstated license;

16 (2) the licensee has violated any lawful rule and regulation  
17 promulgated by the commissioner or violated any lawful order or directive  
18 of the commissioner previously entered by the commissioner;

19 (3) the PBM has engaged in fraudulent activity that constitutes a  
20 violation of state or federal law;

21 (4) the commissioner has received consumer complaints that justify  
22 an action under this section to protect the safety and interest of consumers;

23 (5) the licensee has failed to furnish the commissioner, or the  
24 commissioner's investigators or representatives, any information legally  
25 requested by the commissioner;

26 (6) the PBM has been determined by the commissioner to be in  
27 violation or noncompliance with state or federal law; or

28 (7) the PBM has failed to timely submit a renewal application and the  
29 information required under K.S.A. 40-3824, and amendments thereto. In  
30 lieu of a denial of a renewal application, the commissioner may permit the  
31 PBM to submit to the commissioner a corrective action plan to correct or  
32 cure any deficiencies.

33 (b) This section shall be a part of and supplemental to article 38 of  
34 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

35 New Sec. 2. (a) In addition to any fines or other penalties that the  
36 commissioner may establish through rules and regulations, the

1 commissioner may enforce the provisions of this act as provided by K.S.A.  
2 40-2405 through 40-2408 and 40-2411, and amendments thereto.

3 (b) This section shall be a part of and supplemental to article 38 of  
4 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

5 New Sec. 3. (a) All compensation remitted by, or on behalf of, a  
6 pharmaceutical manufacturer, developer or labeler, directly or indirectly, to  
7 a carrier or to a PBM under contract with a covered entity or plan sponsor,  
8 related to its prescription drug benefits shall be:

9 (1) Remitted directly to the covered person at the point of sale to  
10 reduce the covered person's out-of-pocket cost associated with a particular  
11 prescription drug; or

12 (2) remitted to and retained by the covered entity or plan sponsor.  
13 Compensation remitted to the covered entity shall be utilized by such  
14 covered entity or plan sponsor in its plan design in future plan years to  
15 offset premiums for covered persons.

16 (b) Beginning with the second quarter of a contract between a PBM  
17 and a covered entity or plan sponsor, the PBM shall prepare a quarterly  
18 transparency report summarizing data relating to prescription drug benefits  
19 for the previous quarter. Such transparency report shall be submitted to the  
20 covered entity or plan sponsor before the end of the calendar quarter and  
21 shall include the following information with respect to prescription drug  
22 benefits specific to the covered entity or plan sponsor:

23 (1) The negotiated price between the PBM and pharmacies for each  
24 therapeutic category of prescription drugs dispensed to the covered entity's  
25 or plan sponsor's covered persons during the previous calendar quarter;

26 (2) the aggregate paid claims count and aggregate dollar amount of  
27 payments made by the PBM to all pharmacies for each therapeutic  
28 category of prescription drugs dispensed to the covered entity's or plan  
29 sponsor's covered persons during the previous calendar quarter;

30 (3) the aggregate dollar amount of rebates that the PBM expects to  
31 receive for each therapeutic category of prescription drugs dispensed to the  
32 covered entity's or plan sponsor's covered persons during the previous  
33 calendar quarter;

34 (4) the aggregate dollar amount of any other fees or other  
35 compensation the PBM has received from a drug manufacturer or  
36 wholesale drug distributor related to the management or dispensing of  
37 prescription drugs to plan sponsor's enrollees exclusive of prescription  
38 drug rebates required in paragraph (3);

39 (5) if the PBM has a contract, agreement or other arrangement with a  
40 drug manufacturer to exclusively dispense or provide a drug to a covered  
41 entity's or plan sponsor's covered persons, and the application of all  
42 consideration or economic benefits collected or received pursuant to any  
43 such arrangement;

- 1 (6) prescription drug utilization information for the covered entity's or  
2 plan sponsor's covered persons;
- 3 (7) de-identified claims level information in an electronic format that  
4 allows the covered entity or plan sponsor to sort and analyze the following  
5 information for each claim:
- 6 (A) If the claim required prior authorization;
- 7 (B) the amount paid to the pharmacy for each prescription, net of the  
8 aggregate amount of fees or other assessments imposed on the pharmacy,  
9 including point-of-sale and retroactive charges;
- 10 (C) any spread between the net amount paid to the pharmacy in  
11 subparagraph (B) and the amount charged to the covered entity or plan  
12 sponsor;
- 13 (D) if the pharmacy is under common control or ownership with the  
14 PBM;
- 15 (E) if the pharmacy is a preferred pharmacy under the plan;
- 16 (F) if the pharmacy is a mail order pharmacy; and
- 17 (G) if covered entity's or plan sponsor's covered persons are required  
18 by the plan to use the pharmacy;
- 19 (8) the aggregate paid claims count and aggregate dollar amount of  
20 payments made by the PBM to pharmacies owned or controlled by the  
21 PBM on behalf of the sponsor's plan;
- 22 (9) the aggregate paid claims amount and aggregate dollar amount of  
23 payments made by the PBM to pharmacies not owned or controlled by the  
24 PBM on behalf of the sponsor's plan; and
- 25 (10) the aggregate amount of the fees imposed on, or collected from,  
26 network pharmacies or other assessments made against network  
27 pharmacies, including point-of-sale fees and retroactive charges and the  
28 application of those amounts collected pursuant to the contract with the  
29 plan sponsor.
- 30 (c) A PBM may require a covered entity or plan sponsor to agree to a  
31 nondisclosure agreement that specifies that the information reported under  
32 this section is confidential and proprietary information. The PBM shall not  
33 be required to disclose the information to the plan sponsor until the plan  
34 sponsor has executed the nondisclosure agreement, if so required by the  
35 PBM.
- 36 (d) (1) On or before the 15<sup>th</sup> day of each month, a PBM shall provide  
37 each covered person with a full explanation of benefits for all claims  
38 processed during the previous calendar month for the covered person. This  
39 explanation of benefits shall be provided in a format approved by the  
40 commissioner and, at a minimum for each prescription claim during the  
41 covered month, contain:
- 42 (A) The plan ID;
- 43 (B) the beneficiary ID;

- 1 (C) the national drug code number;
- 2 (D) the drug name;
- 3 (E) the quantity;
- 4 (F) the claim amount;
- 5 (G) plan write-off amount;
- 6 (H) fees and adjustments including any applied rebates;
- 7 (I) the covered person's cost-sharing amount;
- 8 (J) ingredient reimbursement paid to the pharmacy;
- 9 (K) the professional dispensing fee paid to pharmacy; and
- 10 (L) any fee charged by the PBM to the pharmacy related to that
- 11 specific claim.

12 (2) Each report furnished to a covered person under this subsection  
13 may be delivered either by electronic mail or by United States postal  
14 service delivery.

15 (e) On and after July 1, 2021, and annually thereafter, each PBM shall  
16 submit to the commissioner a transparency report containing data from the  
17 prior calendar year as it pertains to covered entities and plan sponsors  
18 doing business in Kansas. The report shall contain the following  
19 information:

20 (1) The aggregate paid claims count and aggregate dollar amount of  
21 payments made by the PBM to all pharmacies for each therapeutic  
22 category of prescription drugs for all of the PBM's covered entity and plan  
23 sponsor clients, and such payments net of all rebates and other fees and  
24 payments, direct or indirect, that were credited against such payments  
25 from all sources;

26 (2) the aggregate dollar amount of all rebates that the PBM received  
27 from all drug manufacturers for all of the PBM's covered entity and plan  
28 sponsor clients. The aggregate dollar amount of all rebates shall include  
29 any utilization discounts that the PBM received from a drug manufacturer  
30 or wholesale drug distributor;

31 (3) the aggregate dollar amount of all fees from all sources, direct or  
32 indirect, that the PBM received for all the PBM's covered entity and plan  
33 sponsor clients;

34 (4) the aggregate dollar amount of all retained rebates and other fees,  
35 as described in paragraphs (2) and (3), that the PBM received from all  
36 sources, direct or indirect, that were not passed through to plan sponsors;

37 (5) the percentage of the aggregate dollar amount of all rebates that  
38 the retained rebate and fees represents;

39 (6) the highest, lowest and mean aggregate retained rebate and fees  
40 percentage for all of the PBM's plan sponsor clients; and

41 (7) de-identified claims level information in an electronic format that  
42 allows the commissioner to sort and analyze the following information for  
43 each claim:

- 1 (A) The drug and quantity for each prescription;  
2 (B) if the claim required prior authorization;  
3 (C) the patient's cost-sharing paid on each prescription. This data is  
4 classified pursuant to subsection (h);  
5 (D) the amount paid to the pharmacy for each prescription, net of the  
6 aggregate amount of fees or other assessments imposed on the pharmacy,  
7 including point-of-sale and retroactive charges. This data is classified  
8 pursuant to subsection (h);  
9 (E) any spread between the net amount paid to the pharmacy in  
10 subparagraph (D) and the amount charged to the plan sponsor. This data is  
11 classified pursuant to subsection (h);  
12 (F) the identity of the pharmacy for each prescription;  
13 (G) if the pharmacy is under common control or ownership with the  
14 PBM;  
15 (H) if the pharmacy is a preferred pharmacy under the plan;  
16 (I) if the pharmacy is a mail order pharmacy; and  
17 (J) if the covered entity's or plan sponsor's covered persons are  
18 required by the plan to use the pharmacy.
- 19 (f) (1) Within 60 days of receipt of the transparency report, the  
20 commissioner shall publish the report from each PBM on the department's  
21 website.
- 22 (2) The transparency report shall be published in a manner that shall  
23 not disclose the identity of a specific plan sponsor, the prices charged for a  
24 specific prescription drug or classes of drugs, or the amount of any rebates  
25 provided for a specific prescription drug or classes of drugs.
- 26 (g) The aggregate retained rebate and fee percentage shall be  
27 calculated for each plan sponsor for rebates and fees in the previous  
28 calendar year as follows: The total dollar amount of rebates and fees from  
29 all drug manufacturers for all utilization by covered persons of a covered  
30 entity or plan sponsor that were not passed through to the plan sponsor  
31 divided by the sum total dollar amount of all rebates and fees received  
32 from all sources, direct or indirect, for covered persons of a covered entity  
33 or plan sponsor.
- 34 (h) Data, documents, materials or other information in the possession  
35 or control of the commissioner of insurance that are obtained by, created  
36 by or disclosed to the commissioner pursuant to this section shall be  
37 considered confidential and privileged. Such data, documents, materials or  
38 other information are not subject to subpoena and are not subject to  
39 discovery or admissible in evidence in any private civil action. The  
40 commissioner may use the data, documents, materials or other information  
41 in the furtherance of a regulatory or legal action brought as a part of the  
42 commissioner's official duties. The commissioner shall not otherwise make  
43 the data, documents, materials or other information public without the

1 prior written consent of the PBM. Neither the commissioner nor any  
2 person who received data, documents, materials or other information while  
3 acting under the authority of the commissioner are permitted or required to  
4 testify in any private civil action concerning data, documents, materials, or  
5 information subject to this subsection that are classified as confidential,  
6 protected nonpublic, or both. The provisions of this subsection shall expire  
7 on July 1, 2025, unless the legislature reviews and reenacts this provision  
8 pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2025.

9 (i) This section shall be a part of and supplemental to article 38 of  
10 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

11 New Sec. 4. (a) A PBM has a fiduciary duty to a health carrier client  
12 and shall discharge that duty in accordance with all applicable provisions  
13 of state and federal law.

14 (b) A PBM shall exercise good faith and fair dealing in the  
15 performance of its contractual duties. Any provision in a contract between  
16 a PBM and a covered entity or a network pharmacy that attempts to waive  
17 or limit this obligation is void.

18 (c) A PBM shall not charge a pharmacist or pharmacy a fee related to  
19 the adjudication of a claim, including without limitation a fee for:

20 (1) The submission of a claim;

21 (2) enrollment or participation in a retail pharmacy network; or

22 (3) the development or management of claims processing services or  
23 claims payment services related to participation in a retail pharmacy  
24 network.

25 (d) A PBM shall not deny, limit or terminate a pharmacy's contract  
26 based on the employment status of any employee who has an active  
27 license to dispense, despite probation status, with the state board of  
28 pharmacy.

29 (e) A PBM shall notify a covered entity in writing of any of its  
30 activities, policies or practices that may directly or indirectly present a  
31 conflict of interest with the duties imposed in this section.

32 (f) A PBM shall not impose pharmacy accreditation standards or  
33 recertification requirements for a pharmacy to participate in a network that  
34 are inconsistent with, more stringent than, or in addition to federal and  
35 state requirements for licensure as a pharmacy in this state unless  
36 authorized under this act.

37 (g) A PBM shall not retain any portion of spread pricing.

38 (h) This section shall be a part of and supplemental to article 38 of  
39 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

40 New Sec. 5. (a) A PBM shall provide an adequate and accessible  
41 retail pharmacy network for the provision of prescription drugs. Retail  
42 pharmacy networks shall comply with the following access standards:

43 (1) At least 90% of covered persons in the health benefit plan's urban

1 service area live within two miles of a retail pharmacy participating in the  
2 health benefit plan's retail pharmacy network;

3 (2) at least 90% of covered persons in the health benefit plan's urban  
4 service area live within five miles of a retail pharmacy designated as a  
5 preferred participating pharmacy in the health benefit plan's retail  
6 pharmacy network;

7 (3) at least 90% of covered persons in the health benefit plan's  
8 suburban service area live within five miles of a retail pharmacy  
9 participating in the health benefit plan's retail pharmacy network;

10 (4) at least 90% of covered persons in the health benefit plan's  
11 suburban service area live within seven miles of a retail pharmacy  
12 designated as a preferred participating pharmacy in the health benefit  
13 plan's retail pharmacy network;

14 (5) at least 70% of covered persons in the health benefit plan's rural  
15 service area live within 15 miles of a retail pharmacy participating in the  
16 health benefit plan's retail pharmacy network;

17 (6) at least 70% of covered persons in the health benefit plan's rural  
18 service area live within 18 miles of a retail pharmacy designated as a  
19 preferred participating pharmacy in the health benefit plan's retail  
20 pharmacy network; and

21 (7) mail order pharmacies shall not be used to meet access standards  
22 for retail pharmacy networks.

23 (b) A PBM shall submit an annual pharmacy network adequacy  
24 report to the commissioner describing the pharmacy network and  
25 pharmacy accessibility in this state, with the PBM's license application and  
26 renewal, in a manner prescribed by the commissioner.

27 (c) A PBM may apply for a waiver from the commissioner if the  
28 PBM is unable to meet the network adequacy requirements under  
29 subsection (a). A waiver application shall be submitted to the  
30 commissioner on a form prescribed by the commissioner and shall:

31 (1) Demonstrate with specific data why the PBM is not able to meet  
32 the requirements; and

33 (2) include a detailed action plan describing the steps that were and  
34 will be taken to address network adequacy.

35 (d) If a waiver is granted by the commissioner, the waiver shall  
36 automatically expire after one year. If a renewal of the waiver is sought,  
37 the commissioner shall consider what steps the PBM has taken and how  
38 the PBM has addressed network adequacy over the past three-year period.

39 (e) This section shall be a part of and supplemental to article 38 of  
40 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

41 New Sec. 6. (a) A PBM that has a direct or indirect ownership interest  
42 or an ownership interest through an affiliate or subsidiary in a pharmacy  
43 shall disclose to its covered entity or plan sponsor client any difference

1 between the amount paid to that pharmacy and the amount charged to its  
2 covered entity or plan sponsor client.

3 (b) Except as provided in subsection (c), a PBM or covered entity or  
4 plan sponsor is prohibited from penalizing, requiring or providing  
5 financial incentives, including variations in premiums, deductibles, co-  
6 payments or coinsurance to incentivize a covered person to use a specific  
7 retail pharmacy, mail order pharmacy, specialty pharmacy, or other  
8 network pharmacy provider in which a PBM has an ownership interest or  
9 in which the pharmacy provider has an ownership interest in the PBM.

10 (c) Subsection (b) shall not apply if the PBM or covered entity or  
11 plan sponsor offers a covered person the same financial incentives for  
12 using a retail pharmacy, mail order pharmacy, specialty pharmacy or other  
13 network pharmacy provider in which the PBM has no ownership interest.

14 (d) A PBM or covered entity or plan sponsor is prohibited from  
15 imposing limits, including quantity or refill frequency limits, on a covered  
16 person's access to medication that differ based solely on whether the health  
17 carrier or PBM has an ownership interest in a pharmacy or whether the  
18 pharmacy has an ownership interest in the PBM.

19 (e) Nothing in subsection (d) is construed to prohibit a PBM from  
20 imposing different limits, including quantity or refill frequency limits, on a  
21 covered person's access to medication based on whether the enrollee uses a  
22 mail order pharmacy or retail pharmacy so long as the covered person has  
23 the option to use a mail order pharmacy or retail pharmacy in which the  
24 PBM or health carrier does not have an ownership interest with the same  
25 limits imposed.

26 (f) A PBM shall not reimburse a pharmacy or pharmacist in the state  
27 an amount less than the amount that the PBM reimburses a pharmacy  
28 owned by or under common ownership with a PBM for providing the  
29 same covered services. The reimbursement amount paid to the pharmacy  
30 shall be equal to the reimbursement amount calculated on a per-unit basis  
31 using the same generic product identifier or generic code number paid to  
32 the PBM-owned or PBM-affiliated pharmacy.

33 (g) A PBM or health insurer shall not prohibit a pharmacy authorized  
34 to participate in the federal 340B drug pricing program under section 340B  
35 of the public health service act, 42 U.S.C. 6A § 340B, or a pharmacy under  
36 contract with an entity authorized to participate in the program to provide  
37 pharmacy services, from participating in the PBM's or health insurer's  
38 provider network. A PBM or health insurer shall not reimburse a pharmacy  
39 authorized to participate in the program or a pharmacy under contract with  
40 an entity participating in the federal 340B drug pricing program differently  
41 from other similarly situated pharmacies.

42 (h) (1) Any pharmacy that has a contract or pharmacist who has a  
43 contract, either directly or indirectly through a pharmacy services



1 administration organization, with a PBM administering any type of drug or  
2 pharmacy benefit plan to provide covered drugs, devices or services at a  
3 contractual reimbursement rate may decline to provide a covered drug,  
4 device or service if the pharmacy or pharmacist is currently reimbursed or  
5 will be reimbursed at less than the acquisition cost for the covered drug,  
6 device or service.

7 (2) If the pharmacy or pharmacist declines to provide the drug, device  
8 or service as authorized in this subsection, then the pharmacy or  
9 pharmacist shall provide the customer with adequate information for the  
10 customer to determine where the prescription for the drug, device or  
11 service may be filled.

12 (i) A PBM, pharmacy services administration organization or any  
13 person acting for, or on behalf of, a PBM or pharmacy services  
14 administration organization shall not cancel any contract with a pharmacy  
15 or pharmacist, sue for breach of contract, use the decision to decline as a  
16 cause for not renewing the contract or retaliate against or penalize the  
17 pharmacy or pharmacist in any way for exercising the pharmacy's or  
18 pharmacist's rights under this section.

19 (j) This section shall be a part of and supplemental to article 38 of  
20 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

21 New Sec. 7. (a) A PBM or health carrier shall not require or  
22 demonstrate a preference for a pharmacy to dispense a therapeutically  
23 equivalent or therapeutically alternative drug that costs the enrollee more  
24 out-of-pocket than the prescribed drug, unless the substitution is made for  
25 medical reasons that benefit the patient. Substitution made under this  
26 section shall comply with the pharmacy act of the state of Kansas.

27 (b) This section shall be a part of and supplemental to article 38 of  
28 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

29 New Sec. 8. (a) A PBM that contracts with a specialty pharmacy shall  
30 disclose to a covered person, upon such covered person's request, the  
31 covered person's out-of-pocket cost at the specialty pharmacy and the  
32 covered person's out-of-pocket cost at a retail pharmacy identified by the  
33 covered person as being an in-network pharmacy with the covered person's  
34 health plan, for the prescription drug referenced by the covered person.

35 (b) A PBM is required to allow any pharmacy that can legally obtain  
36 medications defined as specialty medications within a given health plan to  
37 provide those medications to a covered person upon such covered person's  
38 request.

39 (c) This section shall be a part of and supplemental to article 38 of  
40 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

41 New Sec. 9. (a) A PBM that uses a preferred network of pharmacies  
42 shall disclose to a covered person, upon such covered person's request, the  
43 covered person's out-of-pocket cost at the preferred pharmacy and the

1 covered person's out-of-pocket cost at a nonpreferred pharmacy identified  
2 by the covered person as being an in-network provider with the covered  
3 person's health plan, for the prescription drug referenced by the covered  
4 person.

5 (b) A PBM shall not deny any pharmacy the opportunity to  
6 participate in any pharmacy network at preferred participation status.

7 (c) A PBM, or representative of a PBM, shall not cause or knowingly  
8 permit the use of advertisement, promotion, solicitation, representation,  
9 proposal or offer that is untrue, deceptive or misleading to patients or the  
10 general public regarding access to pharmacies in a pharmacy network.

11 (d) This section shall be a part of and supplemental to article 38 of  
12 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

13 New Sec. 10. (a) A PBM shall permit a pharmacy to collect the  
14 amount of a covered person's cost share from any source.

15 (b) Except as provided in subsection (c), a PBM shall not deny or  
16 reduce a reimbursement to a pharmacy or a pharmacist after the  
17 adjudication of a disputed claim, unless:

18 (1) The pharmacy or pharmacist fraudulently submitted the original  
19 claim;

20 (2) the original reimbursement was incorrect because:

21 (A) The pharmacy or pharmacist had already been paid for the  
22 pharmacy service; or

23 (B) an unintentional error resulted in an incorrect reimbursement; or

24 (3) the pharmacy service was not rendered by the pharmacy or  
25 pharmacist.

26 (c) Subsection (b) shall not apply if an investigative audit of  
27 pharmacy records for fraud, waste, abuse or other intentional  
28 misrepresentation indicates that the pharmacy or pharmacist engaged in  
29 criminal wrongdoing, fraud or other intentional misrepresentation.

30 (d) This section shall be a part of and supplemental to article 38 of  
31 chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

32 Sec. 11. K.S.A. 2019 Supp. 40-3821 is hereby amended to read as  
33 follows: 40-3821. (a) K.S.A. 2019 Supp. 40-3821 through 40-3828 *and*  
34 *sections 1 through 10*, and amendments thereto, shall be known and may  
35 be cited as the pharmacy benefits manager-~~registration~~ *licensure* act.

36 (b) *On and after January 1, 2021, a person shall not perform, act or*  
37 *do business in this state as a PBM unless such person has a valid license*  
38 *issued by the commissioner pursuant to this act.*

39 (c) This act shall apply to any ~~pharmacy benefits manager~~ PBM that  
40 provides claims processing services, other prescription drug or device  
41 services, or both, to covered persons who are residents of this state.

42 ~~(e)(d)~~ This act shall not apply to any ~~pharmacy benefits manager~~  
43 PBM that holds a certificate of registration as an administrator pursuant to

1 K.S.A. 40-3810, and amendments thereto.

2 *(e) A license issued in accordance with this act shall be*  
3 *nontransferable.*

4 Sec. 12. K.S.A. 2019 Supp. 40-3822 is hereby amended to read as  
5 follows: 40-3822. For purposes of this act:

6 (a) "Commissioner" means the commissioner of insurance as defined  
7 by K.S.A. 40-102, and amendments thereto.

8 (b) (1) "Covered entity" means:

9 (A) A nonprofit hospital or medical service corporation, health  
10 insurer, health benefit plan or health maintenance organization;

11 (B) a health program administered by a department or the state in the  
12 capacity of provider of health coverage; or

13 (C) an employer, labor union or other group of persons organized in  
14 the state that provides health coverage to covered individuals who are  
15 employed or reside in the state.

16 (2) "Covered entity" shall not include any:

17 (A) Self-funded plan that is exempt from state regulation pursuant to  
18 ERISA;

19 (B) plan issued for coverage for federal employees; or

20 (C) health plan that provides coverage only for accidental injury,  
21 specified disease, hospital indemnity, medicare supplement, disability  
22 income, long-term care or other limited benefit health insurance policies  
23 and contracts.

24 (c) "Covered person" means a member, policyholder, subscriber,  
25 enrollee, beneficiary, dependent or other individual participating in a  
26 health benefit plan.

27 (d) "Department" means the department of insurance.

28 (e) "Health benefit plan" means the same as defined in K.S.A. 40-  
29 4602, and amendments thereto.

30 (f) "Health insurer" means the same as defined in K.S.A. 40-4602,  
31 and amendments thereto.

32 (g) "Maximum allowable cost" or "MAC" means the maximum  
33 amount that a pharmacy benefits manager will reimburse a pharmacy for  
34 the cost of a generic drug.

35 (h) "Pharmacy benefits management" means:

36 (1) Any of the following services provided with regard to the  
37 administration of the following pharmacy benefits:

38 (A) Mail service pharmacy;

39 (B) claims processing, retail network management and payment of  
40 claims to pharmacies for prescription drugs dispensed to covered  
41 individuals;

42 (C) clinical formulary development and management services;

43 (D) rebate contracting and administration;

1 (E) certain patient compliance, therapeutic intervention and generic  
2 substitution programs; or

3 (F) disease management programs involving prescription drug  
4 utilization; and

5 (2) (A) the procurement of prescription drugs by a prescription  
6 benefits manager at a negotiated rate for dispensation to covered  
7 individuals within this state; or

8 (B) the administration or management of prescription drug benefits  
9 provided by a covered insurance entity for the benefit of covered  
10 individuals.

11 ~~(e)~~(i) "Pharmacy benefits manager" or "PBM" means a person,  
12 business or other entity that performs pharmacy benefits management.  
13 "Pharmacy benefits manager" includes any person or entity acting in a  
14 contractual or employment relationship for a pharmacy benefits manager  
15 in the performance of pharmacy benefits management for a covered entity.  
16 ~~The term "Pharmacy benefits manager" shall~~ does not include a covered  
17 insurance entity.

18 ~~(f)~~(j) "Person" means an individual, partnership, corporation,  
19 organization or other business entity.

20 Sec. 13. K.S.A. 2019 Supp. 40-3823 is hereby amended to read as  
21 follows: 40-3823. Registration requirement to act as a pharmacy benefits  
22 manager.

23 (a) No person shall act or operate as a ~~pharmacy benefits manager~~  
24 ~~PBM~~ without first obtaining a ~~valid certificate of registration license~~  
25 issued by the commissioner.

26 (b) Each person seeking a ~~certificate of registration license~~ to act as a  
27 ~~pharmacy benefits manager PBM~~ shall file with the commissioner an  
28 application for a ~~certificate of registration license~~ upon a form to be  
29 furnished by the commissioner. *At a minimum*, the application form shall  
30 include *the following information*:

31 (1) *The name, address and telephone number of the PBM.*

32 (2) The name, address, official position and professional  
33 qualifications of each individual who is responsible for the conduct of the  
34 affairs of the ~~pharmacy benefits manager PBM~~, including all members of  
35 the board of directors, board of trustees, executive committee, other  
36 governing board or committee, the principal officers in the case of a  
37 corporation, the partners or members in the case of a partnership or  
38 association and any other person who exercises control or influence over  
39 the affairs of the ~~pharmacy benefits manager PBM~~.

40 ~~(2)~~(3) The name and address of the applicant's agent for service of  
41 process in the state.

42 (4) *The name, address, phone number, email address, official position*  
43 *and professional qualifications of each person responsible for setting*

1 *MAC prices, including all persons with authority to modify MAC prices in*  
 2 *response to MAC appeals.*

3 ~~(3)~~(5) A nonrefundable application fee of ~~\$140~~ \$2,500.

4 (c) (1) *Upon receipt of an application, the commissioner may require*  
 5 *additional documentation or information necessary to verify the*  
 6 *information contained in the application. Within 30 days of receiving an*  
 7 *application, the commissioner may request additional information or*  
 8 *submissions from an applicant for licensure and shall obtain any*  
 9 *document or information reasonably necessary to verify the information*  
 10 *contained in the application.*

11 (2) *Within 90 days after receipt of a completed application, the*  
 12 *network adequacy report and the applicable license fee, the commissioner*  
 13 *shall review the application and issue a license if the applicant is deemed*  
 14 *qualified under this section. If the commissioner determines the applicant*  
 15 *is not qualified, the commissioner shall notify the applicant and shall*  
 16 *specify the reason for the denial.*

17 Sec. 14. K.S.A. 2019 Supp. 40-3824 is hereby amended to read as  
 18 follows: 40-3824. (a) Each pharmacy benefits manager ~~registration~~ license  
 19 shall expire on March 31 each year and may be renewed annually on the  
 20 request of the ~~registrant~~ licensee. The application for renewal shall be  
 21 submitted on a form furnished by the commissioner and accompanied by a  
 22 renewal fee of ~~\$140~~ \$2,500. The application for renewal shall be in such  
 23 form and contain such matters as the commissioner prescribes.

24 (b) If a ~~registration~~ license renewal fee is not paid by the prescribed  
 25 date, the amount of the fee, plus a penalty fee of ~~\$140~~ \$2,500 shall be paid.  
 26 The pharmacy benefits manager ~~registration~~ license may be revoked or  
 27 suspended by the commissioner until the renewal fee and any penalty  
 28 assessed has been paid.

29 (c) Any person who performs or is performing any pharmacy benefits  
 30 management service ~~on the effective date of this act must obtain a~~  
 31 ~~certificate of registration~~ July 1, 2020, shall be required to obtain a license  
 32 as a pharmacy benefits manager from the commissioner ~~within 90 days~~  
 33 ~~after the effective date of this act by October 1, 2020~~, in order to continue  
 34 to do business in Kansas.

35 Sec. 15. K.S.A. 2019 Supp. 40-3825 is hereby amended to read as  
 36 follows: 40-3825. ~~In accordance with the provisions of the rules and~~  
 37 ~~regulations filing act, K.S.A. 77-415 et seq., and amendments thereto, (a)~~  
 38 The commissioner may adopt, amend and revoke rules and regulations  
 39 governing the administration and enforcement of this act, including, but  
 40 not limited to:

41 ~~(a)~~(1) The content of the application form;

42 ~~(b)~~(2) the content of any other form or report required to implement  
 43 this act; and

1       (e)(3) such other rules and regulations as the commissioner may deem  
2 necessary to ~~carry out~~ *implement and administer* the provisions of this act.

3       (b) *The commissioner shall adopt, amend and revoke all such*  
4 *necessary rules and regulations not later than July 1, 2022.*

5       Sec. 16. K.S.A. 2019 Supp. 40-3826 is hereby amended to read as  
6 follows: 40-3826. Any person who acts as a ~~pharmacy benefits manager~~  
7 *PBM* without being ~~registered~~ *licensed* as required by this act shall be  
8 subject to a fine of ~~\$500 for each~~ *\$5,000 for the period that the PBM is*  
9 *found to be in violation.*

10       (b) *If a PBM is found to be in violation of or non-compliant with any*  
11 *state or federal law, the PBM shall be subject to a fine of \$5,000 per*  
12 *violation and \$5,000 per occurrence of non-compliance.*

13       Sec. 17. K.S.A. 2019 Supp. 40-3827 is hereby amended to read as  
14 follows: 40-3827. *There is hereby established in the state treasury the*  
15 *pharmacy benefits manager licensure fund. Such fund shall be*  
16 *administered by the commissioner for costs related to administering the*  
17 *pharmacy benefits manager licensing act. All expenditures from the*  
18 *pharmacy benefits manager licensure fund shall be made in accordance*  
19 *with appropriation acts upon warrants of the director of accounts and*  
20 *reports issued pursuant to vouchers approved by the commissioner or by*  
21 *the commissioner's designee. The commissioner shall remit all moneys*  
22 *received by or for the commissioner under the provisions of this act to the*  
23 *state treasurer at least monthly in accordance with the provisions of K.S.A.*  
24 *75-4215, and amendments thereto. Upon receipt of each such remittance,*  
25 *the state treasurer shall deposit the entire amount thereof in the state*  
26 *treasury and such amount shall be credited to the pharmacy benefits*  
27 *manager registration licensure fund.*

28       Sec. 18. K.S.A. 2019 Supp. 40-3829 is hereby amended to read as  
29 follows: 40-3829. As used in ~~this act~~ *K.S.A. 2019 Supp. 40-3829 and 40-*  
30 *3830, and amendments thereto:*

31       (a) ~~"List" means the list of drugs for which maximum allowable costs~~  
32 ~~have been established;~~

33       (b) ~~"Maximum allowable cost" or "MAC" means the maximum~~  
34 ~~amount that a pharmacy benefits manager will reimburse a pharmacy for~~  
35 ~~the cost of a generic drug includes without limitation:~~

36       (1) *Average acquisition cost, including national average drug*  
37 *acquisition cost;*

38       (2) *average manufacture price;*

39       (3) *average wholesale price;*

40       (4) *brand effective rate or generic effective rate;*

41       (5) *discount indexing;*

42       (6) *federal upper limits;*

43       (7) *wholesale acquisition cost; and*

1 (8) any other term that a pharmacy benefits manager or a healthcare  
2 insurer may use to establish reimbursement rates to a pharmacist or  
3 pharmacy for pharmacist services;

4 (b) "maximum allowable cost list" or "MAC list" means a listing of  
5 drugs or other methodology used by a pharmacy benefits manager,  
6 directly or indirectly, that sets the maximum allowable payment to a  
7 pharmacy or pharmacist for a generic drug, brand-name drug, biologic  
8 product or other prescription drug;

9 (c) "network pharmacy" means a pharmacy that contracts with a  
10 pharmacy benefits manager; and

11 (d) "pharmacy benefits manager" or "PBM" ~~shall have the same~~  
12 ~~meaning as~~ means the same as defined in K.S.A. 2019 Supp. 40-3822(e),  
13 and amendments thereto.

14 Sec. 19. K.S.A. 2019 Supp. 40-3830 is hereby amended to read as  
15 follows: 40-3830. A pharmacy benefits manager shall:

16 (a) Not pay or reimburse a pharmacy or pharmacist for the  
17 ingredient drug product component of pharmacist services in an amount  
18 less than:

19 (1) The pharmacy's usual and customary price;

20 (2) the national average drug acquisition cost; or

21 (3) the pharmacy's wholesale acquisition cost if the national average  
22 drug acquisition cost is unavailable.

23 (b) Pay to every pharmacy a professional dispensing fee that is equal  
24 to the dispensing fee set in the state program for medical assistance,  
25 authorized by K.S.A. 39-709, and amendments thereto.

26 (c) Use a single MAC list to establish the maximum amount to be  
27 paid to a pharmacy provider for a generic drug or a brand-name drug that  
28 has at least one generic alternative available. A PBM shall use the same  
29 MAC list for each pharmacy provider.

30 (d) ~~Shall~~ Not place a drug on a MAC list unless there are at least two  
31 therapeutically equivalent multi-source generic drugs, or at least one  
32 generic drug available from at least one manufacturer, generally available  
33 for purchase, *without conditions*, by network pharmacies from national or  
34 regional wholesalers and the *national drug code, NDC*, for the drug is not  
35 obsolete.

36 ~~(b) Shall~~(e) Provide to each network pharmacy at the beginning of  
37 the term of a contract and upon request thereafter, the sources utilized to  
38 determine the ~~maximum allowable cost~~ MAC price.

39 ~~(c) Shall provide a process for each network pharmacy provider to~~  
40 ~~readily access the maximum allowable price specific to that provider.~~(f)

41 Upon request of a network pharmacy, disclose the sources utilized for  
42 setting MAC price rates on each MAC price list included under the  
43 contract and identify each MAC price list for each plan sponsor and

1 *pharmacy network rate schedule that applies to the network pharmacy. A*  
 2 *PBM shall make the list of the maximum allowable costs available in its*  
 3 *entirety, in a readily accessible format to all contracted pharmacies.*

4 (g) *Ensure that the MAC prices are set at sufficient levels to ensure*  
 5 *products are readily available to pharmacies to purchase at or below the*  
 6 *MAC price established for similarly situated pharmacies within the PBM's*  
 7 *preferred network.*

8 ~~(d) Shall(h)~~ *Review and update each applicable—maximum—*  
 9 ~~allowable cost~~ *MAC list every seven business days, noting any price*  
 10 *changes from the previous list, including retroactive MAC adjustments*  
 11 *based on successful MAC appeals by a participating pharmacy in a*  
 12 *separate section of the list, provide a means by which network pharmacies*  
 13 *may promptly review current prices in an electronic, print or telephonic*  
 14 *format and apply the updates to reimbursements no later than one business*  
 15 *day at no cost to the pharmacy. Such information shall be available to the*  
 16 *pharmacy or the pharmacy's representative in a comprehensive*  
 17 *downloadable format that includes all national drug codes, the unit MAC*  
 18 *price allowed and an identifying code connecting fee schedules and*  
 19 *patients to the respective MAC list used to price claims for reimbursement.*

20 (i) *Ensure that the MAC prices are not set below sources utilized by*  
 21 *the PBM.*

22 ~~(e) Shall(j)~~ *Ensure that dispensing fees are not included in the*  
 23 *calculation of maximum allowable cost.*

24 ~~(f) Shall(k)~~ *Establish a process by which a network pharmacy may*  
 25 *appeal reimbursement for a drug subject to maximum allowable cost as*  
 26 *follows:*

27 (1) *The network pharmacy—must shall file an appeal—no not later than*  
 28 *10 15 business days after the fill date.*

29 (2) *The PBM shall provide a response to the appealing network*  
 30 *pharmacy—no not later than—10 7 business days after receiving an appeal*  
 31 *request containing information sufficient for the PBM to process the*  
 32 *appeal as specified by the contract.*

33 (3) *If the appeal is upheld, the PBM:*

34 (A) *Shall make the adjustment in the drug price effective no later than*  
 35 *one business day after the appeal is resolved;*

36 (B) *shall make the adjustment applicable to all similarly situated*  
 37 *network pharmacy providers, as determined by the plan sponsor or*  
 38 *pharmacy benefits manager, as appropriate; and*

39 (C) *permit the appealing pharmacy to reverse and rebill the appealed*  
 40 *claim.*

41 (4) *If the appeal is denied, the PBM shall provide the appealing*  
 42 *pharmacy the specific sources utilized for setting the maximum allowable*  
 43 *cost, including the national drug code number from a national or regional*



1 wholesaler operating in Kansas where the drug is generally available for  
2 purchase at a price equal to or less than the maximum allowable cost, and  
3 when applicable, may be substituted lawfully.

4 (5) *If an appeal is upheld, the PBM shall:*

5 (A) *Make an adjustment to the MAC price not later than one business*  
6 *day after the date of determination and update the MAC price in the*  
7 *adjudication system so that the pharmacy may reverse and reprocess the*  
8 *claim for the increased reimbursement; and*

9 (B) *make the determined price adjustment applicable to all similarly*  
10 *situated network pharmacy providers. The PBM shall waive timely filing*  
11 *requirements to allow pharmacies the ability to reverse and reprocess*  
12 *claims to comply with this paragraph.*

13 Sec. 20. K.S.A. 65-16,123 is hereby amended to read as follows: 65-  
14 16,123. (a) ~~The~~ *Unless prohibited by federal requirements or regulations,*  
15 *an entity conducting the a pharmacy audit shall follow the following*  
16 *procedures:*

17 (1) ~~An entity conducting an on-site audit must~~ Give the pharmacy at  
18 ~~least seven days~~ *14 days'* written notice of an on-site audit before  
19 conducting an initial audit;

20 (2) ~~an audit that involves clinical or professional judgment must be~~  
21 ~~conducted by or in~~ *conduct an audit involving clinical or professional*  
22 *judgment in consultation with a licensed pharmacist;*

23 (3) ~~the period covered by the audit may not exceed~~ *not conduct an*  
24 *audit period exceeding two years from the date that the claim was*  
25 *submitted to or adjudicated by the entity;*

26 (4) ~~the pharmacy may request~~ *grant a pharmacy upon its request, an*  
27 *extension not to exceed seven days from the date of an originally*  
28 *scheduled on-site audit;*

29 (5) ~~the pharmacy may use~~ *allow the pharmacy to use the records of a*  
30 *hospital, physician or other authorized practitioner to validate the*  
31 *pharmacy record;*

32 (6) *use any legal prescription, in compliance with the requirements of*  
33 *the state board of pharmacy, may be used to validate claims in connection*  
34 *with prescriptions, refills or changes in prescriptions;*

35 (7) ~~each pharmacy shall be audited~~ *audit each pharmacy under the*  
36 *same standards and parameters as other similarly situated pharmacies; and*

37 (8) ~~the entity conducting the audit must~~ *establish a written appeals*  
38 *process;*

39 (9) *provide the pharmacy with an unmasked list that provides the*  
40 *specific prescription numbers and fill dates that the entity seeks to audit;*

41 (10) *not conduct audits during the first five business days of the*  
42 *month or on a Monday, unless expressly consented to by the pharmacy;*  
43 *and*

1       (11) *not enter the pharmacy area unless escorted by pharmacy*  
2 *personnel where patient-specific information is available and remain out*  
3 *of sight and hearing of pharmacy customers to the greatest extent possible.*

4       (b) The entity conducting the audit shall also comply with the  
5 following requirements:

6       (1) A finding of overpayment or underpayment must be based on the  
7 actual overpayment or underpayment and not a projection based on the  
8 number of patients served having a similar diagnosis or on the number of  
9 similar orders or refills for similar drugs;

10       (2) the entity conducting the audit shall not use extrapolation in  
11 calculating the recoupments or penalties for audits, unless required by state  
12 or federal contracts;

13       (3) the auditing company or agent may not receive payment based on  
14 a percentage of the amount recovered, unless required by contracts; ~~and~~

15       (4) interest may not accrue during the audit period;

16       (5) *any amendment to pharmacy audit terms in a contract between a*  
17 *PBM and a pharmacy shall be disclosed by the PBM to the pharmacy at*  
18 *least 60 days prior to the effective date of the proposed change;*

19       (6) *audit parameters shall consider consumer-oriented parameters*  
20 *based on manufacturer listings;*

21       (7) *a pharmacy's usual and customary price for compounded*  
22 *medications shall be considered the reimbursable cost, unless the pricing*  
23 *methodology is outlined in the pharmacy provider contract;*

24       (8) *calculations of overpayments shall not include dispensing fees,*  
25 *unless a prescription was not actually dispensed, the prescriber denied*  
26 *authorization, the prescription dispensed was a medication error by the*  
27 *pharmacy or the identified overpayment is solely based on an extra*  
28 *dispensing fee;*

29       (9) (A) *a pharmacy shall be allowed up to five business days to*  
30 *correct any identified clerical or record-keeping error; such as a*  
31 *typographical error, scrivener's error or computer error regarding a*  
32 *required document or record and be allowed to resubmit the adjusted*  
33 *claim without being subject to recoupment; and*

34       (B) *an entity shall not consider any of the errors contained in*  
35 *subparagraph (A) as fraud. Such errors may be subject to recoupment if*  
36 *the error is not corrected, pursuant to the provisions of subparagraph (A);*

37       (10) *in the case of errors that have no actual financial effect on the*  
38 *patient or plan, the PBM shall not assess any chargebacks. Errors that*  
39 *result from the pharmacy failing to comply with a formal corrective action*  
40 *plan may be subject to recovery; and*

41       (11) *the entity conducting the audit shall establish a written appeals*  
42 *process that shall include appeals of preliminary reports and final reports.*

43       (c) ~~This section shall take effect on and after July 1, 2011.~~ *A PBM*

1 shall not require information to be written on a prescription unless the  
 2 information is required to be written on the prescription by state or federal  
 3 law. Recoupment shall be assessed for items not written on a prescription  
 4 if:

5 (1) The information is required by the food and drug administration  
 6 or the information is required by the drug manufacturer's product safety  
 7 program; and

8 (2) the information required in paragraph (1) was not readily  
 9 available for the auditor at the time of the audit.

10 (d) Claims that adjudicate successfully without rejection at the time  
 11 of claim submission shall not be subject to audit for issues related to prior  
 12 authorization or drug utilization review requirements after the date of  
 13 initial claim approval.

14 (e) This section shall not apply to:

15 (1) Any investigative audit that involves suspected fraud, willful  
 16 misrepresentation or abuse; or

17 (2) any audit completed by Kansas healthcare programs.

18 Sec. 21. K.S.A. 65-16,124 is hereby amended to read as follows: 65-  
 19 16,124. (a) Any preliminary audit report ~~must~~ shall be delivered to the  
 20 pharmacy within 60 days after the conclusion of the audit. Any pharmacy  
 21 shall be allowed at least ~~30~~ 45 days following receipt of the preliminary  
 22 audit to provide documentation to address any discrepancy found in the  
 23 audit. ~~Any~~ The final audit report shall be delivered to the pharmacy within  
 24 120 days after receipt of the preliminary audit report or final appeal,  
 25 whichever is later. An entity shall remit any money due to a pharmacy or  
 26 pharmacist as a result of an underpayment of a claim within 45 days after  
 27 the appeals process has been exhausted and the final audit report has been  
 28 issued.

29 (b) Recoupment of any disputed funds or repayment of funds to the  
 30 entity by the pharmacy, if permitted pursuant to contracts, shall occur, to  
 31 the extent demonstrated or documented in the pharmacy audit findings,  
 32 after final internal disposition of the audit including the appeals process. If  
 33 the identified discrepancy for an individual audit exceeds \$20,000, any  
 34 future payments to the pharmacy may be withheld pending finalization of  
 35 the audit. Unless otherwise required by the federal or state law, any audit  
 36 information ~~may~~ shall not be shared. Auditors shall only have access to  
 37 previous audit reports on a particular pharmacy conducted by that same  
 38 entity.

39 ~~(c) This section shall take effect on and after July 1, 2011.~~

40 Sec. 22. K.S.A. 65-16,125 is hereby amended to read as follows: 65-  
 41 16,125. ~~(a)~~ Any auditing entity, upon request of the plan sponsor, shall  
 42 provide a copy of the final report, including the disclosure of any ~~money~~  
 43 moneys recouped in the audit. Any recouped moneys shall be returned to

1 *the plan sponsor.* The pharmacy may provide a copy of the report to the  
 2 commissioner of insurance, provided such report shall not contain any  
 3 personally identifiable health information in violation of the provisions of  
 4 the health insurance portability and accountability act of 1996-~~6~~, Pub. L.  
 5 No. 104-191).

6 ~~(b) This section shall take effect on and after July 1, 2011.~~

7 Sec. 23. K.S.A. 65-16,126 is hereby amended to read as follows: 65-  
 8 16,126. ~~(a) This~~ *The pharmacy audit integrity* act shall apply to contracts  
 9 between an auditing entity and a pharmacy entered into, extended or  
 10 renewed on or after ~~the effective date of this act~~ *July 1, 2011*. This act shall  
 11 not apply to any audit, review or investigation that is initiated based upon  
 12 ~~suspected or alleged~~ fraud, willful misrepresentation or abuse. *The audit*  
 13 *entity shall have sufficient documentation of such fraud, willful*  
 14 *misrepresentation or abuse to qualify for the exemption provided by this*  
 15 *section.*

16 ~~(b) This section shall take effect on and after July 1, 2011.~~

17 Sec. 24. K.S.A. 65-16,123, 65-16,124, 65-16,125 and 65-16,126 and  
 18 K.S.A. 2019 Supp. 40-3821, 40-3822, 40-3823, 40-3824, 40-3825, 40-  
 19 3826, 40-3827, 40-3829 and 40-3830 are hereby repealed.

20 Sec. 25. This act shall take effect and be in force from and after its  
 21 publication in the statute book.