An Act To Restore Market-based Competition for Pharmacy Benefits Management Services

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1711-E, sub-§1, ¶G, as enacted by PL 2005, c. 589, §1, is amended to read:

G. "Pharmacy benefits manager" has the same meaning as in ~~section 2699, subsection 1, paragraph F~~Title 24#A, section 1913, subsection 1, paragraph A.

Sec. 2. 22 MRSA c. 603, sub-c. 4, as amended, is repealed.

Sec. 3. 22 MRSA §8702, sub-§8-B, as amended by PL 2007, c. 695, Pt. A, §26, is further amended to read:

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" ~~means an entity that performs pharmacy benefits management as defined in section 2699, subsection 1, paragraph E~~has the same meaning as in Title 24#A, section 1913, subsection 1, paragraph A.

Sec. 4. 24-A MRSA §1913, as enacted by PL 2009, c. 581, §4, is repealed and the following enacted in its place:

§ 1913. Registration of pharmacy benefits managers

Beginning April 1, 2011, a person may not act as a pharmacy benefits manager in this State without first paying the registration fee required under section 601, subsection 28.

1. Definitions. As used in this section, the following terms have the following meanings.

A. "Pharmacy benefits manager" means a person or entity that contracts with a plan sponsor, health care service plan, health maintenance organization or insurer to manage or administer a contract, agreement or arrangement between a carrier or administrator and a pharmacy, as defined in Title 32, section 13702#A, subsection 24, in which the pharmacy agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that pharmacy.

2. Rules. The superintendent may adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to administer and enforce the registration requirements of this section.

3. Enforcement. The superintendent may enforce this section under sections 220 and 223 and other provisions of this Title.

Sec. 5. 24-A MRSA §4317, sub-§3, as enacted by PL 2009, c. 519, §1 and affected by §2, is amended to read:

3. Exception. ~~This section does~~Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254#D.

Sec. 6. 24-A MRSA §4317, sub-§§4 to 11 is enacted to read:

4. Participation in contracts . A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.

5. Prohibition. The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.

6. Pharmacy benefits manager duties. All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in Title 22, section 2699#A.

7. Complaints, grievances and appeals. A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.

8. Denial or limitation of benefits. A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.

9. Written notice required. At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or

B. A finding of fraud.

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.

10. Audits. Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist.

B. The auditor may not use extrapolation in calculating recoupments or penalties.

C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist.

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

11. Audit information and reports. A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 10. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

Effective 90 days following adjournment of the 125th Legislature, First Regular Session, unless otherwise indicated.