126th MAINE LEGISLATURE

SECOND REGULAR SESSION-2014

Legislative Document **No. 1624**

H.P. 1196 House of Representatives, December 30, 2013

An Act Concerning Pricing Disclosure Requirements and Oversight of Pharmacy Benefits Managers

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Received by the Clerk of the House on December 23, 2013. Referred to the Committee on Labor, Commerce, Research and Economic Development pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative BECK of Waterville.
Cosponsored by Representatives: COOPER of Yarmouth, GILBERT of Jay, LONGSTAFF of Waterville, NADEAU of Winslow, RANKIN of Hiram, THERIAULT of Madawaska, TREAT of Hallowell.

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

Sec. 1. 22 MRSA §1711-E, sub-§1, ¶G, as amended by PL 2011, c. 443, §1, is further amended to read:

G. "Pharmacy benefits manager" has the same meaning as in Title ~~24-A~~ 32, section ~~1913~~ 13800, subsection 1, paragraph ~~A~~ C.

Sec. 2. 22 MRSA §8702, sub-§8-B, as amended by PL 2011, c. 443, §3, is further amended to read:

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" has the same meaning as in Title ~~24-A~~ 32, section ~~1913~~ 13800, subsection 1, paragraph ~~A~~ C.

Sec. 3. 22 MRSA §8706, sub-§2, ¶C, as amended by PL 2007, c. 136, §5, is further amended to read:

C. The operations of the organization must be supported from 3 sources as provided in this paragraph:

(1) Fees collected pursuant to paragraphs A and B;

(2) Annual assessments of not less than $100 assessed against the following entities licensed under Titles 24 ~~and~~, 24-A and 32: nonprofit hospital and medical service organizations, health insurance carriers and health maintenance organizations on the basis of the total annual health care premium; and 3rd-party administrators, carriers that provide only administrative services for a plan sponsor and pharmacy benefits managers that process and pay claims on the basis of claims processed or paid for each plan sponsor. The assessments are to be determined on an annual basis by the board. Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under this subparagraph. For purposes of this subparagraph, policies issued for dental services are not considered to be limited benefit health insurance policies. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (3); and

(3) Annual assessments of not less than $100 assessed by the organization against providers. The assessments are to be determined on an annual basis by the board. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (2).

The aggregate level of annual assessments under subparagraphs (2) and (3) must be an amount sufficient to meet the organization's expenditures authorized in the state budget established under Title 5, chapter 149. The annual assessment may not exceed $1,346,904 in fiscal year 2002-03. In subsequent fiscal years, the annual assessment may increase above $1,346,904 by an amount not to exceed 5% per fiscal year. The board may waive assessments otherwise due under subparagraphs (2) and (3) when a waiver is determined to be in the interests of the organization and the parties to be assessed.

Sec. 4. 24-A MRSA §601, sub-§28, as enacted by PL 2009, c. 581, §3, is repealed.

Sec. 5. 24-A MRSA §1913, as repealed and replaced by PL 2011, c. 443, §4, is repealed.

Sec. 6. 24-A MRSA §4317, sub-§12 is enacted to read:

12. Maximum allowable cost. This subsection governs the maximum allowable cost for a drug as determined by a pharmacy benefits manager.

A. As used in this subsection, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager pays toward the cost of a drug.

(2) "Nationally available" means available to all pharmacies in this State for purchase, without limitation, from regional or national wholesalers and not obsolete or temporarily available.

(3) "Therapeutically equivalent drug substitute" means a drug identified as therapeutically or pharmaceutically equivalent to another drug by the United States Food and Drug Administration.

B. A pharmacy benefits manager may not set a maximum allowable cost for a prescription drug if that prescription drug does not have 3 or more nationally available therapeutically equivalent drug substitutes.

C. A pharmacy benefits manager shall remove a maximum allowable cost for a prescription drug or modify the maximum allowable cost as necessary for the cost of the prescription drug to remain consistent with changes in the national marketplace for prescription drugs. A removal or modification made under this paragraph must be made in a timely fashion.

D. A pharmacy benefits manager shall disclose to a pharmacy for which the pharmacy benefits manager processes claims, makes payment of claims or procures drugs:

(1) At the beginning of each calendar year, the basis of the methodology and the sources used to establish the maximum allowable costs used by the pharmacy benefits manager. A pharmacy benefits manager shall give prompt written notification to a pharmacy of any change made to a maximum allowable cost; and

(2) At least once every 7 business days, the maximum allowable costs used by the pharmacy benefits manager.

E. A pharmacy benefits manager shall establish a procedure by which a pharmacy may contest a maximum allowable cost. A procedure established under this paragraph must require a pharmacy benefits manager to respond to a pharmacy that has contested a maximum allowable cost within 15 calendar days. If the pharmacy benefits manager changes the maximum allowable cost, the change must:

(1) Become effective on the date on which the pharmacy initiated proceedings under this paragraph; and

(2) Apply to all pharmacies in the network of pharmacies served by the pharmacy benefits manager.

F. A pharmacy benefits manager shall disclose to a carrier with which the pharmacy benefits manager has entered into a contract:

(1) At the beginning of each calendar year, the basis of the methodology and the sources used to establish the maximum allowable costs used by the pharmacy benefits manager;

(2) As soon as practicable, any change made to a maximum allowable cost;

(3) The maximum allowable costs for prescription drugs dispensed at a retail community pharmacy not later than 21 business days after these costs are set; and

(4) Whether the pharmacy benefits manager used the same maximum allowable cost for billing the carrier and for reimbursing a pharmacy and, if the pharmacy benefits manager did not use the same maximum allowable cost, the difference between the amount billed and the amount reimbursed.

Sec. 7. 32 MRSA §13800 is enacted to read:

§13800. Registration of pharmacy benefits managers

A person may not act as a pharmacy benefits manager in this State without first paying the registration fee established by the board by rule.

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

A. "Administrator" has the same meaning as in Title 24-A, section 1901, subsection 1.

B. "Health maintenance organization" has the same meaning as in Title 24-A, section 4202-A, subsection 10.

C. "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.

D. "Plan sponsor" has the same meaning as in Title 24-A, section 1901, subsection 8.

2. Rules. The board may adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to administer and enforce the registration requirements of this section. Pharmacy benefits manager registration fees established by the board may not exceed $100 for an original registration or an annual renewal registration.

3. Enforcement. The board may enforce this section.

Sec. 8. Maine Board of Pharmacy to adopt rules. The Department of Professional and Financial Regulation, Maine Board of Pharmacy shall adopt routine technical rules pursuant to the Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A to administer and enforce the requirements regarding the registration of pharmacy benefits managers in Title 32, section 13800 no later than January 1, 2015.

Sec. 9. Effective date. Those sections of this Act that enact the Maine Revised Statutes, Title 32, section 13800, amend Title 22, section 1711-E, subsection 1, paragraph G, Title 22, section 8702, subsection 8-B and Title 22, section 8706 and repeal Title 24-A, section 601, subsection 28 and Title 24-A, section 1913 take effect January 1, 2015.

SUMMARY

This bill sets limits on the use of maximum allowable cost pricing by pharmacy benefits managers and requires pharmacy benefits managers to make disclosures regarding that pricing. It also transfers oversight and enforcement of the laws governing the registration of pharmacy benefits managers from the Superintendent of Insurance to the Department of Professional and Financial Regulation, Maine Board of Pharmacy.