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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2015

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - PRESCRIPTION DRUG BENEFITS

Introduced By: Senator William A. Walaska

Date Introduced: January 22, 2015

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18-33 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-33. Drug coverage. – (a) No group health insurer subject to the provisions of this chapter that provides coverage for prescription drugs under a group plan master contract delivered, issued for delivery, or renewed in this state may require any person covered under the contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for the drugs.

(b) No group health insurer shall refuse to contract with a qualified pharmacy provider willing to meet the terms and conditions of the group health insurer for pharmacy participation.

(c) A group health insurer may not require a pharmacy provider to participate in one network in order to participate in another network. The group health insurer may not exclude an otherwise qualified pharmacy provider from participation in one network solely because the pharmacy provider declined to participate in another network managed by the insurer.

This subsection shall not be construed to limit a group health insurer's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the entity makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this

subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

(d) The agreement between a group health insurer and a pharmacy provider shall not require a pharmacy provider to assume liability for acts solely of the group health insurance provider.

(e) Group health insurers shall distribute payments received for the services of a pharmacy provider as required by law.

(f) No group health insurer shall terminate the contract of or penalize a pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance or appeal. Termination by mutual agreement shall not be restricted.

(g) No group health insurer shall terminate the contract of a pharmacy provider for expressing disagreement with a group health insurer's decision to deny or limit benefits to an enrollee, or because the pharmacy provider assists the enrollee to seek reconsideration of the group health insurer's decision or because the pharmacy provider discusses alternative medications.

(h) At least sixty (60) days before a group health insurer terminates a pharmacy provider's participation in the plan or network, the group health insurer shall give the pharmacy provider a written explanation of the reason for the termination, unless the termination is based on either the loss of the pharmacy provider's license to practice pharmacy or cancellation of professional liability insurance or a finding of fraud.

(i) Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy provider is conducted by a group health insurer, the audit shall be conducted in accordance with the following criteria:

(1) 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 provider.

(2) The auditor may not use extrapolation in calculating recoupments or penalties.

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

(4) A group health insurer conducting an audit shall establish an appeals process under which a pharmacy provider may appeal an unfavorable preliminary audit report to the insurer.

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

(6) A preliminary audit report must be delivered to the pharmacy provider within sixty (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty (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 provider within ninety (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 provider conducted by that same entity.

(7) Prior to an audit, the group health insurer conducting an audit shall give the pharmacy provider ten (10) days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit.

(8) A pharmacy provider has the right to request mediation by a private mediator, agreed upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for mediation does not waive any existing rights of appeal available to a pharmacy provider.

(j) Maximum allowable cost provisions:

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

(2) "Nationally available" means that all pharmacies in this state can purchase the drug, without limitation, from regional or national wholesalers and that the product is not obsolete or temporarily available.

(3) "Therapeutically equivalent" means the drug is identified as therapeutically or pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

(4) A pharmacy benefits manager may not place a prescription drug on a maximum allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if the prescription drug does not have three (3) or more nationally available and therapeutically equivalent drug substitutes.

(5) A pharmacy benefits manager shall remove a prescription drug from a maximum allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and modifications are necessary to remain consistent with changes in the national marketplace for prescription drugs. Eliminations and modifications made under this subsection must be made in a timely fashion.

(6) A pharmacy benefits manager shall disclose to a pharmacy for which the pharmacy

benefits manager processes claims, makes payment of claims or procures drugs:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(ii) At least once every seven (7) business days, the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(7) A pharmacy benefits manager shall give prompt written notification to a pharmacy provider of any change made to a maximum allowable cost pricing index or maximum allowable cost rates.

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

(i) Become effective on the date on which the pharmacy provider initiated proceedings under this subsection; and

(ii) Apply to all pharmacy providers in the network of pharmacy providers served by the pharmacy benefits manager.

(9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the pharmacy benefits manager has entered into a contract:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager;

(ii) As soon as practicable, any change made to a maximum allowable cost pricing index or maximum allowable cost rates;

(iii) Not later than twenty-one (21) business days after implementing the practice, the utilization of a maximum allowable cost pricing index or maximum allowable cost rates for prescription drugs dispensed at a retail community pharmacy provider; and

(iv) Whether the pharmacy benefits manager used identical maximum allowable cost rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider and, if the pharmacy benefits manager used different maximum allowable cost rates, the difference between the amount billed and the amount reimbursed.

(k) The department of business regulation shall exercise oversight and enforcement of this section.

SECTION 2. Section 27-19-26 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-26. Drug coverage. – (a) No group health insurer subject to the provisions of this chapter that provides coverage for prescription drugs under a group plan master contract delivered, issued for delivery, or renewed in this state may require any person covered under the contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for the drugs.

(b) No nonprofit hospital service corporation shall refuse to contract with a qualified pharmacy provider willing to meet the terms and conditions of the nonprofit hospital service corporation for pharmacy participation.

(c) A nonprofit hospital service corporation may not require a pharmacy provider to participate in one network in order to participate in another network. The nonprofit hospital service corporation may not exclude an otherwise qualified pharmacy provider from participation in one network solely because the pharmacy provider declined to participate in another network managed by the insurer.

This subsection shall not be construed to limit a nonprofit hospital service corporation's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the entity makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

(d) The agreement between a nonprofit hospital service corporation and a pharmacy provider shall not require a pharmacy provider to assume liability for acts solely of the group health insurance provider.

(e) Nonprofit hospital service corporations shall distribute payments received for the services of a pharmacy provider as required by law.

(f) No nonprofit hospital service corporation shall terminate the contract of or penalize a pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance, or appeal. Termination by mutual agreement shall not be restricted.

(g) No nonprofit hospital service corporation shall terminate the contract of a pharmacy provider for expressing disagreement with a nonprofit hospital service corporation's decision to deny or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek reconsideration of the nonprofit hospital service corporation's decision or because the pharmacy

provider discusses alternative medications.

(h) At least sixty (60) days before a nonprofit hospital service corporation terminates a pharmacy provider's participation in the plan or network, the nonprofit hospital service corporation shall give the pharmacy provider a written explanation of the reason for the termination, unless the termination is based on either the loss of the pharmacy provider's license to practice pharmacy, or cancellation of professional liability insurance, or a finding of fraud.

(i) Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy provider is conducted by a nonprofit hospital service corporation, the audit shall be conducted in accordance with the following criteria:

(1) 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 provider.

(2) The auditor may not use extrapolation in calculating recoupments or penalties.

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

(4) A nonprofit hospital service corporation conducting an audit shall establish an appeals process under which a pharmacy provider may appeal an unfavorable preliminary audit report to the insurer.

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

(6) A preliminary audit report must be delivered to the pharmacy provider within sixty (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty (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 provider within ninety (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 provider conducted by that same entity.

(7) Prior to an audit, the nonprofit hospital service corporation conducting an audit shall give the pharmacy provider ten (10) days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit.

(8) A pharmacy provider has the right to request mediation by a private mediator, agreed upon by the pharmacy and the listed entity, to resolve any disagreement. A request for mediation does not waive any existing rights of appeal available to a pharmacy provider.

(j) Maximum allowable cost provisions:

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

(2) "Nationally available" means that all pharmacies in this state can purchase the drug, without limitation, from regional or national wholesalers and that the product is not obsolete or temporarily available.

(3) "Therapeutically equivalent" means the drug is identified as therapeutically or pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

(4) A pharmacy benefits manager may not place a prescription drug on a maximum allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if the prescription drug does not have three (3) or more nationally available and therapeutically equivalent drug substitutes.

(5) A pharmacy benefits manager shall remove a prescription drug from a maximum allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and modifications are necessary to remain consistent with changes in the national marketplace for prescription drugs. Eliminations and modifications made under this subsection must be made in a timely fashion.

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

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(ii) At least once every seven (7) business days, the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(7) A pharmacy benefits manager shall give prompt written notification to a pharmacy provider of any change made to a maximum allowable cost pricing index or maximum allowable cost rates.

(8) A pharmacy benefits manager shall establish a procedure by which a pharmacy provider may contest a maximum allowable cost rate. A procedure established under this subsection must require a pharmacy benefits manager to respond to a pharmacy provider that has contested a maximum allowable cost within fifteen (15) calendar days. If the pharmacy benefits

manager changes the rate, the change must:

(i) Become effective on the date on which the pharmacy provider initiated proceedings under this subsection; and

(ii) Apply to all pharmacy providers in the network of pharmacy providers served by the pharmacy benefits manager.

(9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the pharmacy benefits manager has entered into a contract:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager;

(ii) As soon as practicable, any change made to a maximum allowable cost pricing index or maximum allowable cost rates;

(iii) Not later than twenty-one (21) business days after implementing the practice, the utilization of a maximum allowable cost pricing index or maximum allowable cost rates for prescription drugs dispensed at a retail community pharmacy; and

(iv) Whether the pharmacy benefits manager used identical maximum allowable cost rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider and, if the pharmacy benefits manager used different maximum allowable cost rates, the difference between the amount billed and the amount reimbursed.

(k) The department of business regulation shall exercise oversight and enforcement of this section.

SECTION 3. Section 27-20-23 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-23. Drug coverage. – (a) No group health insurer subject to the provisions of this chapter that provides coverage for prescription drugs under a group plan master contract delivered, issued for delivery, or renewed in this state may require any person covered under the contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for the drugs.

(b) No nonprofit medical service corporation shall refuse to contract with a qualified pharmacy provider willing to meet the terms and conditions of the nonprofit medical service corporation for pharmacy participation.

(c) A nonprofit medical service corporation may not require a pharmacy provider to participate in one network in order to participate in another network. The nonprofit medical service corporation may not exclude an otherwise qualified pharmacy provider from participation

in one network solely because the pharmacy provider declined to participate in another network managed by the insurer.

This subsection shall not be construed to limit a nonprofit medical service corporation's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the entity makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

(d) The agreement between a nonprofit medical service corporation and a pharmacy provider shall not require a pharmacy provider to assume liability for acts solely of the group health insurance provider.

(e) Nonprofit medical service corporations shall distribute payments received for the services of a pharmacy provider as required by law.

(f) No nonprofit medical service corporation shall terminate the contract of or penalize a pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance or appeal. Termination by mutual agreement shall not be restricted.

(g) No nonprofit medical service corporation shall terminate the contract of a pharmacy provider for expressing disagreement with a nonprofit medical service corporation's decision to deny or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek reconsideration of the nonprofit medical service corporation's decision or because the pharmacy provider discusses alternative medications.

(h) At least sixty (60) days before a nonprofit medical service corporation terminates a pharmacy provider's participation in the plan or network, the nonprofit medical service corporation shall give the pharmacy provider a written explanation of the reason for the termination, unless the termination is based on either the loss of the pharmacy provider's license to practice pharmacy or cancellation of professional liability insurance or a finding of fraud.

(i) Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy provider is conducted by a nonprofit medical service corporation, the audit shall be conducted in accordance with the following criteria:

(1) 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 provider.

(2) The auditor may not use extrapolation in calculating recoupments or penalties.

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

(4) A nonprofit medical service corporation conducting an audit shall establish an appeals process under which a pharmacy provider may appeal an unfavorable preliminary audit report to the insurer.

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

(6) A preliminary audit report must be delivered to the pharmacy provider within sixty (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty (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 provider within ninety (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 provider conducted by that same entity.

(7) Prior to an audit, the nonprofit medical service corporation conducting an audit shall give the pharmacy provider ten (10) days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit.

(8) A pharmacy provider has the right to request mediation by a private mediator, agreed upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for mediation does not waive any existing rights of appeal available to a pharmacy provider.

(j) Maximum allowable cost provisions:

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

(2) "Nationally available" means that all pharmacies in this state can purchase the drug, without limitation, from regional or national wholesalers and that the product is not obsolete or temporarily available.

(3) "Therapeutically equivalent" means the drug is identified as therapeutically or pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

(4) A pharmacy benefits manager may not place a prescription drug on a maximum allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if

the prescription drug does not have three (3) or more nationally available and therapeutically equivalent drug substitutes.

(5) A pharmacy benefits manager shall remove a prescription drug from a maximum allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and modifications are necessary to remain consistent with changes in the national marketplace for prescription drugs. Eliminations and modifications made under this subsection must be made in a timely fashion.

(6) A pharmacy benefits manager shall disclose to a pharmacy provider for which the pharmacy benefits manager processes claims, makes payment of claims or procures drugs:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(ii) At least once every seven (7) business days, the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(7) A pharmacy benefits manager shall give prompt written notification to a pharmacy provider of any change made to a maximum allowable cost pricing index or maximum allowable cost rates.

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

(i) Become effective on the date on which the pharmacy provider initiated proceedings under this subsection; and

(ii) Apply to all pharmacy providers in the network of pharmacy providers served by the pharmacy benefits manager.

(9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the pharmacy benefits manager has entered into a contract:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager;

(ii) As soon as practicable, any change made to a maximum allowable cost pricing index or maximum allowable cost rates;

(iii) Not later than twenty-one (21) business days after implementing the practice, the

utilization of a maximum allowable cost pricing index or maximum allowable cost rates for prescription drugs dispensed at a retail community pharmacy; and

(iv) Whether the pharmacy benefits manager used identical maximum allowable cost rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider and, if the pharmacy benefits manager used different maximum allowable cost rates, the difference between the amount billed and the amount reimbursed.

(k) The department of business regulation shall exercise oversight and enforcement of this section.

SECTION 4. Section 27-41-38 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-38. Drug coverage. – (a) No health maintenance organization that provides coverage for prescription drugs under a group plan master contract delivered, issued for delivery, or renewed in this state may require any person covered under the contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for the drugs.

(b) No health maintenance organization shall refuse to contract with a qualified pharmacy provider willing to meet the terms and conditions of the health maintenance organization for pharmacy participation.

(c) A health maintenance organization may not require a pharmacy provider to participate in one network in order to participate in another network. The health maintenance organization may not exclude an otherwise qualified pharmacy provider from participation in one network solely because the pharmacy provider declined to participate in another network managed by the insurer.

This subsection shall not be construed to limit a health maintenance organization's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the entity makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

(d) The agreement between a health maintenance organization and a pharmacy provider shall not require a pharmacy provider to assume liability for acts solely of the group health insurance provider.

(e) Health maintenance organizations shall distribute payments received for the services of a pharmacy provider as required by law.

(f) No health maintenance organization shall terminate the contract of or penalize a pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance, or appeal. Termination by mutual agreement shall not be restricted.

(g) No health maintenance organization shall terminate the contract of a pharmacy provider for expressing disagreement with a health maintenance organization's decision to deny or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek reconsideration of the health maintenance organization's decision or because the pharmacy provider discusses alternative medications.

(h) At least sixty (60) days before a health maintenance organization terminates a pharmacy provider's participation in the plan or network, the health maintenance organization shall give the pharmacy provider a written explanation of the reason for the termination, unless the termination is based on either the loss of the pharmacy provider's license to practice pharmacy or cancellation of professional liability insurance or a finding of fraud.

(i) Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy provider is conducted by a health maintenance organization, the audit shall be conducted in accordance with the following criteria:

(1) 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 provider.

(2) The auditor may not use extrapolation in calculating recoupments or penalties.

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

(4) A health maintenance organization conducting an audit shall establish an appeals process under which a pharmacy provider may appeal an unfavorable preliminary audit report to the insurer.

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

(6) A preliminary audit report must be delivered to the pharmacy provider within sixty (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty (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 provider within ninety (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 provider conducted by that same entity.

(7) Prior to an audit, the health maintenance organization conducting an audit shall give the pharmacy provider ten (10) days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit.

(8) A pharmacy provider has the right to request mediation by a private mediator, agreed upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for mediation does not waive any existing rights of appeal available to a pharmacy provider.

(j) Maximum allowable cost provisions:

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

(2) "Nationally available" means that all pharmacies in this state can purchase the drug, without limitation, from regional or national wholesalers and that the product is not obsolete or temporarily available.

(3) "Therapeutically equivalent" means the drug is identified as therapeutically or pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

(4) A pharmacy benefits manager may not place a prescription drug on a maximum allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if the prescription drug does not have three (3) or more nationally available and therapeutically equivalent drug substitutes.

(5) A pharmacy benefits manager shall remove a prescription drug from a maximum allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and modifications are necessary to remain consistent with changes in the national marketplace for prescription drugs. Eliminations and modifications made under this subsection must be made in a timely fashion.

(6) A pharmacy benefits manager shall disclose to a pharmacy provider for which the pharmacy benefits manager processes claims, makes payment of claims or procures drugs:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(ii) At least once every seven (7) business days, the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager.

(7) A pharmacy benefits manager shall give prompt written notification to a pharmacy provider of any change made to a maximum allowable cost pricing index or maximum allowable cost rates.

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

(i) Become effective on the date on which the pharmacy provider initiated proceedings under this subsection; and

(ii) Apply to all pharmacy providers in the network of pharmacy providers served by the pharmacy benefits manager.

(9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the pharmacy benefits manager has entered into a contract:

(i) At the beginning of each calendar year, the basis of the methodology and the sources used to create the maximum allowable cost pricing index or maximum allowable cost rates used by the pharmacy benefits manager;

(ii) As soon as practicable, any change made to a maximum allowable cost pricing index or maximum allowable cost rates;

(iii) Not later than twenty-one (21) business days after implementing the practice, the utilization of a maximum allowable cost pricing index or maximum allowable cost rates for prescription drugs dispensed at a retail community pharmacy; and

(iv) Whether the pharmacy benefits manager used identical maximum allowable cost rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider and, if the pharmacy benefits manager used different maximum allowable cost rates, the difference between the amount billed and the amount reimbursed.

(k) The department of business regulation shall exercise oversight and enforcement of this section.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - PRESCRIPTION DRUG BENEFITS

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This act would regulate the business relationship between providers of pharmacy services and group health insurers, nonprofit hospital service corporations, nonprofit medical service corporations and health maintenance organizations including establishment of the relationship and the requirements needed to be considered an acceptable pharmacy service provider, termination of the relationship, audits, acceptance or denial of benefits, substitution of drugs with therapeutic equivalents, cost limitations, maximum allowable cost rates and grievance procedures between the parties, and liability sharing requirements.

The department of business regulation is declared the state agency in charge of oversight of the business relationship between pharmacy providers and health service organizations.

This act would take effect upon passage.

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