

# **LAWS THAT PROVIDE REGULATION OF THE BUSINESS PRACTICES OF PHARMACY BENEFIT MANAGERS**

## **ARKANSAS**

### **Title 17, Chapter 92**

#### **Section 17-92-1201, et.seq.**

- Sets forth standards for audits by a managed care company, an insurance company, a third-party payor or any entity that represents such companies or groups.
- Pharmacy must be given at least one week advance notice of an audit.
- If clinical or professional judgment is required audit must be conducted by or in consultation with a pharmacist.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record.
- Recoupment of claims has to be based on actual overpayment unless it is part of a settlement with the pharmacy.
- Period covered by audit cannot exceed 24 months from the date the claim was submitted to or adjudicated by the entity.
- Unless consented to by the pharmacy, the audit cannot take place during the first 7 days of the month due to high volume of prescriptions filled during that time.
- Preliminary audit report must be delivered within 120 days after the conclusion of the audit - final report must be delivered within 6 months.
- Use of extrapolation audits for calculation of recoupments or penalties is prohibited.
- Copy of the final audit report to be provided to the plan sponsor.
- Applies to audits of claims submitted after January 1, 2008.
- Effective: 04.03.07

## **CONNECTICUT**

### **Public Act No. 07-200**

#### **Registration of Pharmacy Benefit Managers**

- PBM must obtain a certificate of registration from the Insurance Department.
- PBM must complete an application form and include the name and address for an agent for service of process, pay a fee and provide evidence of a surety bond.
- PBM operating as a line of business or affiliate of a health insurer or other entity does not have to obtain a certificate of registration but must provide annual notification to the Commissioner of its status.
- Registration may be denied and a hearing process is provided for an appeal.
- Commissioner has the authority to suspend, revoke or refuse to issue or renew for conduct of a character likely to mislead, deceive or defraud the public or the commissioner, unfair or deceptive business practices or nonpayment of renewal fee.
- Effective: 01.01.08

## **GEORGIA**

### **Title 26, Chapter 26-4.110.1**

- Requires a PBM to be licensed as a pharmacy, with a few exceptions, if it provides the services or benefits that constitute the practice of pharmacy.
- If the PBM is licensed then the Board can inspect its premises whether they are located within or outside the state.
- Effective: 05.22.02

### **Title 26, Chapter 4 – 26-4-118**

#### **The Pharmacy Audit Bill of Rights**

- Requires certain procedures when an audit of pharmacy records is undertaken by a managed care company, insurance company, third-party payor or any entity that represents such companies (which would include PBMs).

- Pharmacy must be given notice at least one week prior to conducting the audit.
- Any audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.
- A finding of an overpayment or underpayment may be 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; however recoupment of claims must be based on the actual overpayment or underpayment unless the pharmacy agrees as part of a settlement.
- Pharmacy must be allowed at least 30 days following the receipt of the audit report to produce documentation to address any discrepancy found during the audit.
- Period covered by the audit may not exceed two years from the date that the claim was submitted to or adjudicated by the entity.
- An audit may not be scheduled during the first 7 calendar days of any month without the consent of the pharmacy.
- The preliminary report must be delivered to the pharmacy within 120 days after conclusion of the audit.
- Extrapolation is prohibited in calculating recoupments or penalties for audits.
- Each entity conducting an audit shall establish an appeals process.
- Plan sponsor must be provided with a copy of the audit report.
- Effective: 04.19.06 (applies to audits to claims submitted for payment after 07/01/06)

**IOWA**  
**Title XIII Commerce**  
**Subtitle 1 Insurance and Related Regulation**  
**Chapter 510B.1 – 510B.9**

- PBM must obtain a certificate as a third party administrator.
- PBM must perform its duties exercising good faith and fair dealing.
- PBM must notify the covered entity in writing of any conflicts.
- PBM cannot contact a covered individual without permission of the covered entity.
- PBM cannot require more stringent record keeping than that required by state or federal law or regulation.
- PBM must notify the pharmacy when it receives notice from a covered entity of a contract cancellation within 10 working days.
- Within 3 business days of a price increase notification by a manufacturer or supplier the PBM must adjust its payment to the pharmacy consistent with the price increase.
- Commissioner must enforce the provisions and adopt rules concerning timely payment of pharmacy claims and a process for adjudication of complaints and settlement of disputes between a PBM and a pharmacy related to auditing practices and termination of pharmacy agreements.
- Legislative Council is directed to establish an interim committee on PBMs to review transparency, disclosure, confidentiality protections, ability of covered entities to audit PBMs and appropriate remedies for covered entities to enforce the provisions in the Act.
- Effective: 01.01.08

**KANSAS**  
**Chapter 154**  
**Pharmacy Benefits Manager Registration Act**

- Requires PBMs to obtain a valid certificate of registration issued by the insurance commissioner in order to operate in the state.
- PBM must file an application form which includes:
  - (a) Name, address, official position and professional qualification of each individual who is responsible for the conduct of the affairs of the PBM, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the PBM.

- (b) Name and address of the applicant's agent for service of process in the state and
- (c) A nonrefundable application fee of \$140.

- Registration expires on March 31<sup>st</sup> of each year and the renewal fee is \$140.
- If the fee is not paid the registration may be revoked or suspended.
- PBMs must register within 90 days after the effective date of the act.
- Insurance commissioner may adopt rules.
- If a PBM acts without registering, it will be subject to a fine of \$500 per violation.
- Effective: 04.28.06

## **MAINE**

### **Title 22, Chapter 603, Subchapter 4, Section 2699 Prescription drug practices**

- Provides that a PBM owes a fiduciary duty to a covered entity and must discharge that duty in accordance with the provisions of state and federal law.
- Requires PBM to perform its duties with care, skill, prudence and diligence in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims.
- Requires PBM to notify the covered entity in writing of any practice that is a conflict of interest.
- Upon request by the covered entity, the PBM must provide all financial and utilization information relating to services to that covered entity.
- The PBM may designate any information provided to the covered entity as confidential and the information may not be disclosed without the permission of the PBM except that disclosure may be ordered by a court. Also this provision does not limit the Attorney General's use of its investigative authority.
- Requires PBM to transfer in full to the covered entity any benefit or payment received as a result of a substitution.
- Requires PBM to disclose to the covered entity all financial terms and arrangements for remuneration of any kind that apply between the PBM and any drug manufacturer or labeler, including formulary management, drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees. The PBM may designate the information as confidential. However disclosure may be ordered by a court and this provision does not limit the Attorney General's use of its investigative authority.
- Provides that a violation of the Act is a violation of the Maine Unfair Trade Practices Act and subject to a fine of not more than \$10,000.
- Applies to contracts executed or renewed on or after September 13, 2003.
- Effective: 04.13.05 (On 06/05/06, the U. S. Supreme Court denied the Petition for a Writ of Certiorari filed by PCMA seeking to overturn the Maine law on the grounds that ERISA preempted it. The Supreme Court ruling ended PCMA's legal challenges to the law.)

## **MARYLAND**

### **Title 15, Subtitle 10B, Section 15-10B-20 Private Review Agents**

- Requires the Insurance Department to conduct an examination of any PBM registered as a private review agent at least once every three years.
- Requires the Commissioner to issue a report based on the examinations.
- Effective: 05.13.03

## **MISSISSIPPI**

### **Title 73 – Professions and Vocations Chapter 21 – Pharmacists Sections 73- 21-151 – 73-21-159 Pharmacy Benefit Prompt Pay Act**

- Requires PBMs to file financial statements with the Insurance Department.
- PBMs must use a nationally recognized reference in pricing calculations when reimbursing pharmacies and must update that reference no less than every three business days.

- Clean claims filed electronically must be paid within 15 days (not later than 35 days if filed as a paper claim).
- The Board of Pharmacy shall monitor PBMs for compliance with the law and is authorized to subject PBMs to administrative penalties for non-compliance.
- Effective: 06.30.06

**NEW MEXICO**  
**Chapter 61 – Article 11**  
**61-11-18.2**

- Requires a managed care company, insurance company, third-party payor or representative of the managed care company, insurance company or third-party payor to conduct audits according to certain criteria.
- Must give pharmacy at least 2 weeks notice prior to conducting an initial on-site audit.
- An audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.
- Pharmacy can use the records of a hospital, physician or other authorized practitioner for the purposes of validating the pharmacy record.
- A finding of overpayment or underpayment cannot be based on a projection and recoupment of claims must be based on actual overpayment or underpayment unless a statistically justifiable method of projection is part of an agreed settlement.
- Pharmacy must be allowed at least 21 days, with reasonable extensions, to produce documentation to address any discrepancies.
- Audit period cannot exceed 2 years, unless agreed by contract, from the date that the claim was submitted or adjudicated.
- Audit may not be initiated or scheduled during the first 5 calendar days of a month unless consented to by the pharmacy.
- Preliminary audit report must be delivered within 120 days, with reasonable extensions allowed, after the conclusion of the audit.
- Final report must be delivered within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.
- Audit criteria apply to all audits of claims submitted after July 1, 2007.
- Extrapolation audits are prohibited in calculating recoupments or penalties.
- Each entity conducting an audit must have an appeals process. If the discrepancy exceeds \$25,000 future payments to the pharmacy may be withheld pending finalization of the audit.
- Law does not apply to any investigative audit that involves fraud or willful misrepresentation.
- Effective: 07.01.07

**NORTH DAKOTA**  
**Chapter 26.1-27**

- Defines a PBM as an administrator and requires PBM to be registered as an administrator.
- Requires disclosure of ownership interest in the PBM by an insurer or a pharmaceutical manufacturer.
- Requires the PBM to notify the Commissioner in writing within 5 business days of any material change in the PBM's ownership.
- Requires PBM to comply with statutory provisions concerning substitution of one drug for another.
- PBM may not exclude an otherwise qualified pharmacy from its network if the pharmacy accepts the terms, conditions and reimbursement rates of the PBM's contract.
- PBM may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract.
- PBM must offer to the covered entity contracting options that must include: a transaction fee without a sharing of a payment received by the PBM, a combination of transaction fee and a sharing of the payment received by the PBM or a transaction fee based on the covered entity receiving all of the benefits of payments received by the PBM.

- Agreement between the PBM and the covered entity must include a provision allowing the covered entity to audit the PBM's books, accounts and records as necessary to confirm that the benefit of a payment received by the PBM is being shared as required by the contract.
- During an examination of a covered entity, the Commissioner may examine any contracts between the covered entity and the PBM in order to determine whether payments received from the PBM are being applied to reduce the covered entity's rates or have been distributed to covered individuals.
- Covered entity must disclose annually the benefits of the payments received and describe how the benefits received were applied towards reducing rates or distributed to covered individuals.
- Any information disclosed to the Commissioner is considered a trade secret.
- Commissioner may adopt rules as necessary.
- Effective: 08.01.05

**RHODE ISLAND**  
**Title 27 – Insurance**  
**Chapter 27-29.1**

- Includes PBMs in the definition of third-party administrator under Chapter 20.7 which requires filing an annual report with the Department of Business Regulation.
- Annual report must include: contractual language that provides a complete description of the financial arrangements between the third-party administrator and each of the insurers covering benefit contracts delivered in Rhode Island.
- If the third-party administrator is owned by or affiliated with another entity or entities, it shall include an organization chart and brief description which shows the relationships among all affiliates within a holding company or otherwise affiliated.
- Report must be in a format required by the director and filed with the department as a public record.
- Effective: 07.05.04

**SOUTH DAKOTA**  
**Chapter 58-29E -- Pharmacy Benefits Management**

- Requires PBMs to be licensed as a third party administrator.
- Requires PBM to perform its duties by exercising good faith and fair dealing toward the covered entity.
- Gives the covered entity the option to request information from the PBM on rebate revenues and retrospective utilization discounts.
- Gives the covered entity the option to request information on the nature, type and amount of all other revenue received from a pharmaceutical manufacturer or labeler for programs that the covered entity offers to its enrollees.
- Prohibits PBM from contacting a covered individual without express written permission of the covered entity.
- Provides that information disclosed to the covered entity shall be confidential and proprietary information; however insurance department may request information but it will be considered confidential and privileged and not open to public inspection or disclosure.
- Provides that the covered entity may audit the PBM's records as they relate to rebates and other information described in the law.
- Prescription may be substituted if it is a lower priced generic or if the substitution is for medical reasons but PBM must obtain prior approval from the prescriber.
- Allows the Division of Insurance to promulgate rules.
- Applies to contracts entered into or renewed after June 30, 2004.
- Effective: 03.09.04

**TENNESSEE**  
**Titles 56 and 63**

- Establishes standards for audits of pharmacies conducted by PBMs.
- At least 2 weeks prior written notice must be given to the pharmacy before conducting the initial on-site audit.
- If clinical or professional judgment is required audit must be conducted in consultation with a pharmacist who has knowledge of the Tennessee Pharmacy Practice Act.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record.
- Unless consented to by the pharmacy, the audit cannot take place during the first 7 days of the month due to high volume of prescriptions filled during that time.
- Pharmacist must be given no less than 30 days following receipt of the audit report to produce documentation to address any discrepancy.
- PBM must establish an appeals process and provide the pharmacist a written explanation of the process.
- Use of extrapolation audits for calculation of recoupments or penalties is prohibited.
- Preliminary audit report must be delivered within 120 days and the final report must be delivered within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.
- Period covered by an audit cannot exceed 2 years from the date the claim was submitted or adjudicated.
- Recoupment of any disputed funds cannot take place until after the final internal disposition of the audit including any appeal process.
- If PBM uses a nationally recognized reference to calculate reimbursement then the PBM must use the most current reference price or amount.
- Requires PBMs to provide timely updates to pharmacy product pricing files used to calculate prescription prices and reimburse pharmacies. Files must be updated no less than every 3 business days.
- Effective: 07.01.07

**VERMONT**  
**18 V.S.A. Chapter 221, Sections 9421, 9471 – 9473**  
**Pharmacy Benefit Managers**

- PBM must discharge its duties with reasonable care and diligence and be fair and truthful.
- PBM must provide notice to a health insurer that the following terms may be included in its PBM contract:
  - (1) all financial and utilization information requested by the insurer relating to the provision of benefits to beneficiaries through that insurer's health plan (information may be designated as confidential);
  - (2) notification of any proposed or ongoing activity that, directly or indirectly, poses a conflict of interest;
  - (3) if a substitute drug is to be dispensed which costs more than the prescribed drug and the PBM receives a payment or benefit then the cost of both drugs and the benefit or payment must be disclosed;
  - (4) if PBM derives any benefit based on volume of sales for certain drugs or classes or brands of drugs, that payment or benefit must be passed on in full to the health insurer; and
  - (5) disclosure of all financial terms and arrangement for remuneration of any kind that apply between the PBM and the drug manufacturer including formulary management and drug-switch programs, educational support, claims process and pharmacy network fees charged from retail pharmacies and data sales fees (information may be designated as confidential).
- PBM must register before doing business in the state.
- PBM must notify health insurers that they are entitled to a quote for an administrative-services-only (ASO) contract with full pass through of negotiated prices, rebates and other such financial benefits which would identify to the insurer external sources of revenue and profit generally available and whether the PBM offers that type of arrangement.

- In order to verify the pricing arrangements of ASO contracts, the PBM must allow access to the Commissioner to conduct an audit.
- Department's expenses in conducting the audit must be paid by the PBM.
- Applies to all contracts executed or renewed on or after September 1, 2007.
- Effective: 07.01.07

**DISTRICT OF COLUMBIA**  
**Title 48, Subtitle II, Chapter 8A, Subchapter II.**  
**Transparent Business Practices Among Pharmacy Benefit Managers**

- Requires a PBM to act as a fiduciary.
- PBM must perform its duties with care, skill, prudence and diligence.
- Requires the PBM to notify the covered entity in writing of any practice that is a conflict of interest.
- Requires any payments/benefits that a PBM receives from a drug manufacturer or labeler based on volume of sales or market share must be paid in full to the covered entity; however covered entity can agree to return a portion of the benefit or payment to the PBM.
- Upon request by the covered entity, the PBM must provide information on all rebates, discounts and other similar payments.
- Upon request by the covered entity, the PBM must disclose all financial terms and arrangements for remuneration of any kind between the PBM and a drug manufacturer or labeler including formulary management, drug substitution programs, educational support, claims processing and data sales fees.
- PBM may designate the information provided as confidential.
- If a PBM substitutes another prescription drug for a prescribed drug and if the substitute drug costs more than the prescribed drug, the PBM must disclose the costs of both drugs and any benefit or payment directly or indirectly that accrues to the PBM as a result of the substitution. Any benefit or payment received as a result of the substitution must be transferred in full to the covered entity.
- Violations are subject to a fine of not more than \$10,000.
- Effective: 09.16.06