MISSISSIPPI LEGISLATURE REGULAR SESSION 2006

By: Senator(s) Mettetal

To: Public Health and Welfare

SENATE BILL NO. 2697

AN ACT TO CREATE THE PHARMACY BENEFIT MANAGEMENT REGULATION ACT; TO PROVIDE DEFINITIONS; TO REQUIRE A CERTIFICATE OF AUTHORITY FROM THE STATE BOARD OF PHARMACY BEFORE OPERATING IN THIS STATE; TO PROVIDE FOR USAGE OF NATIONALLY RECOGNIZED BENCHMARKS TO CALCULATE THE REIMBURSEMENT TO BE PAID TO PHARMACIES OR PHARMACISTS; TO PROVIDE FOR COORDINATION OF BENEFITS REQUIREMENTS; TO PROVIDE FOR RECOUPMENT OF CLAIMS; TO PROVIDE PENALTIES FOR VIOLATIONS OF THE ACT; TO AUTHORIZE CERTAIN ASSESSMENTS AND FEES; TO REQUIRE PHARMACY BENEFIT MANAGERS TO FILE CONTRACT FORMS WITH THE BOARD OF PHARMACY; TO PROHIBIT CERTAIN ACTS BY PHARMACY BENEFIT MANAGERS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Board" means the State Board of Pharmacy.

(b) "Cease and desist" is an order of the board prohibiting a pharmacy benefit manager or other person or entity from continuing a particular course of conduct, which violates this act or its rules and regulations.

(c) "Day" means a calendar day, unless otherwise defined or limited.

(d) "Electronic claim" means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a pharmacy benefit manager and approved by the department.

(e) "Electronic adjudication" means the process of electronically receiving, reviewing and accepting or rejecting an electronic claim.

(f) "Enrollee" means an individual who has been enrolled in a pharmacy benefit management plan.

(g) "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. However, "health insurance coverage" shall not include benefits due under the workers' compensation laws of this or any other state.

(h) "Pharmacy benefit manager" means a business that administers the prescription drug/device portion of health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. For purposes of this act, a "pharmacy benefit manager" shall not include the pharmacy benefit manager of the State and School Employees Health Insurance Plan or the Division of Medicaid or its contractors when performing services for the Division of Medicaid.

(i) "Pharmacy benefit management plan" means an arrangement for the delivery of pharmacist's services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist's services for an enrollee on a prepaid or insured basis which (i) contains one or more incentive arrangements intended to influence the cost or level of pharmacist's services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist's services; and (ii) requires or creates benefit payment differential incentives for enrollees to use under contract with

the pharmacy benefit manager. A pharmacy benefit plan does not mean any employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, 29 USCS Section 1002(1)), which is self-insured or self-funded.

(j) "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

(k) "Uniform claim form" means a form prescribed by rule by the State Board of Pharmacy.

(l) "Plan sponsors" means the employers, insurance companies, unions and health maintenance organizations that contract with a pharmacy benefit manager for delivery of prescription services.

SECTION 2. (1) No person or organization shall establish or operate a pharmacy benefit manager in this state to provide pharmacy benefit management plans without obtaining a certificate of authority from the State Board of Pharmacy in accordance with this act and all applicable federal and state laws. All pharmacy benefit managers providing pharmacy benefit management plans in this state shall obtain a certificate of authority from the State Board of Pharmacy every four (4) years.

(2) A nonrefundable application fee of Five Hundred Dollars ($500.00) shall accompany each application for a certificate of authority.

(3) The board may suspend or revoke any certificate of authority issued to a pharmacy benefit manager under this act or deny an application for a certificate of authority if it finds:

(a) That the pharmacy benefit manager is operating significantly in contravention of its basic organizational document.

(b) The pharmacy benefit manager does not arrange for pharmacist's services.

(c) That the pharmacy benefit manager has failed to meet the requirements for issuance of a certificate of authority as set forth in this act and all applicable federal and state laws.

(d) That the pharmacy benefit manager is unable to fulfill its obligation to furnish pharmacist's services as required under its pharmacy benefit management plan.

(e) The pharmacy benefit manager is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The pharmacy benefit manager, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.

(g) The continued operation of the pharmacy benefit manager would be hazardous to its enrollees.

(h) The pharmacy benefit manager has failed to file an annual financial statement, as prescribed by the board, with the board in a timely manner.

(i) The pharmacy benefit manager has otherwise failed to substantially comply with this act and any rules and regulations under this act.

When the certificate of authority of a pharmacy benefit manager is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. The board may permit such further operation of the organization as the board may find to be in the best interest of enrollees to the end that the enrollees will be afforded the greatest practical opportunity to obtain pharmacist's services.

SECTION 3. (1) Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products

and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefit manager, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the nonelectronic claim.

(2) Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.

(3) (a) All benefits payable under a pharmacy benefit management plan shall be paid within ten (10) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within ten (10) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by an pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefit manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that

prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

(b) A clean claim does not include any of the following:

(i) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

(ii) Claims which are submitted fraudulently or that are based upon material misrepresentations;

(iii) Claims that require information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits or subrogation provisions under the plan sponsor's health insurance plan; or

(iv) Claims submitted by a pharmacist or pharmacy more than thirty (30) days after the date of service; if the pharmacist or pharmacy does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the pharmacist or pharmacy to the insured.

(c) Not later than ten (10) days after the date the pharmacy benefit manager actually receives an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist

or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the pharmacy benefit manager shall be paid within twenty (20) days after receipt.

(4) Any pharmacy benefit manager, agent or other party responsible for reimbursement for prescription drugs and other products and supplies that does not comply with the requirements of this section shall be subject to administrative penalty provisions to the extent of any amount not paid in accordance with the requirements of this section. Such penalties shall be assessed on the following basis:

(a) If the board finds that a pharmacy benefit manager, during any calendar year, has paid at least eighty-five percent (85%), but less than ninety-five percent (95%), of all clean claims, as defined in Section 3 of this act, received from all pharmacists or pharmacies during that year, the board may levy an aggregate penalty in an amount not to exceed Ten Thousand Dollars ($10,000.00). If the board finds that a pharmacy benefit manager, during any calendar year, has paid at least fifty percent (50%), but less than eighty-five percent (85%), of all clean claims received from all pharmacists or pharmacies during that year, the board may levy an aggregate penalty in an amount of not less than Ten Thousand Dollars ($10,000.00) nor more than One Hundred Thousand Dollars ($100,000.00). If the board finds that a pharmacy benefit manager, during any calendar year, has paid less than fifty percent (50%) of all clean claims received from all pharmacists or pharmacies during that year, the board may levy an aggregate penalty in an amount not less than One Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred Thousand Dollars ($200,000.00). In determining the amount of any fine, the board

shall take into account whether the failure to adequately pay claims was due to circumstances beyond the control of the pharmacy benefit manager. The pharmacy benefit manager may request an administrative hearing to contest the assessment of any administrative penalty imposed by the board pursuant to this subsection within thirty (30) days after receipt of the notice of assessment.

(b) Examinations to determine compliance with this subsection may be conducted by the board or any of its examiners. The board may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the pharmacy benefit manager examined.

(c) Nothing in the provisions of this section shall require a pharmacy benefit manager to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance or prepaid coverage.

(e) The board may adopt rules and regulations necessary to ensure compliance with this subsection.

SECTION 4. (1) Coordination of benefit requirements adopted by pharmacy benefit managers shall, at a minimum, adhere to the following requirements:

(a) No plan shall contain a provision that its benefits are "always excess" or "always secondary" except in accordance with rules adopted by the board pursuant to this act.

(b) A coordination of benefit provision may not be used that permits a plan to reduce its benefits on the basis of any of the following:

(i) That another plan exists and the covered person did not enroll in the plan.

(ii) That a person is or could have been covered under another plan, except with respect to Part B of Medicare.

(iii) That a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

(2) The board shall be authorized to adopt such reasonable regulations as necessary for determining the order of benefit payments when a person is covered by two (2) or more plans of health insurance coverage.

SECTION 5. (1) As used in this section, "recoupment" shall mean a reduction, offset, adjustment or other act to lower or lessen the payment of a claim or any other amount owed to a pharmacy or pharmacist for any reason unrelated to that claim or other amount owed to a pharmacy or pharmacist.

(2) Prior to any recoupment unrelated to a claim for payment of prescription drugs, other products and supplies, and pharmacist services provided by a pharmacy or pharmacist or any other amount owed by a pharmacy benefit manager to a pharmacy or pharmacist, the pharmacy benefit manager shall provide the pharmacy or pharmacist written notification that includes the name of the patient, the date or dates of provision of prescription drugs, other products and supplies, and pharmacist services, and an explanation of the reason for recoupment. A pharmacy or pharmacist shall be allowed thirty (30) days from receipt of written notification of recoupment to appeal the pharmacy benefit manager's action and to provide the pharmacy benefit manager the name of the patient, the date or dates of provision of prescription drugs, other products and supplies, pharmacist services, and an explanation of the reason for the appeal.

(3) (a) When a pharmacy or pharmacist fails to respond timely and in writing to a pharmacy benefit manager's written notification of recoupment, the pharmacy benefit manager may consider the recoupment accepted.

(b) If a recoupment is accepted, the pharmacy or pharmacist may remit the agreed amount to the pharmacy benefit

manager at the time of any written notification of acceptance or may permit the pharmacy benefit manager to deduct the agreed amount from future payments due to the pharmacy or pharmacist.

(4) (a) If a pharmacy or pharmacist disputes a pharmacy benefit manager's written notification of recoupment and a contract exists between the pharmacy or pharmacist and the pharmacy benefit manager, the dispute shall be resolved according to the general dispute resolution provisions in the contract.

(b) If a pharmacy or pharmacist disputes a pharmacy benefit manager's written notification of recoupment and no contract exists between the pharmacy or pharmacist and the pharmacy benefit manager, the dispute shall be resolved as any other dispute under Mississippi law.

(5) If the recoupment directly affects the payment responsibility of the insured, the pharmacy benefit manager shall provide at the same time a revised explanation of benefits to the pharmacy or pharmacist and the covered person for whose claim the recoupment is being made. Unless the recoupment of a health insurance claim payment directly affects the payment responsibility of the insured, such recoupment shall not result in any increased liability of an insured.

(6) For purposes of this section, a pharmacy benefit manager shall include its agent or any other party that makes payment directly to a pharmacy or pharmacist for prescription drugs, other products and supplies, and pharmacist services identified on a claim.

SECTION 6. (1) Whenever the board has reason to believe that any pharmacy benefit manager is not in full compliance with the requirements of this act, he shall notify such pharmacy benefit manager and, after notice and opportunity for hearing pursuant to law, the board shall issue and cause to be served an order requiring the pharmacy benefit manager to cease and desist from any violation and order any one or more of the following:

(a) Payment of a monetary penalty of not more than One Thousand Dollars ($1,000.00) for each and every act or violation, not to exceed an aggregate penalty of One Hundred Thousand Dollars ($100,000.00). However, if the pharmacy benefit manager knew or reasonably should have known that it was in violation of this act, the penalty shall be not more than Twenty-five Thousand Dollars ($25,000.00) for each and every act or violation, but not to exceed an aggregate penalty of Two Hundred Fifty Thousand Dollars ($250,000.00) in any six-month period.

(b) Suspension or revocation of the certificate of authority of the pharmacy benefit manager to operate in this state if it knew or reasonably should have known it was in violation of this act.

(2) Any pharmacy benefit manager who violates a cease and desist order issued by the board pursuant to this section while such order is in effect shall, after notice and opportunity for hearing, be subject at the discretion of the board to any one or more of the following:

(a) A monetary penalty of not more than Twenty-five Thousand Dollars ($25,000.00) for each and every act or violation, not to exceed an aggregate of Two Hundred Fifty Thousand Dollars ($250,000.00).

(b) Suspension or revocation of the certificate of authority of the pharmacy benefit manager to operate in this state.

(3) All fines imposed under this section shall be deposited into the Board of Pharmacy Special Fund to defray the expenses of administering this act.

SECTION 7. (1) Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year.

(2) The statement shall be on forms prescribed by the board and shall include:

(a) A financial statement of the organization, including its balance sheet and income statement for the preceding year;

(b) The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year; and

(c) Any other information relating to the operations of the pharmacy benefit manager required by the board under this act.

(3) If the pharmacy benefit manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within thirty (30) days of the report being final.

(4) The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However, the board shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by subsection (1) of this section. Any pharmacy benefit manager which fails to file its annual statement within the time prescribed by this section may have its license revoked by the board or its certificate of authority revoked or suspended by the board until the annual statement is filed. The board may waive the requirements for filing financial information for the pharmacy benefit manager if an affiliate of the pharmacy benefit manager is already required to file such information under current law.

SECTION 8. (1) In lieu of or in addition to making its own financial examination of a pharmacy benefit manager, the board may accept the report of a financial examination of other persons responsible for the pharmacy benefit manager under the laws of another state certified by the applicable official of such other state.

(2) The board shall coordinate financial examinations of a pharmacy benefit manager that provides pharmacy management benefit plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation. The pharmacy benefit manager being examined shall pay the cost of the examination. The cost of the examination shall be deposited in a special fund that shall provide all expenses for the regulation, supervision and examination of all entities subject to regulation under this act.

SECTION 9. (1) The expense of administering this act shall be assessed annually by the board against all pharmacy benefit managers operating in this state. Before determining the assessment, the board shall determine an estimate of all expenses for the regulation, supervision and examination of all entities subject to regulation under this act. The assessment shall be in proportion to the business done in this state.

(2) All fees assessed under this act and paid to the board shall be deposited in a special fund that shall provide all expenses for the regulation, supervision and examination of all entities subject to regulation under this act.

(3) The board shall give each pharmacy benefit manager notice of the assessment, which shall be paid to the board on or before March 1 of each year. Any pharmacy benefit manager that fails to pay the assessment on or before the date herein prescribed shall be subject to a penalty imposed by the board. The penalty shall be ten percent (10%) of the assessment and interest for the period between the due date and the date of full payment. If a payment is made in an amount later found to be in error, the board shall: (a) if an additional amount is due, notify the company of the additional amount and the company shall pay the additional amount within fourteen (14) days of the date of the notice; or (b) if an overpayment is made, order a refund.

(4) If an assessment made under this act is not paid to the board by the prescribed date, the amount of the assessment, penalty and interest may be recovered from the defaulting company on motion of the board made in the name and for the use of the state in the appropriate circuit court after ten (10) days' notice to the company. The license of any defaulting company to transact business in this state may be revoked or suspended by the board until it has paid such assessment.

SECTION 10. (1) Any pharmacy benefit manager that contracts with a pharmacy or pharmacist to provide pharmacist's services through a pharmacy management plan for enrollees in this state shall file such contract forms with the board thirty (30) days before the execution of such contract. The contract forms shall be deemed approved unless the board disapproves such contract forms within thirty (30) days after filing with the board. Disapproval shall be in writing, stating the reasons therefor and a copy thereof delivered to the pharmacy benefit manager. The board shall develop formal criteria for the approval and disapproval of pharmacy benefit manager contract forms.

(2) The pharmacy benefit manager is required to provide a contract to the pharmacy that is written in plain English, using terms that will be generally understood by pharmacists.

(3) Any pharmacy benefit manager that contracts with a pharmacy or pharmacist to provide pharmacist's services through a pharmacy management plan for enrollees in this state on behalf of any health plan sponsors shall be identified as the agent of such health plan sponsors. The health plan fiduciary responsibilities shall transfer to the contracting pharmacy benefit manager.

(4) Each contract shall apply the same coinsurance, co-payment and deductible to covered drug prescriptions filled by a pharmacy provider who participates in the network.

(5) Nothing in this section shall be construed to prohibit a contract from applying different coinsurance, co-payment and

deductible factors between generic and brand name drugs that an enrollee may obtain with a prescription, unless such limit is applied uniformly to all pharmacy providers in the insurance policy's network.

(6) No pharmacy benefit management plan shall mandate any pharmacist to change an enrollee's maintenance drug unless the prescribing physician and the enrollee agree to such plan.

(7) A pharmacy's participation in any plan or network offered by a pharmacy benefit manager is at the option and the discretion of the pharmacy. The pharmacy's participation or lack of participation in one (1) plan shall not effect their participation in any other plan or network offered by the pharmacy benefit manager.

(8) Any pharmacy benefit manager that initiates an audit of a pharmacy under the provisions of the contract shall limit methods and procedures that are recognized as fair and equitable for both the pharmacy benefit manager and the pharmacy. Extrapolation calculations in an audit are prohibited. Pharmacy benefit managers shall not recoup any monies due from an audit by setoff from future remittances until the results of the audit are resolved and finalized by both the pharmacy benefit manager and the pharmacy. In the event the findings of an audit cannot be finalized and agreed to by both parties, then the board shall establish an independent review board to adjudicate unresolved grievances.

(9) Prior to the terminating of a pharmacy from the network, the pharmacy benefit manager must give the pharmacy a written explanation of the reason of termination thirty (30) days before the actual termination unless contract termination action is taken in reaction to (a) loss of the pharmacy's license to practice pharmacy or loss of professional liability insurance; or (b) conviction of fraud or misrepresentation in the contract. The

pharmacy may request and receive within thirty (30) days a review of the proposed termination by the board before such termination.

(10) The pharmacy shall not be held responsible for actions of the pharmacy benefit manager or plan sponsors and the pharmacy benefit manager or plan sponsors shall not be held responsible for the actions of the pharmacy.

SECTION 11. (1) The board shall develop formal investigation and compliance procedures with respect to complaints by plan sponsors, pharmacists or enrollees concerning the failure of a pharmacy benefit manager to comply with the provisions of this act. If the board has reason to believe that there is a violation of this act, it shall issue and serve upon the pharmacy benefit manager concerned, a statement of the charges and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty (30) days after notice is served. The notice shall require the pharmacy benefit manager to show cause why an order should not be issued directing the alleged offender to cease and desist from the violation. At such hearing, the pharmacy benefit manager shall have an opportunity to be heard and to show cause why an order should not be issued requiring the pharmacy benefit manager to cease and desist from the violation.

(2) The board may make an examination concerning the quality of services of any pharmacy benefit manager and pharmacists with whom the pharmacy benefit manager has contracts, agreements or other arrangements pursuant to its pharmacy benefit management plan as often as the board deems necessary for the protection of the interests of the people of this state. The pharmacy benefit manager being examined shall pay the cost of the examination.

SECTION 12. (1) No pharmacy benefit manager or its representative may cause or knowingly permit the use of: (a) advertising that is untrue or misleading; (b) solicitation that is untrue or misleading; or (c) any form of evidence of coverage that is deceptive.

(2) No pharmacy benefit manager, unless licensed as an insurer, may use in its name, contracts or literature (a) any of the words "insurance," "casualty," "surety," "mutual"; or (b) any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or fidelity and surety insurer doing business in this state.

(3) No pharmacy benefit manager shall discriminate on the basis of race, creed, color, sex or religion in the selection of pharmacies for participation in the organization.

(4) No pharmacy benefit manager shall unreasonably discriminate against pharmacists when contracting for pharmacist's services.

(5) The pharmacy benefit manager shall be entitled to access to usual and customary pricing only for comparison to the reimbursement of a specific claims payment made by the pharmacy benefit manager. Usual and customary pricing is confidential and any other use or disclosure by the pharmacy benefit manager is prohibited.

(6) A pharmacy benefit manager may not move a plan to another payment network unless it receives written consent from the plan sponsor.

(7) No pharmacy benefit manager shall receive or accept any rebate, kickback or any special payment or favor or advantage of any valuable consideration or inducement for switching a patient's drug product unless it is specified in a written contract that has been filed with the board thirty (30) days before the execution of such contract.

(8) Claims paid by the pharmacy benefit manager shall not be retroactively denied or adjusted after seven (7) days from adjudication of such claims. In no case shall acknowledgement of eligibility be retroactively reversed. The pharmacy benefit manager shall be allowed retroactive denial or adjustment in the

event: (a) the original claim was submitted fraudulently; (b) the original claim payment was incorrect because the provider was already paid for services rendered; or (c) the services were not rendered by the pharmacists.

(9) No pharmacy benefit manager shall terminate a pharmacy from a network because: (a) they express disagreement with a pharmacy benefit manager's decision to deny or limit benefits to an eligible person; (b) a pharmacist discusses with a current, former or prospective eligible person any aspect of such person's medical condition or treatment alternatives whether a covered service or not; (c) of the pharmacist's personal recommendations regarding selecting a pharmacy benefit manager based on the pharmacist's personal knowledge of the health needs of such person; (d) of the pharmacy's protesting or expressing disagreement with a medical decision, medical policy or medical practice of a pharmacy benefit manager; (e) the pharmacy has in good faith communicated with or advocated on behalf of one or more of the pharmacy's current, former or prospective person regarding the provisions, terms or requirements of the pharmacy benefit manager's health benefit plans as they relate to the needs of such persons regarding the method by which the pharmacy is compensated for services provided under such agreement with the pharmacy benefit manager.

(10) No pharmacy benefit manager shall terminate a pharmacy from a network or otherwise penalize a pharmacy solely because of the pharmacy's invoking of the pharmacy's right under this agreement or applicable law or regulation.

(11) Termination from a network for reason of competence and professional behavior shall not release the pharmacy benefit manager from the obligation to make any payment due to the pharmacy for services provided in special circumstances post-termination to the eligible persons at less than agreed upon rates.

(12) Participation or lack of participation by a pharmacy in a plan or network cannot effect participation in any other plan or network offered by the pharmacy benefit manager.

SECTION 13. Any disclosures from the pharmacy benefit manager to the enrollees shall be written in plain English, using terms that will be generally understood by lay readers and a copy of the disclosure shall be provided to all pharmacies that are members of the network. The following shall be provided to the pharmacy benefit manager's enrollees of a pharmacy benefit management plan at the time of enrollment or at the time the contract is issued and shall be made available upon request or at least annually:

(a) A list of the names and locations of all affiliated providers.

(b) A description of the service area or areas within which the pharmacy benefit manager shall provide pharmacist's services.

(c) A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure, if complaints may be resolved through a specified arbitration agreement.

(d) A notice that the pharmacy benefit manager is subject to regulation in this state by the State Board of Pharmacy.

(e) A prominent notice included within the evidence of coverage providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the prescription coverage that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the State Board of Pharmacy." Such notice shall also provide the toll-free telephone number, mailing address and electronic mail address of the State Board of Pharmacy.

SECTION 14. The enrollee in a pharmacy benefit management plan has the right to privacy and confidentiality in regard to pharmacist's services. This right may be expressly waived in writing by the enrollee or the enrollee's guardian.

SECTION 15. (1) If a pharmacy benefit manager becomes insolvent or ceases to be a company in this state in any assessable or license year, the company shall remain liable for the payment of the assessment for the period in which it operated as a pharmacy benefit manager in this state.

(2) In the event of an insolvency of a pharmacy benefit manager, the board may, after notice and hearing, levy an assessment on pharmacy benefit managers licensed to do business in this state. Such assessments shall be paid quarterly to the board, and upon receipt by the board shall be paid over into an escrow account in the special fund. This escrow account shall be solely for the benefit of enrollees of the insolvent pharmacy benefit manager.

SECTION 16. This act shall take effect and be in force from and after July 1, 2006.