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An Act To Protect Consumers from Unfair Practices Related to Pharmacy Benefits Management

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

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

G. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section ~~19134347~~, subsection ~~1~~, paragraph ~~A17~~.

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

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section ~~19134347~~, subsection ~~1~~, paragraph ~~A17~~.

Sec. 3. 24-A MRSA §601, sub-§28, as enacted by PL 2009, c. 581, §3, is repealed.

Sec. 4. 24-A MRSA §601, sub-§28-A is enacted to read:

28-A. Pharmacy benefits manager. Pharmacy benefits manager licensing fees may not exceed:

A. Original issuance fee, \$100; and

B. Renewal fee, \$100.

Sec. 5. 24-A MRSA §1913, as repealed and replaced by PL 2011, c. 443, §4, is repealed.

Sec. 6. 24-A MRSA §4317, sub-§12, as enacted by PL 2015, c. 450, §1, is repealed.

Sec. 7. 24-A MRSA §4317, sub-§13, as enacted by PL 2017, c. 44, §1, is repealed.

Sec. 8. 24-A MRSA c. 56-C is enacted to read:

CHAPTER 56-C

HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG BENEFITS

§ 4347. Definitions

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

1. Average wholesale price. "Average wholesale price" means the average wholesale price of a prescription drug as identified by a national drug pricing source selected by a health insurer. The average wholesale price must be identified by the 11-digit national drug code, as amended from time to time, for the prescription drug dispensed for the quantity dispensed.

2. Brand-name drug. "Brand-name drug" means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.

3. Carrier. "Carrier" has the same meaning as in section 4301-A, subsection 3. "Carrier" also includes the MaineCare program pursuant to Title 22, chapter 855 and the group health plan provided to state employees and other eligible persons pursuant to Title 5, section 285.

4. Compensation. "Compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, charge-backs or other payments or benefits of any kind.

5. Cost-sharing amount. "Cost-sharing amount" means the amount paid by a covered person as required under the covered person's health plan for a prescription drug at the point of sale.

6. Covered person. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health plan. "Covered person" includes the authorized representative of a covered person.

7. Dispensing fee. "Dispensing fee" means the professional fee incurred at the point of sale or service that pays for pharmacy costs, in excess of ingredient cost, associated with ensuring that possession of the appropriate prescription drug is transferred to a covered person.

8. Formulary. "Formulary" means a list of prescription drugs covered by a health plan and any tier levels applicable to a prescription drug.

9. Generic drug. "Generic drug" means a prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance and intended use. "Generic drug" includes a biosimilar product.

10. Health plan. "Health plan" has the same meaning as in section 4301-A, subsection 7.

11. Ingredient cost. "Ingredient cost" means the actual amount paid to a pharmacy provider by a carrier or the carrier's pharmacy benefits manager for a prescription drug, not including the dispensing fee or cost-sharing amount.

12. Mail order pharmacy. "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, by fax or through electronic submissions and to dispense medication to covered persons through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.

13. Maximum allowable cost. "Maximum allowable cost" means the maximum amount a health insurer will pay for a generic drug or brand-name drug that has at least one generic alternative available.

14. Network pharmacy. "Network pharmacy" means a licensed retail pharmacy or other pharmacy provider that contracts with a pharmacy benefits manager.

15. Pharmacy. "Pharmacy" means an established location, either physical or electronic, that is licensed by the State and that has entered into a network pharmacy contract with a pharmacy benefits manager or carrier.

16. Pharmacy and therapeutics committee. "Pharmacy and therapeutics committee" means a committee, board or equivalent body established by a carrier to develop and maintain formularies.

17. Pharmacy benefits manager. "Pharmacy benefits manager" means a person, business or other entity that, pursuant to a contract or under an employment relationship with a carrier, a self-insurance plan or other 3rd-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, self-insurance plan or other 3rd-party payer, including, but not limited to, processing and paying claims for prescription drugs, performing drug utilization review, processing drug prior authorization requests, adjudicating appeals or grievances related to prescription drug coverage, contracting with network pharmacies and controlling the cost of covered prescription drugs.

18. Pharmacy provider. "Pharmacy provider" means a retail pharmacy, mail order pharmacy or licensed pharmacist.

19. Retail pharmacy. "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy or a network of independent pharmacies that is licensed as a pharmacy by this State and that dispenses medications to the public.

§ 4348. Licensure of pharmacy benefits managers

Beginning January 1, 2020, a person may not act as a pharmacy benefits manager in this State without first obtaining a license from the superintendent in accordance with this section and paying the licensing fee required under section 601, subsection 28-A.

1. Applicant information. An applicant for licensure as a pharmacy benefits manager must file with the superintendent at least the following information:

- A. The name of the applicant;
- B. The address and telephone number of the applicant;
- C. The name and address of the applicant's agent for service of process in the State;
- D. The name and address of each person beneficially interested in the applicant; and

E. The name and address of each person with management or control over the applicant.

2. Qualification. The superintendent may issue a pharmacy benefits manager license to an applicant only if the superintendent is satisfied that the applicant possesses the necessary organization, expertise and financial integrity to supply the services sought to be offered.

3. Restrictions permitted. The superintendent may issue a pharmacy benefits manager license subject to restrictions or limitations, including the type of services that may be supplied or the activities in which the pharmacy benefits manager may engage.

4. Valid for 3 years. A license issued pursuant to this section is valid for a period of 3 years and must be renewed.

5. Nontransferable. A license issued pursuant to this section is not transferable.

6. Suspension, revocation or probationary license. The superintendent may suspend, revoke or place on probation a pharmacy benefits manager license under any of the following circumstances:

A. The pharmacy benefits manager has engaged in fraudulent activity that constitutes a violation of state or federal law;

B. The superintendent has received consumer complaints that justify an action under this subsection to protect the safety and interests of consumers;

C. The pharmacy benefits manager fails to pay the original issuance or renewal fee for the license; or

D. The pharmacy benefits manager fails to comply with a requirement set forth in this chapter.

7. Penalty for failure to obtain license. If a pharmacy benefits manager acts without obtaining a license pursuant to this section, the pharmacy benefits manager is subject to a fine of \$5,000 per day for the period the pharmacy benefits manager is found to be in violation.

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

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

10. Registration remains effective until January 1, 2020 or registration date. The registration of a pharmacy benefits manager issued during 2019 in accordance with former section 1913 remains valid until January 1, 2020 or the next yearly anniversary of the registration date, whichever is later. Upon expiration of that registration, the pharmacy benefits manager shall obtain a license under this section in order to do business in this State.

§ 4349. Oversight and contracting responsibilities

1. Compliance. A carrier is responsible for monitoring all activities carried out by the carrier, or all activities carried out on behalf of the carrier by a pharmacy benefits manager if the carrier contracts with a pharmacy benefits manager, related to a carrier's prescription drug benefits and for ensuring that all requirements of this chapter are met.

2. Fiduciary duty. A carrier that contracts with a pharmacy benefits manager to perform any activities related to the carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty to the carrier in the pharmacy benefits manager's management of activities related to the carrier's prescription drug benefits.

3. Contract requirements. A carrier may not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from:

A. Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's carrier if the cash price is less than the covered person's cost-sharing amount; or

B. Providing information to a state or federal agency, law enforcement agency or the superintendent when such information is required by law.

4. Excess payments at point of sale prohibited. A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of:

A. The applicable copayment for the prescription drug;

B. The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and

C. The amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier.

5. Adequate network. A carrier shall provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network. The superintendent may adopt rules as necessary to carry out the purposes of this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

§ 4350. Prescription drug pricing; maximum allowable cost

1. Single maximum allowable cost list. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider.

2. Listing of prescription drug. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug:

A. Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and

B. Is not obsolete and is generally available for purchase in this State from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

3. Changes to maximum allowable cost list. A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a process for removing a prescription drug from a maximum allowable cost list or modifying a maximum allowable cost for a prescription drug in a timely manner to remain consistent with changes to such costs and the availability of the drug in the national marketplace.

4. Disclosure. With regard to a pharmacy with which the carrier, or the pharmacy benefits manager under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits manager under contract with a carrier, shall:

A. Upon request, disclose the sources used to establish the maximum allowable costs;

B. Provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a maximum allowable cost list; and

C. At least once every 7 business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable payment available to a pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits manager under contract with a carrier.

5. Appeal procedure. A carrier, or a pharmacy benefits manager under contract with a carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug.

6. Resolution of appeals. A carrier, or a pharmacy benefits manager under contract with a carrier, shall respond to, investigate and resolve an appeal under subsection 5 within 14 days after the receipt of the appeal. The carrier or pharmacy benefits manager shall respond to an appeal as follows:

A. If the appeal is upheld, the carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or

B. If the appeal is denied, the carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost.

7. Average wholesale price; use of a prescription drug not on maximum allowable cost list.

A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a carrier, or a pharmacy benefits manager under contract with a carrier, must use only one national drug pricing source during a calendar year, except that a carrier, or a pharmacy benefits manager under contract with a carrier, may use a different national drug pricing source if the original pricing source is no longer available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

8. Payment. This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider.

A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier.

C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection.

D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

§ 4350-A. Responsibility to use compensation for benefit of covered persons

1. Compensation used to lower premiums. All compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier, or to a pharmacy benefits manager under contract with a carrier, related to its prescription drug benefits must be remitted to, and retained by, the carrier and must be used by the carrier to lower the premium for covered persons.

2. Compliance. Beginning March 1, 2021 and annually thereafter, a carrier shall file with the superintendent a report in the manner and form determined by the superintendent demonstrating how the carrier has complied with this section.

§ 4350-B. Prescription drug formularies; pharmacy and therapeutics committee

1. Pharmacy and therapeutics committee; use of formulary. A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a pharmacy and therapeutics committee. A carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the carrier's pharmacy benefits manager to use one or more formularies.

2. Pharmacy and therapeutics committee; no conflict of interest for members. A carrier, or a pharmacy benefits manager under contract with a carrier, may not allow a person with a conflict of interest to be a member of its pharmacy and therapeutics committee. A person may not serve as a member of a pharmacy and therapeutics committee if the person:

A. Is employed, or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor; or

B. Receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

3. Compensation prohibited. A carrier, or a pharmacy benefits manager under contract with a carrier, shall prohibit its pharmacy and therapeutics committee or any member of the committee from receiving any compensation from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

4. Accessibility of formulary. A carrier shall display any applicable formulary used for the carrier's health plan and the prescription drug benefit levels applicable to covered persons under that health plan on the carrier's publicly accessible website. The formulary and benefit levels must be electronically searchable by drug name and by any other means as required by the superintendent. The formulary and benefit levels available to a covered person must provide, for each drug on the formulary:

A. An indication of whether the drug is preferred under the carrier's health plan;

B. An indication of whether the drug requires prior authorization or has step therapy or quantity limit restrictions;

C. The specific tier the drug falls under, if the carrier's health plan uses a tiered formulary;

D. The applicability of any covered person's cost-sharing amount; and

E. Whether the drug is subject to a deductible and, if so, the deductible amount.

§ 4350-C. Access to records; audits

1. Requirements; record keeping. A carrier shall maintain and have the ability to access all data related to the administration and provision of prescription drug benefits under a health plan of a carrier, including, but not limited to:

A. The names, addresses, member identification numbers, protected health information and other personal information of covered persons; and

B. All contracts, documentation and records, including transaction and pricing data, related to the dispensing of prescription drugs to covered persons under the health plan.

2. Compliance with federal law. A sale or transaction involving the transfer of any records, information or data described in subsection 1 must comply with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the federal Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 and any regulations adopted pursuant to those laws.

3. Audit records. A carrier may audit all transaction records related to the dispensing of prescription drugs to covered persons under a health plan of the carrier. A carrier may conduct audits at a location of its choosing and with an auditor of its choosing.

4. Maintenance of records. A carrier shall maintain all records, information and data described in subsection 1 and all audit records described in subsection 3 for a period of no less than 5 years.

5. Authority of superintendent. Upon request, a carrier shall provide to the superintendent any records, contracts, documents or data held by the carrier or the carrier's pharmacy benefits manager for inspection, examination or audit purposes.

§ 4350-D. Treatment of pharmacy benefits manager compensation

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage.

B. "Pharmacy benefits manager compensation" means the difference between:

(1) The value of payments made by a carrier of a health plan to its pharmacy benefits manager; and

(2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health plan.

2. Pharmacy benefits manager compensation included as administrative cost.

If a carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation:

- A. Constitutes an administrative cost incurred by the carrier in connection with a health plan; and
- B. May not constitute a benefit provided under a health plan.

A carrier may claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim.

3. Calculation of pharmacy benefits manager compensation. Each rate filing submitted by a carrier with respect to a health plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager must include:

- A. A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and
- B. Such records and supporting information as the superintendent reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

4. Records. Upon request, a carrier shall provide any records to the superintendent that relate to the calculation of the pharmacy benefits manager compensation.

§ 4350-E. Effective date

This chapter takes effect January 1, 2020.

Sec. 9. Effective date. This Act takes effect January 1, 2020.

SUMMARY

This bill replaces the current registration requirement for pharmacy benefits managers doing business in this State with a licensing requirement beginning January 1, 2020. The bill imposes the following requirements on a carrier that provides prescription drug benefits.

1. It makes a carrier responsible for monitoring all activities carried out by the carrier, or all activities carried out on behalf of the carrier by a pharmacy benefits manager, related to a carrier's prescription drug benefits and for ensuring that all requirements of the law are met.

2. If a carrier contracts with a pharmacy benefits manager to perform any activities related to the carrier's prescription drug benefits, it makes the carrier responsible for ensuring that the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty to the carrier.

3. It prohibits a carrier from entering into a contract or agreement or allowing a pharmacy benefits manager or any person acting on the carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from providing a consumer with the option of paying the cash price for the purchase

of a prescription drug and not filing a claim with the consumer's carrier if the cash price is less than the covered person's cost-sharing amount or providing information to a state or federal agency, law enforcement agency or the Superintendent of Insurance when such information is required by law.

4. It prohibits a carrier or pharmacy benefits manager from requiring a consumer to make an excessive payment at the point of sale for a covered prescription drug.

5. It requires a carrier to provide a reasonably adequate retail pharmacy network and specifies that a mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network.

6. It replaces and updates current law related to the use of a maximum allowable cost list by a carrier or pharmacy benefits manager under contract with a carrier. It also clarifies how a carrier or pharmacy benefits manager may determine the average wholesale price of a brand-name drug or generic drug not included on the maximum allowable cost list.

7. It specifies how to calculate the amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug.

8. It requires that all compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier or to a pharmacy benefits manager related to its prescription drug benefits must be remitted to, and retained by, the carrier and used to lower the premium for covered persons. The bill requires a carrier to file annual reports beginning March 1, 2021 demonstrating how the carrier has complied with this requirement.

9. It requires a carrier to use a prescription drug formulary and specifies certain requirements for accessibility and disclosure of the formulary to covered persons. The bill also prohibits a carrier from allowing a person to be a member of its pharmacy and therapeutics committee if the member has a conflict of interest because of a relationship with, or compensation from, a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

10. It requires a carrier to maintain certain records related to the administration and provision of prescription drug benefits under a health plan and authorizes the carrier to audit those activities. The bill also authorizes the superintendent to have access to records upon request.

11. If a carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, it provides that any pharmacy benefits manager compensation constitutes an administrative cost incurred by a carrier for purposes of calculating the anticipated loss ratio. "Pharmacy benefits manager compensation" is defined in the bill as the difference between the value of payments made by a carrier of a health plan to its pharmacy benefits manager and the value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health plan.

12. It provides that the provisions in the bill take effect January 1, 2020.