SESSION OF 2026

SUPPLEMENTAL NOTE ON SENATE BILL NO. 360

As Amended by Senate Committee of the Whole

Brief*

SB 360, as amended, would enact the Kansas Consumer Prescription Protection and Accountability Act (Act). The bill would provide for the regulation of pharmacy benefit managers (PBMs), defining auditing procedures, outlining reporting requirements, and allowing compliance and financial examinations.

The bill would require PBMs to charge a health benefit plan the same price for a prescription drug as the PBM pays a pharmacy for the prescription drug, utilize the most recently published monthly National Average Drug Acquisition Cost (NADAC) as a point of reference, and reimburse pharmacies at an amount not less than the NADAC, plus a professional dispensing fee of $10.50. The bill would provide a reimbursement procedure for drugs not on the NADAC. The bill would also add and amend definitions in the Act, amend monetary penalty fees, and add a severability clause, among other conforming and technical changes.

Definitions (Section 10)

The bill would add to and amend definitions in the Act, including:

- "Covered entity" would mean a health insurance company; health maintenance organization; hospital; medical or dental corporation; health care corporation; any entity that provides, administers,

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at https://klrd.gov/

or manages a self-funded health benefit plan including a governmental plan; or any other entity that provides prescription drug coverage unless specifically excluded by the Act;

- "National Average Drug Acquisition Cost," or NADAC, would mean the monthly survey of retail pharmacies conducted by federal Centers for Medicare and Medicaid Services (CMS) to determine the average acquisition cost for Medicaid-covered outpatient drugs;

- "Pharmacy services administrative organization" would mean any entity that contracts with a pharmacy to assist with covered entity interactions and that may provide a variety of other administrative services, including contracting with PBMs on behalf of pharmacies and managing pharmacies' claim payments from covered entities; and

- "Rebate" would mean any and all payments that accrue to a PBM or such PBM's health plan client, directly or indirectly, from a pharmaceutical manufacturer, including, but not limited to, discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered on behalf of a health plan client. "Rebate" would not include any discount or payment that could be provided to or made to any 340B entity through such program.

Pharmacy Benefit Manager Audits (New Section 1)

The bill would outline requirements for auditing entities conducting a pharmacy audit under the Act, including:

- Keeping information collected during a pharmacy audit confidential. Auditing entities would be able to share the information with the PBM, the covered

entity for which the audit is being conducted, and any regulatory agency and law enforcement agency as required by law;

- Providing the pharmacy being audited with written notice at least 14 calendar days prior to conducting such audit unless both parties agree otherwise. If the pharmacy requests a delay of the audit, the pharmacy must provide notice to the PBM within 72 hours of receiving notice of the audit;

- Accepting paper or electronic signature logs documenting the delivery of prescription or non-proprietary drugs and pharmacist services to a health beneficiary or such beneficiary's caregiver or guardian;

- Providing a complete list of reviewed pharmacy records to an authorized representative of the pharmacy prior to leaving the pharmacy after the on-site portion of the audit has been completed;

- Providing the pharmacy with a written preliminary report of the pharmacy audit, to which the pharmacy would have at least 30 calendar days following receipt to respond. The preliminary report would be required to:
    - Be delivered to the pharmacy or the pharmacy's corporate parent within 60 calendar days after completion of the on-site portion of the audit;
    - Include contact information for the auditing entity conducting the audit and the contact information for an appropriate and accessible contact person so that the audit results, procedures, and any discrepancies can be reviewed; and
    - Include, but not be limited to, claim-level information for any discrepancy found and

total dollar amounts of claims subject to recovery;

- Delivering the final written report to the pharmacy or the pharmacy's corporate parent within 90 calendar days after the completion of the pharmacy audit. The report would be required to include any response provided to the auditing entity by the pharmacy or corporate parent and consider and address all such responses. The bill would provide for the report to be delivered electronically; and

- Providing, upon request of the plan sponsor, a copy of the final report, including the disclosure of any money recouped from the audit.

The auditing entity would be required to provide a copy of the report to the Commissioner of Insurance (Commissioner) upon request, but no report would include the protected health information of any individual.

An auditing entity conducting a pharmacy audit provided in this Act would be able to:

- Have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity, except as otherwise provided in federal or state law; and

- Not charge back, recoup, or collect penalties from a pharmacy until the time to file an appeal of a final pharmacy audit has passed or the appeals process has been exhausted, whichever would be later.

An auditing entity conducting a pharmacy audit as provided in the Act would not be able to:

- Compensate such entity's employees or contractors contracted to conduct a pharmacy audit

based solely on the amount claimed or the actual amount recouped during an audit;

- Initiate or schedule, during the first five days of any month, a pharmacy audit for any pharmacy averaging more than 600 prescriptions filled per week without the express consent of the pharmacy;
- Use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal law;
- Include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill; and
- Seek any fine, charge back, recoupment, or other adjustment for a dispensed product or any portion of a dispensed product unless one or more of the following has occurred:
    - The pharmacy has committed fraud or other intentional and willful misrepresentation, as evidenced by a review of the claims data, statements, physical review, or other investigative method;
    - The pharmacy has dispensed a product in excess of the benefit design as established by the plan sponsor;
    - The pharmacy has not filled prescriptions in accordance with the prescriber's order; or
    - An actual underpayment or overpayment has been made to the pharmacy.

The bill would state that any fee, charge back, recoupment, or other adjustment would be limited to the actual financial harm associated with the dispensed product or portion of the dispensed product or the actual underpayment or overpayment.

Audits Involving Clinical Judgment

The bill would state that a pharmacy audit involving clinical judgment would be conducted by or in consultation with a pharmacist. Such pharmacy audit could not cover:

- A period of more than 24 months after the date that a claim was submitted by the pharmacy to the PBM or covered entity unless a longer period is required by law; or

- More than 250 prescriptions. A refill would not constitute a separate prescription for the purposes of such audits.

When a pharmacy audit is performed, a pharmacy would be able to use:

- Authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital, or health care provider with prescriptive authority to validate the pharmacy record or delivery; or

- Any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, or other documentation outlined in the bill.

Errors and Appeals

Under the bill, a pharmacy being audited would not be subject to a charge back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy. The pharmacy would be able to appeal a final audit in accordance with procedures established by the entity conducting the pharmacy audit.

If an identified discrepancy in a pharmacy audit exceeds $25,000, future payments made by the PBM to the pharmacy in excess of such amount could be withheld pending adjudication of an appeal. No interest could accrue for any party during an audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.

Except for Medicare claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim could not be reversed unless the pharmacy or pharmacist obtained adjudication by fraud or misrepresentation of the claims events.

Exceptions

The provisions outlined for pharmacy audits would not apply if:

- Fraud, waste, abuse, or other intentional misconduct is indicated by physical review or review of claims data or statements; or
- Other investigating methods indicate that the pharmacy is or has been engaged in criminal wrongdoing, fraud, or other intentional or willful misrepresentation.

Auditing Entities (New Section 2)

The bill would state that no person could act or operate as an auditing entity without first registering with the Commissioner.

Each person seeking to register as an auditing entity would be required to file an application with the Commissioner upon a form prescribed by the Commissioner and accompanied by a non-refundable registration fee in an

amount not to exceed $500. At a minimum, the application would require:

- Identity, address, and telephone number of the applicant;
- Name, business address, and telephone number of the contact person for the applicant; and
- Federal employer identification number for the applicant, if applicable.

The Commissioner would issue a certificate of registration to an applicant if the Commissioner determines that the application is complete and the required registration fee is paid. The certificate of registration would be non-transferable and would prominently list the expiration date of the registration.

Each auditing entity registration would expire on March 31 of each year and would be renewed annually at the request of the pharmacy auditing entity on or before March 31 of each year. The application or renewal would be submitted by the auditing entity on a form prescribed by the Commissioner and accompanied by a renewal fee in an amount of no more than $250.

If a registered auditing entity fails to provide a completed application for renewal by March 31 or fails to pay the renewal fee, then a penalty fee would be assessed in an amount of no more than $250. The auditing entity would remit the renewal fee plus penalty fee before the Commissioner would issue the auditing entity's registration renewal.

An auditing entity's registration could be suspended by the Commissioner until the renewal application has been received and the renewal fee and any penalty assessed has been paid. Not later than December 1 of each year, the Commissioner would be required to set and publish such

required fees in the *Kansas Register* for the next calendar year.

Pharmacy Benefit Manager Reporting (New Section 3)

The bill would require each PBM to:

- Annually or more frequently upon the Commissioner's request, for each health plan or covered entity for which the PBM provides services, report the following in aggregate:
  - Amount of rebates received by the PBM;
  - Amount of rebates distributed to each health plan or covered entity contracted with the PBM;
  - Individual amount paid by the health plan or covered entity to the PBM for pharmacist services itemized by pharmacy, product, and goods and services; and
  - Individual amount that a PBM paid for pharmacist services itemized by pharmacy, product, and goods and services;
- Annually, report to the Commissioner and each contracted health plan or covered entity the aggregate difference between the amount that the PBM reimbursed pharmacies and the amount that the PBM charged a health plan;
- Quarterly, report to the Commissioner on all drugs appearing on the NADAC list that are reimbursed at 10 percent and below the national average drug acquisition cost and all drugs that are reimbursed at 10 percent or above the national average drug acquisition cost. For each drug in the report, the PBM would be required to include:
  - The month that the drug was dispensed;

- The quantity of the drug dispensed;
- The amount that the pharmacy was reimbursed;
- Whether the dispensing pharmacy was an affiliate of the PBM ;
- Whether the drug was dispensed pursuant to a government health plan; and
- The average national drug acquisition cost for the month that the drug was dispensed.

The PBM would be required to publish a copy of the report on the PBM's publicly available website for at least 24 months. The report would be exempt from the confidentiality requirements established in the bill.

Annually, each health benefit plan or covered entity would be required to report to the Commissioner the aggregate amount of credits, rebates, discounts, or other such payments received by the health benefit plan or covered entity from a PBM or drug manufacturer. Use of annual reporting provided pursuant to the bill by health benefit plans and covered entities would be limited to verification of data for compliance purposes.

No report provided to the Commissioner would include the protected health information of any individual. The required reports would be filed electronically on a form and in a manner prescribed by the Commissioner.

With the exception of the quarterly report outlined above, all data and information provided by the PBM, health plan, or covered entity, pursuant to reporting requirements established in the bill, would:

- Be considered proprietary and confidential; and
- Not be subject to disclosure under the Kansas Open Records Act (KORA).

Examinations for Compliance (New Section 4)

The bill would state that the Commissioner could examine the affairs of a PBM for compliance with the requirements of the Act and could do so whenever the Commissioner believes it is reasonably necessary. Every examination conducted would follow the examination procedures and requirements provided in current law, though the PBM would not be subject to the requirement that examinations must occur at least once every five years. The Commissioner would be able to assess the costs of the examination to the PBM.

No protected health information would be provided to the Commissioner for the purposes of examinations. The information and data obtained by the Commissioner from a PBM would be considered confidential by law, exempt from disclosure, and not subject to disclosure under KORA.

Requirements for Pharmacy Benefit Managers (New Section 5)

The bill would require PBMs to:

- Charge a health benefit plan the same price for a prescription drug as such PBM pays a pharmacy for the prescription drug; and

- Utilize the most recently published monthly national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the NADAC.

Under the bill, a PBM would not collect from a pharmacy, pharmacist, or pharmacy technician any cost share charged to a covered person that exceeds the total submitted charges by the pharmacy or pharmacist to the PBM.

PBMs would be required to reimburse a pharmacy, pharmacist, or pharmacy technician for a prescription drug or pharmacy service any amount that is not less than the NADAC for the prescription drug or pharmacy service at the time that the drug is administered or dispensed, plus a professional dispensing fee that is the greater of $10.50 or the dispensing fee calculated pursuant to regulation regarding reimbursement of pharmacy services.

If the NADAC cost is not available at the time that a drug is administered or dispensed, a PBM would not reimburse a pharmacy, pharmacist, or pharmacy technician an amount that is less than the wholesale acquisition cost of the drug as defined in federal law, plus a professional dispensing fee that is the greater of $10.50 or the dispensing fee calculated pursuant to regulation regarding reimbursement of pharmacy services. PBMs would not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service any amount less than the amount that the PBM would reimburse itself or an affiliate for the same prescription drug or pharmacy service.

PBMs would not be able to engage in any practice that:

- Includes imposing a point-of-sale fee or retroactive fee; or

- Derives any revenue from a pharmacy or covered person in connection with performing PBM services.

The provisions of this section would not be construed to prohibit PBMs from processing deductibles or copayments approved by a covered person’s health benefit plan.

Reimbursement Methodologies

Any methodology utilized by a PBM in connection with reimbursement would be filed with the Commissioner at the time of initial licensure and at any time thereafter that any methodology is changed by the PBM.

A methodology would not be subject to disclosure and would be treated as confidential and exempt from disclosure under KORA.

Every filed methodology would be required to comply with the provisions of the bill, and no PBM would be able to enter into a contract with a pharmacy that provides for reimbursement methodology that is impermissible under the bill.

The bill would require that any rebate not applied to reduce a covered person's defined cost sharing by the insurer would be passed on to the health plan. Nothing in the Act would be deemed to require or preclude an insurer from decreasing a covered person's defined cost sharing by the application of rebates. The bill would state that these provisions would not apply to self-funded health plans subject to the provisions of the federal Employee Retirement Income Security Act of 1974 (ERISA).

The Commissioner would be able to order reimbursement to a covered person, pharmacy, or dispenser who has incurred a monetary loss as a result of a violation of the Act.

Financial Examinations (Section 8)

The bill would provide for the Commissioner to make or direct to be made a financial examination or market regulation examination of any PBM that conducts business in Kansas. Such examination would be in accordance with the current version of the handbook adopted by the National Association

of Insurance Commissioners at the time the examination is announced by the Commissioner. The bill would subject PBMs to the same examination conditions and requirements as insurance companies.

Audits (Section 9)

The bill would apply the Act to any audit of the records of a pharmacy conducted by a managed care company, third-party payer, PBM, or any entity that represents a covered entity or health benefit plan and the registration of auditing entities.

Licensure of Pharmacy Benefit Managers (Section 11)

The Act would require the form for PBMs to apply for licensure to include an affidavit, executed by an officer or director of the PBM, affirming that any template contract submitted for this purpose is accurate and complete.

Current law requires PBM licensees to report any material change in the information required for their licensure to the Commissioner within 90 days or be subject to a fine of $500. The bill would raise the maximum amount for this fine to $2,000 per occurrence.

License Expiration, Renewal, and Revocation (Sections 12 and 16)

PBM Licensure Renewal

The bill would require the Commissioner to review a complete PBM licensure renewal application within 90 days of receipt, as well as any relevant information received, including quarterly and annual reports. If the Commissioner determines the application is incomplete or the PBM is not in compliance with the Act, the Commissioner would be required

to notify the applicant and specify the reason for denial of the application.

The bill would set March 31 of each year as the deadline for completed renewal applications. The bill would specify that if a PBM fails to provide the completed application or pay the license renewal fee by the deadline, the PBM would be assessed a fee of no more than $2,500, provided for in current law. The PBM would be required to remit the renewal fee plus the penalty fee before the Commissioner would issue the PBM's licensure renewal.

PBM Licensure Suspension

The Commissioner would be able to suspend or revoke a PBM's license until the renewal fee and any penalty assessed was paid.

To a list of reasons the Commissioner could revoke, suspend, or limit a PBM's license; the licensee could be censured or placed under probationary conditions; or an application for a license or for reinstatement of a license could be denied, the bill would add failure to furnish information requested during an examination or failure to timely submit the reporting required under the Act.

Auditing Entity License

If a registered auditing entity fails to provide a completed application for renewal by March 31, or if the license renewal fee is not paid by March 31, the bill would provide for a penalty fee of no more than $250 be assessed. The auditing entity would be required to remit the renewal fee plus the penalty fee before the Commissioner would issue the auditing entity's registration renewal.

Penalties (Section 14)

If a PBM is found to violate the Act, the Commissioner would be able to impose a monetary penalty of not more than $1,000 for each and every act or violation. The bill would remove the limitation that such penalties could not exceed $10,000.

If the Commissioner finds that a PBM knew or reasonably should have known that such manager was in violation of the Act, the bill would provide for a payment of a penalty not to exceed $5,000 for each and every act or violation. The bill would remove the limitation that such penalties could not exceed $50,000 in any six-month period.

In addition to any other penalty provided in the Act, the bill would provide for any person who acts as a PBM without being licensed as required by the Act to be subject to a fine not to exceed $100,000.

Copayments (Section 17)

The bill would state that copayments applied by a health carrier for a prescription drug would not exceed the total submitted charges by the network pharmacy.

Severability (New Section 6)

The bill would state that if any provision or application of the Act to any person or circumstance is held invalid, such invalidity would not affect other provisions or applications of the Act that could be given effect without the invalid provision or application.

Background

The bill was introduced by the Senate Committee on Financial Institutions and Insurance at the request of Senator Shallenburger.

Senate Committee on Financial Institutions and Insurance

In the Senate Committee hearing, **proponent** testimony was provided by the Commissioner and representatives of AuBurn Pharmacy, the National Community Pharmacists Association, Price Pharmacies, and the West Virginia Offices of the Insurance Commissioner. The Commissioner generally stated that the state currently has limited tools to regulate PBMs or assist Kansans with complaints regarding PBMs, and the bill would help increase transparency and accountability. Other proponent conferees noted that the provisions of the bill would help ensure adequate and fair reimbursement for pharmacies and discourage anti-competitive practices.

Written-only proponent testimony was provided by representatives of Cardinal Pharmacy (Hoisington), Cherryvale Pharmacy, Consumer's Pharmacy (Wichita), Corner Drug and Gift (Downs), Damm Pharmacies, El Dorado TrueCare Pharmacy, Four States Pharmacy (Galena), Graves Drug (Winfield), Greeley County Drug and Hamilton County Drug, Hesston Pharmacy and Harvey Drug, Hillsboro Hometown Pharmacy, Humboldt Pharmacy, Hy-Vee, Independent Pharmacy Association of Kansas, Jayhawk Pharmacy, Kansas Hospital Association, Kiowa County Pharmacy, Kollhoff Pharmacy and Compounding (Junction City), Main Street Pharmacy (Coldwater), Mankato Professional Pharmacy, Medical Pharmacy (Holton), The Medicine Store (Basehor), Midwest Family Health (Phillipsburg), Mulvane Pharmacy, Oakley Health Mart Pharmacy, Orchards Drug (Lawrence), Scott City Pharmacy, Walgreens, and Wolkar Drug (Baxter Springs), and many current and retired pharmacists, pharmacy students, pharmacy owners, and private citizens.

Opponent testimony was provided by representatives of Blue Cross and Blue Shield of Kansas, the Kansas Bankers Association, the Kansas Chamber of Commerce, Kansas Employers for Affordable Healthcare, Mid-America

Carpenters Regional Council, and Pharmaceutical Care Management Association. Conferees generally expressed concerns that the bill would increase costs for consumers and would benefit large retail pharmacies more than smaller, independent pharmacies.

Written-only opponent testimony was provided by AHIP, Cigna, and Prime Therapeutics.

No other testimony was provided.

The Senate Committee amended the bill to:

- Remove a requirement for PBMs to report the amount of rebates passed on to the enrollees of each health plan or covered entity at the point-of-sale that reduced such enrollee's applicable deductibles, copayments, coinsurance, or other cost-sharing amounts;
- Remove a requirement that a covered individual's defined cost sharing be calculated at the point-of-sale based on a price that is reduced by an amount equal to 100 percent of all rebates received or to be received in connection with the dispensing or administration of the prescription drug;
- Specify that any rebate not applied to reduce a covered person's defined cost sharing by the insurer would be passed on to the health plan, and that nothing in the Act would be deemed to require or preclude an insurer from decreasing a covered person's defined cost sharing by the application of rebates;
- Exempt self-funded health plans subject to ERISA from reimbursement and rebate requirements set by the bill; and
- Make technical corrections.

Senate Committee of the Whole

The Senate Committee of the Whole amended the bill to:

- Remove a requirement for a health benefit plan or covered entity to annually disclose to the Commissioner the extent to which credits, rebates, discounts, or other payments were passed on to reduce insurance premiums or rates;
- Remove a requirement for the Commissioner to consider the information in an annual health benefit plan or covered entity report when reviewing any premium rates charged for any individual or group accident and health insurance policy;
- Provide that use of annual reporting provided by health benefit plans and covered entities would be limited to verification of data for compliance purposes; and
- Specify that reporting provided to the Commissioner pursuant to the bill would not include protected health information.

Fiscal Information

According to the fiscal note prepared by the Division of the Budget on the bill, as introduced, the Kansas Department of Insurance (KDOI) states that the requirements of the bill would increase its expenditures by $413,363 from the Pharmacy Benefit Manager Licensure Fund in FY 2027. The agency would require 5.00 FTE positions at a cost of $375,863. Of that amount, $120,517 would be for 1.00 attorney position, $125,510 would be for 2.00 financial analyst positions, and $129,836 would be for 2.00 financial examiner positions. To support the new positions, the agency estimates it would also spend $37,500 on office supplies,

furniture, information technology equipment, and communication. For FY 2028, the agency estimates total expenditures of $393,716 from its fee fund to support the provisions of the bill. The bill would generate revenues from auditing entities when they register with KDOI; however, the amount that would be collected and deposited into the Pharmacy Benefit Manager Licensure Fund cannot be estimated. The bill could also generate additional revenues for the State General Fund from penalties and fines collected, but KDOI cannot estimate an amount.

The Office of Judicial Administration and the Office of the Attorney General both state that the bill would not have a fiscal effect. The Board of Pharmacy states that the bill would not have a fiscal effect because its regulatory functions would not be impacted if the bill is enacted. Any fiscal effect associated with the bill is not reflected in *The FY 2027 Governor's Budget Report*.

Kansas Consumer Prescription Protection and Accountability Act; pharmacy benefit managers; pharmacy audits; reporting; examinations