

SESSION OF 2020

**SUPPLEMENTAL NOTE ON SUBSTITUTE FOR HOUSE
BILL NO. 2598**

As Recommended by House Committee on
Insurance

Brief*

Sub. for HB 2598 would enact law and amend requirements requiring registration of pharmacy benefits managers with the Commissioner of Insurance (Commissioner) to instead require licensure under the Pharmacy Benefits Manager Licensure Act (PBM Licensure Act). The bill would establish new licensure, administration and enforcement, reporting, and business practice requirements on pharmacy benefits managers (PBMs); maintain regulation under Chapter 40, Article 38 of the *Kansas Statutes Annotated*; and add new sections to the PBM Licensure Act.

On and after January 1, 2021, a person could not perform, act, or do business in Kansas as a PBM unless the person holds a valid license issued by the Commissioner pursuant to the PBM Licensure Act.

***Licensure and Definitions (New Section 1; Sections 11,
12, 13, and 14)***

Disciplinary Action (New Section 1)

The bill would allow a PBM's license to be revoked, suspended, or limited, or the licensee to be censured or placed under probationary conditions, or an application for a

*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 <http://www.kslegislature.org>

license or reinstatement to be denied upon a finding of the existence of any of the following grounds:

- The applicant or licensee committed fraud or misrepresentation in applying for or securing an original, renewal, or reinstated license;
- The licensee has violated any lawful rule and regulation promulgated by the Commissioner or violated any lawful order or directive of the Commissioner previously entered by the Commissioner;
- The PBM has engaged in fraudulent activity that constitutes a violation of state or federal law;
- The Commissioner has received consumer complaints that justify an action under this section (discipline, licensure actions) to protect the safety and interest of consumers;
- The licensee has failed to furnish the Commissioner, or the Commissioner's investigators or representatives, any information legally requested by the Commissioner;
- The PBM has been determined by the Commissioner to be in violation or noncompliance with state or federal law; or
- The PBM has failed to submit a renewal application and the information required under KSA 40-3824. In lieu of a denial of a renewal application, the Commissioner could permit the PBM to submit to the Commissioner a corrective action plan to correct or cure any deficiencies.

PBM Licensure Act – KSA 40-3821 (Section 11)

PBM Licensure Act. The bill would designate KSA 2019 Supp. 40-3821 through 40-3828 and sections 1 through 10 of the bill as the PBM Licensure Act and would require, on and after January 1, 2021, PBMs performing, acting, or doing business in Kansas to hold a valid license issued by the Commissioner pursuant to this act.

The bill would amend law, previously applying to the registration of PBMs (licensed under provisions of this bill), to provide a license issued in accordance with this act is nontransferable.

PBM Licensure Act – KSA 40-3822 (Section 12)

Definitions. The bill would amend definitions associated with the regulation of PBMs to add definitions for the terms “department,” “health benefit plan,” “health insurer,” and “maximum allowable cost or MAC.” The bill would amend “pharmacy benefit manager” to include “PBM” in that term.

PBM Licensure Act – KSA 40-3823 (Section 13)

Application. The bill would update law requiring registration with the Commissioner to reflect licensure and would require new information to be included on the application form:

- Name, address, and telephone number of the PBM; and
- Name, address, phone number, email address, official position, and professional qualifications of each person responsible for setting MAC prices, including all persons with authority to modify MAC prices in response to MAC appeals.

Application fee. The bill would increase the nonrefundable application fee from \$140 (registration) to \$2,500 (licensure).

Other information. The Commissioner, upon receipt of an application would be permitted to require additional documentation or information necessary to verify the information contained in the application. The bill would also provide:

- Within 30 days of its receipt, the Commissioner may request additional information or submissions from an applicant for licensure and shall obtain any document or information reasonably necessary to verify the information contained in the application; and
- Within 90 days after the receipt of a completed application, the network adequacy report, and the applicable license fee, the Commissioner would be required to review the application and issue a license if the applicant is deemed qualified.

If the Commissioner determines the applicant is not qualified, the bill would require the Commissioner to notify the applicant and specify the reason for the denial.

PBM Licensure Act – KSA 40-3824 (Section 14)

License expiration, renewal. The bill would maintain the current registration expiration date of March 31 each, providing a PBM license would expire on March 31 and permitting annual renewal at the request of the licensee. The bill would increase the renewal fee from \$140 (registration) to \$2,500 (licensure) and would require any person performing pharmacy benefits management service on July 1, 2020, to obtain a license as a PBM by October 1, 2020, in order to continue to do business in Kansas.

Administration and Enforcement
(New Section 2; Sections 15, 16, and 17)

Enforcement (New Section 2)

The bill would permit the Commissioner to enforce provisions of this act as provided in law governing unfair or deceptive trade practices, in addition to using fines or other penalties the Commissioner may establish through rules and regulations.

PBM Licensure Act – KSA 40-3825 (Section 15)

Rules and regulations. The bill would require the Commissioner to adopt, amend, and revoke all necessary rules and regulations no later than July 1, 2022.

PBM Licensure Act – KSA 40-3826 (Section 16)

Fines. The bill would modify the fine associated with failure to register with the Commissioner (\$500) to a fine associated with failure to be licensed and set this fine at \$5,000 for the period of time the PBM is found to be in violation. The bill would further provide a PBM found to be in violation of or non-compliant with any state or federal law shall be subject to a fine of \$5,000 per violation and \$5,000 per occurrence of non-compliance.

PBM Licensure Act – KSA 40-3827 (Section 17)

Licensure fund. The bill would rename the PBM Registration Fund as the Pharmacy Benefits Manager Licensure Fund (Fund) and establish the Fund in the State Treasury, require administration by the Commissioner for costs associated with licensing, and provide for expenditures from this Fund. As in current law, all moneys deposited in the Fund would be credited to the Fund.

***Reporting Requirements; Transparency
(New Sections 3, 6, 8, and 9)***

Drug Rebates (New Section 3)

The bill would provide that all compensation remitted by, or on behalf of, a pharmaceutical manufacturer, developer, or labeler, directly or indirectly, to a carrier or to a PBM under contract with a covered entity or plan sponsor and related to its prescription drug benefits shall be:

- Remitted directly to the covered person at a point of sale to reduce the covered person's out-of-pocket cost associated with a particular prescription drug; or
- Remitted to and retained by the covered entity or plan sponsor. Compensation remitted to the covered entity shall be utilized by such covered entity or plan sponsor in its plan design in future plan years to offset premiums for covered persons.

Transparency Reporting (New Section 3)

Quarterly reporting. The bill would require, beginning with the second quarter of a contract between a PBM and a covered entity or plan sponsor, the PBM prepare a quarterly transparency report summarizing data relating to prescription drug benefits for the previous quarter. This bill would require this report to be submitted to the covered entity or plan sponsor before the end of the calendar quarter and to include the following information with respect to prescription drug benefits specific to the covered entity or plan sponsor:

- The aggregate paid claims count and aggregate dollar amount of payments made by the PBM to all pharmacies for all prescription drugs dispensed to the covered entity's or plan sponsor's covered persons during the previous calendar quarter;

- The aggregate dollar amount of rebates that the PBM expects to receive for all prescription drugs dispensed to the covered entity's or plan sponsor's covered persons during the previous calendar quarter;
- The aggregate dollar amount of any other fees or other compensation the PBM has received from a drug manufacturer or wholesale drug distributor related to the management or dispensing of prescription drugs to the plan sponsor's enrollees exclusive of prescription drugs rebates, as required in a separate reporting requirement in the bill;
- If the PBM has a contract, agreement, or other arrangement with a drug manufacturer to exclusively dispense or provide a drug to a covered entity's or plan sponsor's covered persons, and the application of all consideration or economic benefits collected or received pursuant to any such arrangement;
- Prescription drug utilization information for the covered entity's or plan sponsor's covered persons;
- De-identified claims level information in an electronic format that allows the covered entity or plan sponsor to sort and analyze the following information for each claim:
 - If the claim required prior authorization;
 - The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
 - Any spread between the net amount paid to the pharmacy (in the preceding requirement, amount paid to the pharmacy for each

prescription) and the amount charged to the plan sponsor;

- If the pharmacy is under common control or ownership with the PBM;
 - If the pharmacy is a preferred pharmacy under the plan;
 - If the pharmacy is a mail order pharmacy; and
 - If the covered entity's or plan sponsor's covered persons are required by the plan to use the pharmacy;
- The aggregate paid claims count and aggregate dollar amount of payments made by the PBM to pharmacies owned or controlled by the PBM on behalf of the sponsor's plan;
 - The aggregate paid claims amount and aggregate dollar amount of payments made by the PBM to pharmacies not owned or controlled by the PBM on behalf of the sponsor's plan; and
 - The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments made against network pharmacies, including point-of-sale fees and retroactive charges and the application of those amounts collected pursuant to the contract with the plan sponsor.

Nondisclosure agreement. The bill would allow a PBM to require a covered entity or plan sponsor to agree to a nondisclosure agreement that specifies the information reported under the reporting provisions in this bill is confidential and proprietary information. The bill would further state the PBM shall not be required to disclose the information to the plan sponsor until the plan sponsor has executed the nondisclosure agreement, if so required by the PBM.

Explanation of benefits (EOB). The bill would require, on or before the the 15th day of each month, the PBM provide each covered person with a full EOB for all claims processed during the previous calendar month for the covered person. The bill would require this EOB to be provided in a format approved by the Commissioner and, at a minimum for each prescription claim during the covered month, contain:

- The plan ID;
- The beneficiary ID;
- The National Drug Code (NDC) Number;
- The drug name;
- The quantity;
- The claim amount;
- Plan write-off amount;
- Fees and adjustments including any applied rebates;
- The covered person's cost-sharing amount;
- Ingredient reimbursement paid to the pharmacy;
- The professional dispensing fee paid to the pharmacy; and
- Any fee charged by the PBM to the pharmacy related to the specific claim.

The bill would permit EOB reports provided to a covered person to be delivered either by electronic mail or by U.S. Postal Service delivery.

Annual reporting. The bill would require, on and after July 1, 2021, each PBM to submit to the Commissioner an

annual transparency report containing data from the prior calendar year as it pertains to covered entities and plan sponsors doing business in Kansas. The report would be required to contain:

- The aggregate paid claims count and aggregate dollar amount of payments made by the PBM to all pharmacies for each therapeutic category of prescription drugs for all of the PBM's covered entity and plan sponsor clients, and such payments net of all rebates and other fees and direct or indirect payments that were credited against such payments from all sources;
- The aggregate dollar amount of all rebates that the PBM received from all drug manufacturers for all of the PBM's covered entity and plan sponsor clients. The aggregate dollar amount of all rebates must include any utilization discounts the PBM received from a drug manufacturer or wholesale drug distributor;
- The aggregate dollar amount of all fees from sources, direct or indirect, that the PBM received for all of the PBM's covered entity and plan sponsor clients;
- The aggregate dollar amount of all retained rebates and other fees (described in the first two paragraphs in this list) the PBM received from all sources, direct or indirect, that were not passed through to plan sponsors;
- The percentage of the aggregate dollar amount of all rebates the retained rebate and fees represents;
- The highest, lowest, and mean aggregate retained rebate and fees percentage for all of the PBM's plan sponsor clients; and

- De-identified claims level information in an electronic format that allows the Commissioner to sort and analyze the following information for each claim:
 - The drug and quantity for each prescription;
 - If the claim required prior authorization;
 - The patient's cost-sharing paid on each prescription (this data would be considered classified under provisions of the bill relating to information disclosed to the Commissioner);
 - The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges (this data would be considered classified under provisions of the bill);
 - Any spread between the net amount paid to the pharmacy (in the preceding provision, amount paid to the pharmacy) and the amount charged to the plan sponsor (this data would be considered classified under provisions of the bill);
 - The identity of the pharmacy for each prescription;
 - If the pharmacy is under common control or ownership with the PBM;
 - If the pharmacy is a preferred pharmacy under the plan;
 - If the pharmacy is a mail order pharmacy; and
 - If the covered entity's or plan sponsor's covered persons are required by the plan to use the pharmacy.

Calculation. The bill would require the aggregate retained rebate and fee percentage to be calculated for each plan sponsor for rebates and fees in the previous calendar year as follows:

- The total dollar amount of rebates and fees from all drug manufacturers for all utilization by covered persons of a covered entity or plan sponsor that were not passed through to the plan sponsor divided by the sum total dollar amount of all rebates and fees received from all sources, direct or indirect, for covered persons of a covered entity or plan sponsor.

Confidential and privileged information; legislative review. The bill would require data, documents, materials, or other information (information) in the possession or control of the Commissioner that are obtained by, created by, or disclosed to the Commission pursuant to the reporting requirements in this section be considered confidential and privileged. The bill would further provide such information is not subject to subpoena and is also not subject to discovery or admissible in evidence in any private civil action. The bill would permit the Commissioner to use the data, documents, materials, or other information in the furtherance of a regulatory or legal action brought as part of the Commissioner's official duties. The Commissioner would not be authorized otherwise to make this information public without the prior written consent of the PBM. The bill would further provide neither the Commissioner nor any person who received this information while acting under the authority of the Commissioner is permitted or required to testify in any private civil action concerning such information subject to the bill's provisions that is classified as confidential, protected nonpublic, or both. The provisions applying to confidential and privileged information would expire on July 1, 2025, unless the Legislature reviews and reenacts this provision pursuant to the legislative review requirements in the Kansas Open Records Act, prior to July 1, 2025.

Ownership Interest (New Section 6)

The bill would require a PBM that has a direct or indirect ownership interest through an affiliate or subsidiary in a pharmacy to disclose to its covered entity or plan sponsor client any difference between the amount paid to that pharmacy and the amount charged to the covered entity or plan sponsor client. With an exception specified in the bill, a PBM, covered entity, or plan sponsor would be prohibited from penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, co-payments, or coinsurance, to incentivize a covered person to use a specific retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy provider in which a PBM has an ownership interest or in which the pharmacy provider has an ownership interest in the PBM. (This provision would not apply if the PBM, covered entity, or plan sponsor offers a covered person the same financial incentives for using such pharmacies or pharmacy providers in which the PBM has no ownership interest.)

Limits, quantity and fill. The bill would prohibit a PBM, covered entity, or plan sponsor from imposing limits, including quantity or refill frequency limits, on a covered person's access to medication that differ based solely on whether the health carrier or PBM has an ownership interest in a pharmacy or whether the pharmacy has an ownership interest in the PBM. The bill would further state nothing in this prohibition on imposing limits should be construed to prohibit a PBM from imposing different limits, including quantity or refill frequency limits, on a covered person's access to medication based on whether the enrollee uses a mail order pharmacy or retail pharmacy in which the PBM or health carrier does not have an ownership interest with the same limits imposed.

Reimbursement. The bill would prohibit a PBM from reimbursing a pharmacy or pharmacist an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM providing the same

covered services. The bill would require the reimbursement amount paid to the pharmacy to be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy.

340B pharmacies. Under the bill, a PBM or health insurer could not prohibit a pharmacy authorized to participate in the federal 340B Drug Pricing Program (Section 340B, Public Health Service Act), or a pharmacy under contract with an entity authorized to participate in the program to provide pharmacy services, from participating in the PBM's or health insurer's provider network. A PBM or health insurer could not reimburse a pharmacy authorized to participate in the program or a pharmacy under contract with an entity participating in the federal 340B Drug Pricing Program differently from other similarly situated pharmacies. [*Note:* The federal 340B program provides discounts on outpatient prescription drugs to safety net providers.]

Declining to provide prescription drugs. The bill would allow any pharmacy that has a contract or pharmacist who has a contract, either directly or indirectly through a pharmacy services administrative organization (PSAO), with a PBM administering any type of drug or pharmacy benefit plan to provide covered drugs, devices, or services at a contractual reimbursement rate to decline to provide a covered drug, device, or service if the pharmacy or pharmacist is currently reimbursed or will be reimbursed at less than the acquisition cost for the covered drug, device, or service. The bill would further provide the pharmacy that or pharmacist who declines to provide the drug, device, or service must provide the customer with adequate information for the customer to determine where the prescription for the drug, device, or service may be filled.

The bill would prohibit PBMs, PSAOs or any person acting for, or on behalf of, a PBM or PSAO from canceling any contract with a pharmacy or pharmacist, suing for breach of contract, using the decision to decline as a cause for not

renewing the contract, or retaliating against or penalizing the pharmacy or pharmacist in any way for exercising the pharmacy's or pharmacist's rights under these provisions of the bill.

Specialty Pharmacy Notification (New Section 8)

The bill would require a PBM contracting with a specialty pharmacy to disclose to a covered person, upon the covered person's request, the covered person's out-of-pocket cost at the specialty pharmacy and the person's out-of-pocket cost at a retail pharmacy identified by the covered person as being an in-network pharmacy with the person's health plan, for the prescription drug referenced by the covered person.

A PBM would be required to allow any pharmacy that can legally obtain medications defined as specialty medications within a given health plan to provide those medications to a covered person upon such person's request.

Preferred Networks (New Section 9)

The bill would require a PBM using a preferred network of pharmacies to disclose to a covered person, upon the person's request, the covered person's out-of-pocket cost at the preferred pharmacy and the person's out-of-pocket cost at a nonpreferred pharmacy identified by the covered person as being an in-network provider with the covered person's health plan, for the prescription drug referenced by the covered person. The bill would further provide:

- A PBM shall not deny any pharmacy in good standing with the Board of Pharmacy (Board) the opportunity to participate in any pharmacy network at preferred participation status; and
- A PBM or its representative shall not cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal, or

other offer that is untrue, deceptive, or misleading to patients or the general public regarding access to pharmacies in a pharmacy network.

General Duties and Business Practices; MAC Pricing Law (New Sections 4-5, 7, 10; Sections 18-19)

Duties and Practices (New Section 4)

The bill would state a PBM has a fiduciary duty to a health carrier client and shall discharge that duty in accordance with all applicable provisions of state and federal law. The bill would further outline duties and business practice expectations on PBMs as follows:

- A PBM shall exercise good faith and fair dealing in the performance of its contractual duties. Any provision in a contract between a PBM and a covered entity or a network pharmacy that attempts to waive or limit this obligation is void;
- A PBM shall not charge a pharmacist or a pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:
 - The submission of a claim;
 - Enrollment or participation in a retail pharmacy network; or
 - The development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;
- A PBM shall not deny, limit, or terminate a pharmacy's contract based on the employment status of any employee who has an active license to dispense, despite probation status, with the Board;

- A PBM shall notify a covered entity in writing of any of its activities, policies, or practices that may directly or indirectly present a conflict of interest with the duties imposed in this section;
- A PBM shall not impose pharmacy accreditation standards or recertification requirements for a pharmacy to participate in a network that are inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state unless authorized under this act.

Network Adequacy and Access (New Section 5)

The bill would require a PBM to provide an adequate and accessible pharmacy network for the provision of prescription drugs. Retail pharmacy networks would be required to comply with the following access standards:

- At least 90 percent of covered persons in the health benefit plan's urban service area live within 2 miles of a retail pharmacy participating in the plan's retail pharmacy network;
- At least 90 percent of covered persons in the plan's urban service area live within 5 miles of a retail pharmacy participating in the plan's retail pharmacy network;
- At least 90 percent of covered persons in the plan's suburban service area live within 5 miles of a retail pharmacy designated as a preferred pharmacy participating in the plan's retail pharmacy network;
- At least 90 percent of covered persons in the health benefit plan's suburban service area live within 7 miles of a retail pharmacy designated as a preferred participating pharmacy in the health benefit plan's retail pharmacy network;

- At least 70 percent of covered persons in the plan's rural service area live within 15 miles of a retail pharmacy participating in the plan's retail pharmacy network;
- At least 70 percent of covered persons in the plan's rural service area live within 18 miles of a retail pharmacy designated as a preferred participating pharmacy in the plan's retail pharmacy network; and
- Mail order pharmacies cannot be used to meet access standards for retail pharmacy networks.

Report and waiver, Commissioner. The bill would require each PBM to submit an annual pharmacy network adequacy report to the Commissioner describing the pharmacy network and pharmacy accessibility in Kansas, with the PBM's license application and renewal, in a manner prescribed by the Commissioner. A PBM would be permitted to apply for a waiver from the Commissioner if the PBM is unable to meet the adequacy standards prescribed in the bill. The bill would require a waiver application to be submitted to the Commissioner on form prescribed by the Commissioner and:

- Demonstrate with specific data why the PBM is not able to meet the requirements; and
- Include a detailed action plan describing the steps that were and will be taken to address network adequacy.

If a waiver is granted, the bill would provide it would expire automatically after one year. If a renewal of a waiver is sought, the bill would require the Commissioner consider what steps the PBM has taken and how the PBM has addressed network adequacy over the past three-year period.

*Therapeutically Equivalent or Alternative Drug
(New Section 7)*

The bill would prohibit PBMs or health carriers from requiring or demonstrating preference for a pharmacy to dispense a therapeutically equivalent or therapeutically alternative drug that costs the enrollee more out-of-pocket than the prescribed drug, unless the substitution is made for medical reasons that benefit the patient. Substitution made under this section would be required to comply with the Pharmacy Act of the State of Kansas (Pharmacy Act).

*Retroactive Adjustments, Adjudication of Claims (New
Section 10)*

The bill would require a PBM to permit a pharmacy to collect the amount of a covered person's cost share from any source. The bill would further provide a PBM could not deny or reduce a reimbursement to a pharmacy or pharmacist after the adjudication of a disputed claim unless:

- The pharmacy or pharmacist fraudulently submitted the original claim;
- The original reimbursement was incorrect because:
 - The pharmacy or pharmacist had already been paid for the pharmacy service; or
 - An unintentional error resulted in an incorrect reimbursement; or
- The pharmacy service was not rendered by the pharmacy or pharmacist.

The bill would provide the provisions relating to denial and reductions in reimbursement would not apply if an investigative audit of pharmacy records for fraud, waste, abuse, or other intentional misrepresentation indicates the pharmacy or pharmacist engaged in criminal wrongdoing, fraud, or other intentional misrepresentation.

*Maximum Allowable Cost – KSA 40-3829 and 40-3830
(Sections 18-19)*

Definitions. The bill would amend law relating to MAC pricing and reimbursements to pharmacies. The bill would remove the definition of “list” and provide a broader definition for “maximum allowable cost list or MAC list”: a listing of drugs or other methodology used by a PBM, directly or indirectly, that sets the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product, or other prescription.

The bill would also expand the definition of “MAC” to include, without limitation:

- Average acquisition cost, including national average drug acquisition cost;
- Average manufacture price;
- Average wholesale price;
- Brand effective rate or generic effective rate;
- Discount indexing;
- Federal upper limits;
- Wholesale acquisition cost; and
- Any other term that a PBM or healthcare insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.

Reimbursement. The bill would add requirements on PBMs, directing a PBM to:

- Not pay or reimburse a pharmacy for the ingredient drug product component of pharmacist services in an amount less than the:

- Pharmacy's usual and customary price;
 - National average drug acquisition cost (NADAC); or
 - Pharmacy's wholesale acquisition cost if the NADAC is unavailable;
- Pay to every pharmacy a professional dispensing fee that is equal to the dispensing fee set in the State Program for Medical Assistance (Medicaid);
 - Use a single MAC list to establish the maximum amount to be paid to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A PBM would be required to use the same MAC list for each pharmacy provider;
 - Upon request of a network pharmacy, disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list for each plan sponsor and pharmacy network rate schedule that applies to the network pharmacy. A PBM would be required to make the MAC list available in its entirety, in a readily accessible format, to all contracted pharmacies;
 - Ensure that MAC prices are set at sufficient levels to ensure products are readily available to pharmacies to purchase at or below the MAC price established for similarly situated pharmacies within the PBM's preferred network;
 - Review and update each applicable MAC list every seven business days, noting any price changes from the previous list, including retroactive MAC adjustments based on successful MAC appeals by a participating pharmacy in a separate section of the list, provide a means by which network pharmacies may promptly review current prices in

an electronic, print, or telephone format and apply the updates to reimbursements no later than one business day at no cost to the pharmacy;

- Such information must be available to the pharmacy or pharmacy's representative in a comprehensible downloadable format that includes all NDCs, the unit MAC price allowed, and an identifying code connecting fee schedules and patients to the respective MAC list used to price claims for reimbursement [*Note*: current law referenced only the two time requirements relating to updates and reimbursements] and
- Ensure that MAC prices are not set below sources utilized by the PBM.

Appeals. The bill would create the following requirements on the PBM if an appeal for reimbursement of a drug subject to MAC is upheld:

- The PBM must adjust the MAC price not later than one business day after the date of determination and update the MAC price in the adjudication system so that the pharmacy may reverse and reprocess the claim for the increased reimbursement; and
- The PBM must also make the determined price applicable to all similarly situated network pharmacy providers. The PBM would be required to waive timely filing requirements to allow pharmacies the ability to reverse and reprocess claims to comply with these new provisions.

Technical Amendments

The bill would make several technical amendments, including changes of references of “pharmacy benefits manager” to “PBM.”

Background

The bill was introduced by the House Committee on Insurance at the request of Representative Bishop.

In the House Committee hearing on February 17, 2020, a representative of the Kansas Pharmacists Association, pharmacist owners or representatives of Graves Drug and Gibson’s Pharmacy, and the City of Winfield Human Resources Director testified as proponents. The former owner of Gardner Pharmacy (a registered pharmacist) and a State of Kansas retiree also testified as proponents. Proponents generally stated the bill would provide transparency, oversight, and accountability for PBMs and protect consumer choice. Proponents also stated the bill ensures PBMs do not steer patients into using mail-order pharmacies or mandate patients use pharmacies PBMs own and will ensure that patients are aware of the lowest cost drug available to them.

Written-only proponent testimony was provided by representatives of Balls Food Stores, Community Care Network of Kansas, Gregwire Drug Store, Kex Rx Pharmacy & Home Care, Latinis Rheumatology, the National Alliance of State Pharmacy Associations, the National Community Pharmacists Association, and Oakley Health Mart Pharmacy; a physician with Rose Hill Family MedCenter; the Chief Executive Officer of the William Newton Hospital; and the Superintendent for Winfield Public Schools. Private citizens, including pharmacists, also provided written-only proponent testimony.

In the House Committee hearing on February 19, 2020, opponent testimony was provided by representatives of

America's Health Insurance Plans, Cigna, the Kansas Chamber of Commerce, Pharmaceutical Care Management Association, and Prime Therapeutics. Opponents generally stated the bill would impede the PBMs' ability to negotiate lower drug prices and interferes with private contracts. Opponents also stated the bill would increase costs in the health care system and the new required transparency sections would damage the ability of PBMs to negotiate drug prices by allowing protected proprietary information to be made public.

Written-only opponent testimony was provided by a representative of Medica. No neutral testimony was provided.

The House Committee amended the bill to:

- Remove provisions relating to certain information to be submitted by PBMs to covered entities or plan sponsors (negotiated price for each therapeutic category of prescription drugs) and replace two references to "each therapeutic drug category of" with "all" in reference to prescription drugs dispensed during a reporting period;
- Remove provisions that would have required the annual transparency report (with limitations on data appearing in the report) to be published by the Commissioner within 60 days of receipt on the website of the Kansas Insurance Department (Department);
- Remove language prohibiting a PBM from retaining any portion of spread pricing;
- Add clarifying language in provisions applying to preferred pharmacies to reference pharmacies in good standing with the Board;
- Remove a health program administered by a department or the State in the capacity of provider

of health coverage from the definition of a “covered entity”; and

- Remove sections of the bill that would have amended the Pharmacy Audit Integrity Act (KSA 65-16,121 *et seq.*).

The House Committee recommended a substitute bill incorporating the amendments described above.

According to the revised fiscal note prepared by the Division of the Budget on the bill as introduced, the Department states enactment of the bill would require a more complex review of PBM applications and renewal materials. In addition, it would require the Department to review transparency reports, publish the transparency reports on its website, develop reports, review annual pharmacy network adequacy reports, and review waiver applications. As a result of these additional duties created by the bill, the Department would require 1.00 Policy Examiner FTE position at a cost of \$72,000 from its Insurance Department Service Regulation Fund in FY 2021. Of that amount, \$67,000 would be for salary and wage expenditures and \$5,000 would be for one-time office start-up costs.

The Board indicates it could receive additional complaint referrals from the Commissioner based on information received from PBMs and associated dispensing pharmacies that could constitute noncompliance with the Pharmacy Act. Any additional inspections and investigations to ensure compliance with the law would be absorbed within existing resources.

Since the original fiscal effect statement was issued, the Kansas Department of Health and Environment (KDHE) has provided information on the fiscal effect of this bill. KDHE states the bill would require it to make changes to the Medicaid information system because of the reimbursement changes set in the bill. In addition, the bill would require the PBM to also make system changes and those costs are

typically passed on to the managed care organization which in turn passes the cost onto the State. An exact dollar amount of the fiscal effect of the bill is unknown but, given the size of the Kansas Medicaid program, the additional expenditures could be significant. Any fiscal effect associated with the bill is not reflected in *The FY 2021 Governor's Budget Report*.

A revised fiscal note for the substitute bill, as recommended by House Committee, was not immediately available following House Committee action.