LEGISLATURE OF THE STATE OF IDAHO
Sixty-seventh Legislature Second Regular Session - 2024

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 596

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO PHARMACY BENEFIT MANAGERS; AMENDING SECTION 41-349, IDAHO CODE, TO DEFINE TERMS, TO PROVIDE A LIMIT ON CHARGES FOR HEALTH PLANS OR PROGRAMS AND TO PROVIDE EXCEPTIONS, TO REQUIRE REPORTING, TO ESTABLISH PROVISIONS REGARDING PRICING MODELS, TO ESTABLISH PROVISIONS REGARDING NETWORK PARTICIPATION, TO ESTABLISH PROVISIONS REGARDING ACCREDITATION STANDARDS, TO ESTABLISH PROVISIONS REGARDING CONTINUITY OF CARE FOR REVISIONS TO A FORMULARY, TO ESTABLISH PROVISIONS REGARDING ADMINISTRATIVE APPEALS, TO PROHIBIT CERTAIN ACTIONS OF A PHARMACY BENEFIT MANAGER, AND TO MAKE TECHNICAL CORRECTIONS; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-349, Idaho Code, be, and the same is hereby amended to read as follows:

41-349. PHARMACY BENEFIT MANAGERS. (1) As used in this section:

(a) "Brand name or generic effective rate" means the contractual rate set forth by a pharmacy benefit manager for the reimbursement of covered brand name or generic drugs, calculated using the total payments in the aggregate, by drug type, during the performance period. The effective rates are typically calculated as a discount from industry benchmarks, such as average wholesale price or wholesale acquisition cost.

(b) "Dispensing fee" means a fee intended to cover reasonable costs associated with providing a drug to a covered person. This cost includes but is not limited to the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.

(c) "Effective rate guarantee" means the minimum ingredient cost reimbursement a pharmacy benefit manager guarantees it will pay for pharmacist services during the applicable measurement period.

~~(a)~~ (d) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a generic drug.

(e) "Maximum allowable cost appeal pricing adjustment" means a retrospective positive payment adjustment made to a pharmacy by the pharmacy benefits plan or program or by the pharmacy benefit manager pursuant to an approved maximum allowable cost appeal request submitted by the same pharmacy to dispute the amount reimbursed for a drug based on the pharmacy benefit manager's listed maximum allowable cost price.

(f) "Participation contract" means any agreement between a pharmacy benefit manager and pharmacy for the provision and reimbursement of pharmacist services and any exhibits, attachments, amendments, or addendums to such agreement.

(g) "Pass-through pricing model" means a payment model used by a pharmacy benefit manager in which the payments made by the pharmacy benefits plan or program to the pharmacy benefit manager for the covered outpatient drugs are:

(i) Equivalent to the payments the pharmacy benefit manager makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the pharmacy benefit manager and its network of pharmacies. Such dispensing fee would be paid if the pharmacy benefits plan or program was making the payments directly; and

(ii) Passed through in their entirety by the pharmacy benefits plan or program or by the pharmacy benefit manager to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.

~~(b)~~ (h) "Pharmacy benefit manager" means a person or entity doing business in this state that contracts with pharmacies on behalf of an insurer, third-party administrator, or managed care organization to administer prescription drug benefits to residents of this state.

(i) "Spread pricing" means the practice in which a pharmacy benefit manager charges a pharmacy benefits plan or program a different amount for pharmacist services than the amount the pharmacy benefit manager reimburses a pharmacy for such pharmacist services.

(j) "Usual and customary price" means the amount charged to cash customers for a pharmacist service exclusive of sales tax or other amounts claimed.

(2) A person may not perform, offer to perform, or advertise any pharmacy benefit management service in this state unless the person is registered as a pharmacy benefit manager with the department of insurance. A person may not utilize the services of another person as a pharmacy benefit manager if the person knows or has reason to know that the other person does not have a registration with the department. Such registration must occur annually no later than April 1 of each year and shall be on a form prescribed by the director. The department may utilize applicable sections of this title to administer registration as provided in this subsection.

(3) A pharmacy benefit manager shall not prohibit a pharmacist or retail pharmacy from providing a covered person information on the amount of the cost share for a prescription drug and the clinical efficacy of a more affordable alternative drug if one is available, and a pharmacy benefit manager may not penalize a pharmacist or retail pharmacy for disclosing such information to a covered person or for selling to a covered person a more affordable alternative if one is available.

(4) A pharmacy benefit manager shall not directly or indirectly charge a pharmacy benefits plan or program a different amount for a prescription drug's ingredient cost or dispensing fee than the amount the pharmacy benefit manager reimburses a pharmacy for the prescription drug's ingredient cost or dispensing fee where the pharmacy benefit manager retains the amount of any such difference.

(5) The pharmacy benefit manager shall pass along or return one hundred percent (100%) of any manufacturer rebate to a pharmacy benefits plan or pro-

gram, including any payment, discount, incentive, fee, price concession, or other remuneration.

(6) The pharmacy benefit manager shall provide full and complete disclosure of:

(a) The cost, price, and reimbursement of the prescription drug to each health plan, payer, and pharmacy with which the pharmacy benefit manager has a contract or agreement to provide pharmacy benefit management services;

(b) Each fee, markup, and discount charged or imposed by the pharmacy benefit manager to each health plan, payer, and pharmacy with which the pharmacy benefit manager has a contract or agreement for pharmacy benefit management services; or

(c) The aggregate amount of all remuneration the pharmacy benefit manager receives from a prescription drug manufacturer for a prescription drug, including any rebate, discount, administration fee, and any other payment or credit obtained or agreement for pharmacy benefit management services to a health plan or payer.

~~(4)~~ (7) A pharmacy benefit manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the pharmacy benefit manager does the following:

(a) Ensures that the drug:

(i) 1. Is listed as ~~"A" or "B" rated~~ A-rated or B-rated 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

2. Has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(ii) Is available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(b) Provides to a network pharmacy, at the time a contract is entered into or renewed with the network pharmacy, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(c) Reviews and updates maximum allowable cost price information at least once every seven (7) business days to reflect any modification of maximum allowable cost pricing;

(d) Establishes a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(e) Establishes a process by which a network pharmacy, or a network pharmacy's contracting agent, may appeal the reimbursement for a generic drug no later than thirty (30) days after such reimbursement is made; and

(f) Provides a process for each of its network pharmacies to readily access the maximum allowable cost list specific to that provider.

~~(5)~~ (8) No pharmacy benefit manager may retroactively deny or reduce a claim for reimbursement of the cost of services after the claim has been adjudicated by the pharmacy benefit manager unless:

(a) The adjudicated claim was submitted fraudulently or improperly; or

(b) The pharmacy benefit manager's payment on the adjudicated claim was incorrect because the pharmacy or pharmacist had already been paid for the services.

~~(6)~~ (9) If the director finds a pharmacy benefit manager has violated this section or any provision of title 41, Idaho Code, then the director may subject the pharmacy benefit manager to any or all of the actions, penalties, and remedies referenced in sections 41-117, 41-1016, and 41-1026, Idaho Code.

(10)(a) No later than January 1, 2025, and each year thereafter, each licensed pharmacy benefit manager shall report to the director of the department of insurance the following information:

(i) The aggregate amount of the difference between the amount the pharmacy benefit manager paid each pharmacy on behalf of the health plan for prescription drugs; and

(ii) If at any time during the reporting year the pharmacy benefit manager moved or reassigned a prescription drug to a formulary tier that has a higher cost, higher copayment, higher coinsurance, higher deductible to a consumer, or lower reimbursement to a pharmacy, an explanation of the reason why the drug was moved or reassigned, including whether the move or reassignment was determined or requested by a prescription drug manufacturer or other entity.

(b) Any pharmacy benefit manager that owns, controls, or is affiliated with a pharmacy shall also report any difference in reimbursement rates or practices, direct and indirect remuneration fees or other price concessions, and clawbacks between a pharmacy that is owned, controlled, or affiliated with the pharmacy benefit manager and any other pharmacy.

(11) In addition to any other requirements in this title, all contractual arrangements executed, amended, adjusted, or renewed between a pharmacy benefit manager and a pharmacy benefits plan or program must include, in substantial form, requirements, to the extent allowable by law, to:

(a) Use a pass-through pricing model;

(b) Exclude terms that allow for the direct or indirect engagement in the practice of spread pricing;

(c) Ensure that funds received in relation to providing services for a pharmacy benefits plan or program or a pharmacy are used or distributed only pursuant to the pharmacy benefit manager's contract with the pharmacy benefits plan or program or with the pharmacy or as otherwise required by applicable law;

(d) Require the pharmacy benefit manager to pass one hundred percent (100%) of all prescription drug manufacturer rebates, including nonresident prescription drug manufacturer rebates, received to the pharmacy benefits plan or program, if the contractual arrangement delegates the negotiation of rebates to the pharmacy benefit manager, for the sole purpose of offsetting defined cost-sharing and reducing premiums of covered persons. Rebates include any payment, discount, incentive, fee, price concession, or other remuneration. Any excess rebate revenue after the pharmacy benefit manager and the pharmacy benefits plan or program have taken all actions required pursuant to this section must be used for the sole purpose of offsetting copayments and deductibles of covered persons;

(e) Include network adequacy requirements that meet or exceed medicare part D program standards for convenient access to the network pharmacies and that:

(i) Do not limit a network to solely include affiliated pharmacies;

(ii) Do not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program. The provisions of this subparagraph do not prohibit a pharmacy benefit manager from operating mail order or delivery programs on an opt-in basis at the sole discretion of a covered person, provided that the covered person is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs;

(iii) For the in-person administration of covered prescription drugs, prohibit requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider; and

(iv) Prohibit offering or implementing pharmacy networks that require or provide a promotional item or an incentive to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs or advertising, marketing, or promoting an affiliated pharmacy to covered persons. Provided, however, a pharmacy benefit manager may include an affiliated pharmacy in communications to covered persons regarding network pharmacies and prices as long as the pharmacy benefit manager includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. The provisions of this subparagraph may not be construed to prohibit a pharmacy benefit manager from entering into an agreement with an affiliated pharmacy to provide pharmacist services to covered persons;

(f) Prohibit a pharmacy benefit manager from conditioning participation in one (1) pharmacy network based on participation in any other pharmacy network or from penalizing a pharmacy for exercising its prerogative not to participate in a specific pharmacy network;

(g) Prohibit a pharmacy benefit manager from instituting a network that requires a pharmacy to meet accreditation standards inconsistent with or more stringent than applicable federal and state requirements for licensure and operation as a pharmacy in this state. However, a pharmacy benefit manager may specify additional specialty networks that require enhanced standards related to safety and competency necessary to meet the United States food and drug administration's limited distribution requirements for dispensing any drug that, on a drug-by-drug basis, requires extraordinary special handling, provider

coordination, or clinical care or monitoring when such extraordinary requirements cannot be met by a retail pharmacy. For purposes of this paragraph, drugs requiring extraordinary special handling are limited to drugs that are subject to a risk evaluation and mitigation strategy approved by the United States food and drug administration and that:

(i) Require special certification of a health care provider to prescribe, receive, dispense, or administer; or

(ii) Require special handling due to the molecular complexity or cytotoxic properties of the biologic or biosimilar product or drug. For participation in a specialty network, a pharmacy benefit manager may not require a pharmacy to meet requirements for participation beyond those necessary to demonstrate the pharmacy's ability to dispense the drug in accordance with the United States food and drug administration's approved manufacturer labeling;

(h) At a minimum, require the pharmacy benefit manager or pharmacy benefits plan or program to, upon revising its formulary of covered prescription drugs during a plan year, provide a sixty (60) day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the patient for a period of sixty (60) days. The sixty (60) day continuity-of-care period commences upon notification to the patient. This requirement does not apply if the covered prescription drug:

(i) Has been approved and made available over the counter by the United States food and drug administration and has entered the commercial market as such;

(ii) Has been removed or withdrawn from the commercial market by the manufacturer; or

(iii) Is subject to an involuntary recall by state or federal authorities and is no longer available on the commercial market;

(i) Require that in-network pharmacies receive dispensing fees that are not less than the Idaho medicaid fee for service dispensing fees in effect on the date of service; and

(j) Prohibit a pharmacy benefit manager from directly or indirectly charging or holding a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including:

(i) The adjudication of a pharmacy benefit claim;

(ii) The processing or transmission of a pharmacy benefit claim;

(iii) The development or management of a claim processing or adjudication network; or

(iv) Participation in a claim processing or adjudication network.

(12) In addition to other requirements in this title, a participation contract executed, amended, adjusted, or renewed between a pharmacy benefit manager and one (1) or more pharmacies or pharmacists must include, in substantial form, to the extent allowable by law, terms that ensure compliance with the provisions of this subsection.

(a) The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement

made under the maximum allowable cost as defined in subsection (1)(d) of this section for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist.

(b) The administrative appeal procedure must include a telephone number and email address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly to the pharmacy benefit manager or through a pharmacy service administration organization. The pharmacy or pharmacist must be given at least thirty (30) business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal.

(c) The pharmacy benefit manager must respond to the administrative appeal within thirty (30) business days after receipt of the appeal.

(i) If the appeal is upheld, the pharmacy benefit manager must:

1. Update the maximum allowable cost pricing information to at least the acquisition cost available to the pharmacy;

2. Permit the pharmacy or pharmacist to reverse and rebill the claim in question;

3. Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and

4. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information; or

(ii) If the appeal is denied, the pharmacy benefit manager must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state that have the drug currently in stock at a price below the maximum allowable cost pricing information.

(d) Every ninety (90) days, a pharmacy benefit manager shall report to the department the total number of appeals received and denied in the preceding ninety (90) day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this subsection.

(13) In addition to other prohibitions in this section, a pharmacy benefit manager may not do any of the following:

(a) Prohibit, restrict, or penalize in any way a pharmacy or pharmacist from disclosing to any person any information that the pharmacy or pharmacist deems appropriate, including but not limited to information regarding any of the following:

(i) The nature of treatment, risks, or alternatives thereto;

(ii) The availability of alternate treatment, consultations, or tests;

(iii) The decision of utilization reviewers or similar persons to authorize or deny pharmacist services;

(iv) The process used to authorize or deny pharmacist services or benefits;

(v) Information on financial incentives and structures used by the pharmacy benefits plan or program;

(vi) Information that may reduce the costs of pharmacist services;

(vii) Whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug;

(viii) A decision by the pharmacy to refuse to accept pharmacy benefit manager payment for the dispensing of an individual prescription on the basis of an aggregate pharmacy benefit manager payment of less than the pharmacy's costs to provide the service; or

(ix) The financial details of a prescription claim;

(b) Prohibit, restrict, or penalize in any way a pharmacy or pharmacist from disclosing information to the department, law enforcement, or state and federal governmental officials, provided that the recipient of the information represents that it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential and before disclosure of information designated as confidential, the pharmacist or pharmacy marks as confidential any document in which the information appears or requests confidential treatment for any oral communication of the information;

(c) Communicate at the point-of-sale, or otherwise require, a cost-sharing obligation for the covered person in an amount that exceeds the lesser of:

(i) The applicable cost-sharing amount under the applicable pharmacy benefits plan or program; or

(ii) The amount that will be retained by the pharmacy;

(d) Transfer or share records relative to prescription information containing patient-identifiable or prescriber-identifiable data to an affiliated pharmacy for any commercial purpose other than the limited purposes of facilitating pharmacy reimbursement, formulary compliance, or utilization review on behalf of the applicable pharmacy benefits plan or program;

(e) Fail to make any payment due to a pharmacy for an adjudicated claim with a date of service before the effective date of a pharmacy's termination from a pharmacy benefit network, unless payments are withheld because of fraud on the part of the pharmacy or except as otherwise required by law; or

(f) Terminate the contract of, penalize, or disadvantage a pharmacist or pharmacy due to a pharmacist or pharmacy:

(i) Disclosing information about pharmacy benefit manager practices in accordance with this section;

(ii) Exercising any of its prerogatives pursuant to this section; or

(iii) Sharing any portion, or all, of the pharmacy benefit manager contract with the department of insurance pursuant to a complaint or a query regarding whether the contract is in compliance with the provisions of this section.

SECTION 2. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after July 1, 2024.