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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2015

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A N A C T

RELATING TO INSURANCE -- HEALTH INSURANCE - PRESCRIPTION DRUG
BENEFITS

Introduced By: Senator William A. Walaska

Date Introduced: January 22, 2015

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-33 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-33. Drug coverage.** – (a) No group health insurer subject to the provisions of this
4 chapter that provides coverage for prescription drugs under a group plan master contract
5 delivered, issued for delivery, or renewed in this state may require any person covered under the
6 contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining
7 benefits for the drugs.

8 (b) No group health insurer shall refuse to contract with a qualified pharmacy provider
9 willing to meet the terms and conditions of the group health insurer for pharmacy participation.

10 (c) A group health insurer may not require a pharmacy provider to participate in one
11 network in order to participate in another network. The group health insurer may not exclude an
12 otherwise qualified pharmacy provider from participation in one network solely because the
13 pharmacy provider declined to participate in another network managed by the insurer.

14 This subsection shall not be construed to limit a group health insurer's ability to offer an
15 enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or
16 variations in the quantities of medications available to the enrollee, to encourage the use of
17 certain preferred pharmacy providers as long as the entity makes the terms applicable to the
18 preferred pharmacy providers available to all pharmacy providers. For purposes of this

1 subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms,
2 conditions and price that the carrier may require for its preferred pharmacy providers.

3 (d) The agreement between a group health insurer and a pharmacy provider shall not
4 require a pharmacy provider to assume liability for acts solely of the group health insurance
5 provider.

6 (e) Group health insurers shall distribute payments received for the services of a
7 pharmacy provider as required by law.

8 (f) No group health insurer shall terminate the contract of or penalize a pharmacy
9 provider solely as a result of the pharmacy provider's filing of a complaint, grievance or appeal.
10 Termination by mutual agreement shall not be restricted.

11 (g) No group health insurer shall terminate the contract of a pharmacy provider for
12 expressing disagreement with a group health insurer's decision to deny or limit benefits to an
13 enrollee, or because the pharmacy provider assists the enrollee to seek reconsideration of the
14 group health insurer's decision or because the pharmacy provider discusses alternative
15 medications.

16 (h) At least sixty (60) days before a group health insurer terminates a pharmacy
17 provider's participation in the plan or network, the group health insurer shall give the pharmacy
18 provider a written explanation of the reason for the termination, unless the termination is based on
19 either the loss of the pharmacy provider's license to practice pharmacy or cancellation of
20 professional liability insurance or a finding of fraud.

21 (i) Notwithstanding any other provision of law, when an on-site audit of the records of a
22 pharmacy provider is conducted by a group health insurer, the audit shall be conducted in
23 accordance with the following criteria:

24 (1) A finding of overpayment or underpayment must be based on the actual overpayment
25 or underpayment and not a projection based on the number of patients served having a similar
26 diagnosis or on the number of similar orders or refills for similar drugs, unless the projected
27 overpayment or denial is a part of a settlement agreed to by the pharmacy provider.

28 (2) The auditor may not use extrapolation in calculating recoupments or penalties.

29 (3) Any audit that involves clinical or professional judgment must be conducted by or in
30 consultation with a pharmacist.

31 (4) A group health insurer conducting an audit shall establish an appeals process under
32 which a pharmacy provider may appeal an unfavorable preliminary audit report to the insurer.

33 (5) This subsection shall not apply to any audit, review or investigation that is initiated
34 based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

1 (6) A preliminary audit report must be delivered to the pharmacy provider within sixty
2 (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty
3 (30) days following receipt of the preliminary audit to provide documentation to address any
4 discrepancy found in the audit. A final audit report must be delivered to the pharmacy provider
5 within ninety (90) days after receipt of the preliminary audit report or final appeal, whichever is
6 later. A charge-back, recoupment or other penalty may not be assessed until the appeal process
7 provided by the pharmacy benefits manager has been exhausted and the final report issued.
8 Except as provided by state or federal law, audit information may not be shared. Auditors may
9 have access only to previous audit reports on a particular pharmacy provider conducted by that
10 same entity.

11 (7) Prior to an audit, the group health insurer conducting an audit shall give the pharmacy
12 provider ten (10) days' advance written notice of the audit and the range of prescription numbers
13 and the range of dates included in the audit.

14 (8) A pharmacy provider has the right to request mediation by a private mediator, agreed
15 upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for
16 mediation does not waive any existing rights of appeal available to a pharmacy provider.

17 (j) Maximum allowable cost provisions:

18 (1) "Maximum allowable cost" means the maximum amount that a pharmacy benefits
19 manager will pay toward the cost of a drug.

20 (2) "Nationally available" means that all pharmacies in this state can purchase the drug,
21 without limitation, from regional or national wholesalers and that the product is not obsolete or
22 temporarily available.

23 (3) "Therapeutically equivalent" means the drug is identified as therapeutically or
24 pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

25 (4) A pharmacy benefits manager may not place a prescription drug on a maximum
26 allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if
27 the prescription drug does not have three (3) or more nationally available and therapeutically
28 equivalent drug substitutes.

29 (5) A pharmacy benefits manager shall remove a prescription drug from a maximum
30 allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and
31 modifications are necessary to remain consistent with changes in the national marketplace for
32 prescription drugs. Eliminations and modifications made under this subsection must be made in a
33 timely fashion.

34 (6) A pharmacy benefits manager shall disclose to a pharmacy for which the pharmacy

1 benefits manager processes claims, makes payment of claims or procures drugs:

2 (i) At the beginning of each calendar year, the basis of the methodology and the sources
3 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
4 by the pharmacy benefits manager.

5 (ii) At least once every seven (7) business days, the maximum allowable cost pricing
6 index or maximum allowable cost rates used by the pharmacy benefits manager.

7 (7) A pharmacy benefits manager shall give prompt written notification to a pharmacy
8 provider of any change made to a maximum allowable cost pricing index or maximum allowable
9 cost rates.

10 (8) A pharmacy benefits manager shall establish a procedure by which a pharmacy
11 provider may contest a maximum allowable cost rate. A procedure established under this
12 subsection must require a pharmacy benefits manager to respond to a pharmacy provider that has
13 contested a maximum allowable cost within fifteen (15) calendar days. If the pharmacy benefits
14 manager changes the rate, the change must:

15 (i) Become effective on the date on which the pharmacy provider initiated proceedings
16 under this subsection; and

17 (ii) Apply to all pharmacy providers in the network of pharmacy providers served by the
18 pharmacy benefits manager.

19 (9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the
20 pharmacy benefits manager has entered into a contract:

21 (i) At the beginning of each calendar year, the basis of the methodology and the sources
22 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
23 by the pharmacy benefits manager;

24 (ii) As soon as practicable, any change made to a maximum allowable cost pricing index
25 or maximum allowable cost rates;

26 (iii) Not later than twenty-one (21) business days after implementing the practice, the
27 utilization of a maximum allowable cost pricing index or maximum allowable cost rates for
28 prescription drugs dispensed at a retail community pharmacy provider; and

29 (iv) Whether the pharmacy benefits manager used identical maximum allowable cost
30 rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider
31 and, if the pharmacy benefits manager used different maximum allowable cost rates, the
32 difference between the amount billed and the amount reimbursed.

33 (k) The department of business regulation shall exercise oversight and enforcement of
34 this section.

1 SECTION 2. Section 27-19-26 of the General Laws in Chapter 27-19 entitled "Nonprofit
2 Hospital Service Corporations" is hereby amended to read as follows:

3 **27-19-26. Drug coverage.** – (a) No group health insurer subject to the provisions of this
4 chapter that provides coverage for prescription drugs under a group plan master contract
5 delivered, issued for delivery, or renewed in this state may require any person covered under the
6 contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining
7 benefits for the drugs.

8 (b) No nonprofit hospital service corporation shall refuse to contract with a qualified
9 pharmacy provider willing to meet the terms and conditions of the nonprofit hospital service
10 corporation for pharmacy participation.

11 (c) A nonprofit hospital service corporation may not require a pharmacy provider to
12 participate in one network in order to participate in another network. The nonprofit hospital
13 service corporation may not exclude an otherwise qualified pharmacy provider from participation
14 in one network solely because the pharmacy provider declined to participate in another network
15 managed by the insurer.

16 This subsection shall not be construed to limit a nonprofit hospital service corporation's
17 ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments
18 or coinsurance or variations in the quantities of medications available to the enrollee, to
19 encourage the use of certain preferred pharmacy providers as long as the entity makes the terms
20 applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes
21 of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified
22 terms, conditions and price that the carrier may require for its preferred pharmacy providers.

23 (d) The agreement between a nonprofit hospital service corporation and a pharmacy
24 provider shall not require a pharmacy provider to assume liability for acts solely of the group
25 health insurance provider.

26 (e) Nonprofit hospital service corporations shall distribute payments received for the
27 services of a pharmacy provider as required by law.

28 (f) No nonprofit hospital service corporation shall terminate the contract of or penalize a
29 pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance,
30 or appeal. Termination by mutual agreement shall not be restricted.

31 (g) No nonprofit hospital service corporation shall terminate the contract of a pharmacy
32 provider for expressing disagreement with a nonprofit hospital service corporation's decision to
33 deny or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek
34 reconsideration of the nonprofit hospital service corporation's decision or because the pharmacy

1 provider discusses alternative medications.

2 (h) At least sixty (60) days before a nonprofit hospital service corporation terminates a
3 pharmacy provider's participation in the plan or network, the nonprofit hospital service
4 corporation shall give the pharmacy provider a written explanation of the reason for the
5 termination, unless the termination is based on either the loss of the pharmacy provider's license
6 to practice pharmacy, or cancellation of professional liability insurance, or a finding of fraud.

7 (i) Notwithstanding any other provision of law, when an on-site audit of the records of a
8 pharmacy provider is conducted by a nonprofit hospital service corporation, the audit shall be
9 conducted in accordance with the following criteria:

10 (1) A finding of overpayment or underpayment must be based on the actual overpayment
11 or underpayment and not a projection based on the number of patients served having a similar
12 diagnosis or on the number of similar orders or refills for similar drugs, unless the projected
13 overpayment or denial is a part of a settlement agreed to by the pharmacy provider.

14 (2) The auditor may not use extrapolation in calculating recoupments or penalties.

15 (3) Any audit that involves clinical or professional judgment must be conducted by or in
16 consultation with a pharmacist.

17 (4) A nonprofit hospital service corporation conducting an audit shall establish an appeals
18 process under which a pharmacy provider may appeal an unfavorable preliminary audit report to
19 the insurer.

20 (5) This subsection shall not apply to any audit, review or investigation that is initiated
21 based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

22 (6) A preliminary audit report must be delivered to the pharmacy provider within sixty
23 (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty
24 (30) days following receipt of the preliminary audit to provide documentation to address any
25 discrepancy found in the audit. A final audit report must be delivered to the pharmacy provider
26 within ninety (90) days after receipt of the preliminary audit report or final appeal, whichever is
27 later. A charge-back, recoupment or other penalty may not be assessed until the appeal process
28 provided by the pharmacy benefits manager has been exhausted and the final report issued.
29 Except as provided by state or federal law, audit information may not be shared. Auditors may
30 have access only to previous audit reports on a particular pharmacy provider conducted by that
31 same entity.

32 (7) Prior to an audit, the nonprofit hospital service corporation conducting an audit shall
33 give the pharmacy provider ten (10) days' advance written notice of the audit and the range of
34 prescription numbers and the range of dates included in the audit.

1 (8) A pharmacy provider has the right to request mediation by a private mediator, agreed
2 upon by the pharmacy and the listed entity, to resolve any disagreement. A request for mediation
3 does not waive any existing rights of appeal available to a pharmacy provider.

4 (j) Maximum allowable cost provisions:

5 (1) "Maximum allowable cost" means the maximum amount that a pharmacy benefits
6 manager will pay toward the cost of a drug.

7 (2) "Nationally available" means that all pharmacies in this state can purchase the drug,
8 without limitation, from regional or national wholesalers and that the product is not obsolete or
9 temporarily available.

10 (3) "Therapeutically equivalent" means the drug is identified as therapeutically or
11 pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

12 (4) A pharmacy benefits manager may not place a prescription drug on a maximum
13 allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if
14 the prescription drug does not have three (3) or more nationally available and therapeutically
15 equivalent drug substitutes.

16 (5) A pharmacy benefits manager shall remove a prescription drug from a maximum
17 allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and
18 modifications are necessary to remain consistent with changes in the national marketplace for
19 prescription drugs. Eliminations and modifications made under this subsection must be made in a
20 timely fashion.

21 (6) A pharmacy benefits manager shall disclose to a pharmacy for which the pharmacy
22 benefits manager processes claims, makes payment of claims or procures drugs:

23 (i) At the beginning of each calendar year, the basis of the methodology and the sources
24 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
25 by the pharmacy benefits manager.

26 (ii) At least once every seven (7) business days, the maximum allowable cost pricing
27 index or maximum allowable cost rates used by the pharmacy benefits manager.

28 (7) A pharmacy benefits manager shall give prompt written notification to a pharmacy
29 provider of any change made to a maximum allowable cost pricing index or maximum allowable
30 cost rates.

31 (8) A pharmacy benefits manager shall establish a procedure by which a pharmacy
32 provider may contest a maximum allowable cost rate. A procedure established under this
33 subsection must require a pharmacy benefits manager to respond to a pharmacy provider that has
34 contested a maximum allowable cost within fifteen (15) calendar days. If the pharmacy benefits

1 manager changes the rate, the change must:

2 (i) Become effective on the date on which the pharmacy provider initiated proceedings
3 under this subsection; and

4 (ii) Apply to all pharmacy providers in the network of pharmacy providers served by the
5 pharmacy benefits manager.

6 (9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the
7 pharmacy benefits manager has entered into a contract:

8 (i) At the beginning of each calendar year, the basis of the methodology and the sources
9 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
10 by the pharmacy benefits manager;

11 (ii) As soon as practicable, any change made to a maximum allowable cost pricing index
12 or maximum allowable cost rates;

13 (iii) Not later than twenty-one (21) business days after implementing the practice, the
14 utilization of a maximum allowable cost pricing index or maximum allowable cost rates for
15 prescription drugs dispensed at a retail community pharmacy; and

16 (iv) Whether the pharmacy benefits manager used identical maximum allowable cost
17 rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider
18 and, if the pharmacy benefits manager used different maximum allowable cost rates, the
19 difference between the amount billed and the amount reimbursed.

20 (k) The department of business regulation shall exercise oversight and enforcement of
21 this section.

22 SECTION 3. Section 27-20-23 of the General Laws in Chapter 27-20 entitled "Nonprofit
23 Medical Service Corporations" is hereby amended to read as follows:

24 **27-20-23. Drug coverage.** – (a) No group health insurer subject to the provisions of this
25 chapter that provides coverage for prescription drugs under a group plan master contract
26 delivered, issued for delivery, or renewed in this state may require any person covered under the
27 contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining
28 benefits for the drugs.

29 (b) No nonprofit medical service corporation shall refuse to contract with a qualified
30 pharmacy provider willing to meet the terms and conditions of the nonprofit medical service
31 corporation for pharmacy participation.

32 (c) A nonprofit medical service corporation may not require a pharmacy provider to
33 participate in one network in order to participate in another network. The nonprofit medical
34 service corporation may not exclude an otherwise qualified pharmacy provider from participation

1 in one network solely because the pharmacy provider declined to participate in another network
2 managed by the insurer.

3 This subsection shall not be construed to limit a nonprofit medical service corporation's
4 ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments
5 or coinsurance or variations in the quantities of medications available to the enrollee, to
6 encourage the use of certain preferred pharmacy providers as long as the entity makes the terms
7 applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes
8 of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified
9 terms, conditions and price that the carrier may require for its preferred pharmacy providers.

10 (d) The agreement between a nonprofit medical service corporation and a pharmacy
11 provider shall not require a pharmacy provider to assume liability for acts solely of the group
12 health insurance provider.

13 (e) Nonprofit medical service corporations shall distribute payments received for the
14 services of a pharmacy provider as required by law.

15 (f) No nonprofit medical service corporation shall terminate the contract of or penalize a
16 pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance
17 or appeal. Termination by mutual agreement shall not be restricted.

18 (g) No nonprofit medical service corporation shall terminate the contract of a pharmacy
19 provider for expressing disagreement with a nonprofit medical service corporation's decision to
20 deny or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek
21 reconsideration of the nonprofit medical service corporation's decision or because the pharmacy
22 provider discusses alternative medications.

23 (h) At least sixty (60) days before a nonprofit medical service corporation terminates a
24 pharmacy provider's participation in the plan or network, the nonprofit medical service
25 corporation shall give the pharmacy provider a written explanation of the reason for the
26 termination, unless the termination is based on either the loss of the pharmacy provider's license
27 to practice pharmacy or cancellation of professional liability insurance or a finding of fraud.

28 (i) Notwithstanding any other provision of law, when an on-site audit of the records of a
29 pharmacy provider is conducted by a nonprofit medical service corporation, the audit shall be
30 conducted in accordance with the following criteria:

31 (1) A finding of overpayment or underpayment must be based on the actual overpayment
32 or underpayment and not a projection based on the number of patients served having a similar
33 diagnosis or on the number of similar orders or refills for similar drugs, unless the projected
34 overpayment or denial is a part of a settlement agreed to by the pharmacy provider.

1 (2) The auditor may not use extrapolation in calculating recoupments or penalties.

2 (3) Any audit that involves clinical or professional judgment must be conducted by or in
3 consultation with a pharmacist.

4 (4) A nonprofit medical service corporation conducting an audit shall establish an appeals
5 process under which a pharmacy provider may appeal an unfavorable preliminary audit report to
6 the insurer.

7 (5) This subsection shall not apply to any audit, review or investigation that is initiated
8 based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

9 (6) A preliminary audit report must be delivered to the pharmacy provider within sixty
10 (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty
11 (30) days following receipt of the preliminary audit to provide documentation to address any
12 discrepancy found in the audit. A final audit report must be delivered to the pharmacy provider
13 within ninety (90) days after receipt of the preliminary audit report or final appeal, whichever is
14 later. A charge-back, recoupment or other penalty may not be assessed until the appeal process
15 provided by the pharmacy benefits manager has been exhausted and the final report issued.
16 Except as provided by state or federal law, audit information may not be shared. Auditors may
17 have access only to previous audit reports on a particular pharmacy provider conducted by that
18 same entity.

19 (7) Prior to an audit, the nonprofit medical service corporation conducting an audit shall
20 give the pharmacy provider ten (10) days' advance written notice of the audit and the range of
21 prescription numbers and the range of dates included in the audit.

22 (8) A pharmacy provider has the right to request mediation by a private mediator, agreed
23 upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for
24 mediation does not waive any existing rights of appeal available to a pharmacy provider.

25 (j) Maximum allowable cost provisions:

26 (1) "Maximum allowable cost" means the maximum amount that a pharmacy benefits
27 manager will pay toward the cost of a drug.

28 (2) "Nationally available" means that all pharmacies in this state can purchase the drug,
29 without limitation, from regional or national wholesalers and that the product is not obsolete or
30 temporarily available.

31 (3) "Therapeutically equivalent" means the drug is identified as therapeutically or
32 pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

33 (4) A pharmacy benefits manager may not place a prescription drug on a maximum
34 allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if

1 the prescription drug does not have three (3) or more nationally available and therapeutically
2 equivalent drug substitutes.

3 (5) A pharmacy benefits manager shall remove a prescription drug from a maximum
4 allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and
5 modifications are necessary to remain consistent with changes in the national marketplace for
6 prescription drugs. Eliminations and modifications made under this subsection must be made in a
7 timely fashion.

8 (6) A pharmacy benefits manager shall disclose to a pharmacy provider for which the
9 pharmacy benefits manager processes claims, makes payment of claims or procures drugs:

10 (i) At the beginning of each calendar year, the basis of the methodology and the sources
11 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
12 by the pharmacy benefits manager.

13 (ii) At least once every seven (7) business days, the maximum allowable cost pricing
14 index or maximum allowable cost rates used by the pharmacy benefits manager.

15 (7) A pharmacy benefits manager shall give prompt written notification to a pharmacy
16 provider of any change made to a maximum allowable cost pricing index or maximum allowable
17 cost rates.

18 (8) A pharmacy benefits manager shall establish a procedure by which a pharmacy
19 provider may contest a maximum allowable cost rate. A procedure established under this
20 subsection must require a pharmacy benefits manager to respond to a pharmacy provider that has
21 contested a maximum allowable cost within fifteen (15) calendar days. If the pharmacy benefits
22 manager changes the rate, the change must:

23 (i) Become effective on the date on which the pharmacy provider initiated proceedings
24 under this subsection; and

25 (ii) Apply to all pharmacy providers in the network of pharmacy providers served by the
26 pharmacy benefits manager.

27 (9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the
28 pharmacy benefits manager has entered into a contract:

29 (i) At the beginning of each calendar year, the basis of the methodology and the sources
30 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
31 by the pharmacy benefits manager;

32 (ii) As soon as practicable, any change made to a maximum allowable cost pricing index
33 or maximum allowable cost rates;

34 (iii) Not later than twenty-one (21) business days after implementing the practice, the

1 utilization of a maximum allowable cost pricing index or maximum allowable cost rates for
2 prescription drugs dispensed at a retail community pharmacy; and

3 (iv) Whether the pharmacy benefits manager used identical maximum allowable cost
4 rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider
5 and, if the pharmacy benefits manager used different maximum allowable cost rates, the
6 difference between the amount billed and the amount reimbursed.

7 (k) The department of business regulation shall exercise oversight and enforcement of
8 this section.

9 SECTION 4. Section 27-41-38 of the General Laws in Chapter 27-41 entitled "Health
10 Maintenance Organizations" is hereby amended to read as follows:

11 **27-41-38. Drug coverage.** – (a) No health maintenance organization that provides
12 coverage for prescription drugs under a group plan master contract delivered, issued for delivery,
13 or renewed in this state may require any person covered under the contract to obtain prescription
14 drugs from a mail order pharmacy as a condition of obtaining benefits for the drugs.

15 (b) No health maintenance organization shall refuse to contract with a qualified
16 pharmacy provider willing to meet the terms and conditions of the health maintenance
17 organization for pharmacy participation.

18 (c) A health maintenance organization may not require a pharmacy provider to participate
19 in one network in order to participate in another network. The health maintenance organization
20 may not exclude an otherwise qualified pharmacy provider from participation in one network
21 solely because the pharmacy provider declined to participate in another network managed by the
22 insurer.

23 This subsection shall not be construed to limit a health maintenance organization's ability
24 to offer an enrollee incentives, including variations in premiums, deductibles, copayments or
25 coinsurance or variations in the quantities of medications available to the enrollee, to encourage
26 the use of certain preferred pharmacy providers as long as the entity makes the terms applicable
27 to the preferred pharmacy providers available to all pharmacy providers. For purposes of this
28 subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms,
29 conditions and price that the carrier may require for its preferred pharmacy providers.

30 (d) The agreement between a health maintenance organization and a pharmacy provider
31 shall not require a pharmacy provider to assume liability for acts solely of the group health
32 insurance provider.

33 (e) Health maintenance organizations shall distribute payments received for the services
34 of a pharmacy provider as required by law.

1 (f) No health maintenance organization shall terminate the contract of or penalize a
2 pharmacy provider solely as a result of the pharmacy provider's filing of a complaint, grievance,
3 or appeal. Termination by mutual agreement shall not be restricted.

4 (g) No health maintenance organization shall terminate the contract of a pharmacy
5 provider for expressing disagreement with a health maintenance organization's decision to deny
6 or limit benefits to an enrollee or because the pharmacy provider assists the enrollee to seek
7 reconsideration of the health maintenance organization's decision or because the pharmacy
8 provider discusses alternative medications.

9 (h) At least sixty (60) days before a health maintenance organization terminates a
10 pharmacy provider's participation in the plan or network, the health maintenance organization
11 shall give the pharmacy provider a written explanation of the reason for the termination, unless
12 the termination is based on either the loss of the pharmacy provider's license to practice pharmacy
13 or cancellation of professional liability insurance or a finding of fraud.

14 (i) Notwithstanding any other provision of law, when an on-site audit of the records of a
15 pharmacy provider is conducted by a health maintenance organization, the audit shall be
16 conducted in accordance with the following criteria:

17 (1) A finding of overpayment or underpayment must be based on the actual overpayment
18 or underpayment and not a projection based on the number of patients served having a similar
19 diagnosis or on the number of similar orders or refills for similar drugs, unless the projected
20 overpayment or denial is a part of a settlement agreed to by the pharmacy provider.

21 (2) The auditor may not use extrapolation in calculating recoupments or penalties.

22 (3) Any audit that involves clinical or professional judgment must be conducted by or in
23 consultation with a pharmacist.

24 (4) A health maintenance organization conducting an audit shall establish an appeals
25 process under which a pharmacy provider may appeal an unfavorable preliminary audit report to
26 the insurer.

27 (5) This subsection shall not apply to any audit, review or investigation that is initiated
28 based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

29 (6) A preliminary audit report must be delivered to the pharmacy provider within sixty
30 (60) days after the conclusion of the audit. A pharmacy provider must be allowed at least thirty
31 (30) days following receipt of the preliminary audit to provide documentation to address any
32 discrepancy found in the audit. A final audit report must be delivered to the pharmacy provider
33 within ninety (90) days after receipt of the preliminary audit report or final appeal, whichever is
34 later. A charge-back, recoupment or other penalty may not be assessed until the appeal process

1 provided by the pharmacy benefits manager has been exhausted and the final report issued.
2 Except as provided by state or federal law, audit information may not be shared. Auditors may
3 have access only to previous audit reports on a particular pharmacy provider conducted by that
4 same entity.

5 (7) Prior to an audit, the health maintenance organization conducting an audit shall give
6 the pharmacy provider ten (10) days' advance written notice of the audit and the range of
7 prescription numbers and the range of dates included in the audit.

8 (8) A pharmacy provider has the right to request mediation by a private mediator, agreed
9 upon by the pharmacy provider and the listed entity, to resolve any disagreement. A request for
10 mediation does not waive any existing rights of appeal available to a pharmacy provider.

11 (j) Maximum allowable cost provisions:

12 (1) "Maximum allowable cost" means the maximum amount that a pharmacy benefits
13 manager will pay toward the cost of a drug.

14 (2) "Nationally available" means that all pharmacies in this state can purchase the drug,
15 without limitation, from regional or national wholesalers and that the product is not obsolete or
16 temporarily available.

17 (3) "Therapeutically equivalent" means the drug is identified as therapeutically or
18 pharmaceutically equivalent or "A" rated by the United States Food and Drug Administration.

19 (4) A pharmacy benefits manager may not place a prescription drug on a maximum
20 allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if
21 the prescription drug does not have three (3) or more nationally available and therapeutically
22 equivalent drug substitutes.

23 (5) A pharmacy benefits manager shall remove a prescription drug from a maximum
24 allowable cost pricing index, or modify maximum allowable cost rates, as such eliminations and
25 modifications are necessary to remain consistent with changes in the national marketplace for
26 prescription drugs. Eliminations and modifications made under this subsection must be made in a
27 timely fashion.

28 (6) A pharmacy benefits manager shall disclose to a pharmacy provider for which the
29 pharmacy benefits manager processes claims, makes payment of claims or procures drugs:

30 (i) At the beginning of each calendar year, the basis of the methodology and the sources
31 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
32 by the pharmacy benefits manager.

33 (ii) At least once every seven (7) business days, the maximum allowable cost pricing
34 index or maximum allowable cost rates used by the pharmacy benefits manager.

1 (7) A pharmacy benefits manager shall give prompt written notification to a pharmacy
2 provider of any change made to a maximum allowable cost pricing index or maximum allowable
3 cost rates.

4 (8) A pharmacy benefits manager shall establish a procedure by which a pharmacy
5 provider may contest a maximum allowable cost rate. A procedure established under this
6 subsection must require a pharmacy benefits manager to respond to a pharmacy provider that has
7 contested a maximum allowable cost within fifteen (15) calendar days. If the pharmacy benefits
8 manager changes the rate, the change must:

9 (i) Become effective on the date on which the pharmacy provider initiated proceedings
10 under this subsection; and

11 (ii) Apply to all pharmacy providers in the network of pharmacy providers served by the
12 pharmacy benefits manager.

13 (9) A pharmacy benefits manager shall disclose to an insurance carrier, with which the
14 pharmacy benefits manager has entered into a contract:

15 (i) At the beginning of each calendar year, the basis of the methodology and the sources
16 used to create the maximum allowable cost pricing index or maximum allowable cost rates used
17 by the pharmacy benefits manager;

18 (ii) As soon as practicable, any change made to a maximum allowable cost pricing index
19 or maximum allowable cost rates;

20 (iii) Not later than twenty-one (21) business days after implementing the practice, the
21 utilization of a maximum allowable cost pricing index or maximum allowable cost rates for
22 prescription drugs dispensed at a retail community pharmacy; and

23 (iv) Whether the pharmacy benefits manager used identical maximum allowable cost
24 rates for billing the provider of the health benefit plan and for reimbursing a pharmacy provider
25 and, if the pharmacy benefits manager used different maximum allowable cost rates, the
26 difference between the amount billed and the amount reimbursed.

27 (k) The department of business regulation shall exercise oversight and enforcement of
28 this section.

29 SECTION 5. This act shall take effect upon passage.

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LC000162
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T
RELATING TO INSURANCE -- HEALTH INSURANCE - PRESCRIPTION DRUG
BENEFITS

1 This act would regulate the business relationship between providers of pharmacy services
2 and group health insurers, nonprofit hospital service corporations, nonprofit medical service
3 corporations and health maintenance organizations including establishment of the relationship
4 and the requirements needed to be considered an acceptable pharmacy service provider,
5 termination of the relationship, audits, acceptance or denial of benefits, substitution of drugs with
6 therapeutic equivalents, cost limitations, maximum allowable cost rates and grievance procedures
7 between the parties, and liability sharing requirements.

8 The department of business regulation is declared the state agency in charge of oversight
9 of the business relationship between pharmacy providers and health service organizations.

10 This act would take effect upon passage.

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LC000162
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