LAWS OF ALASKA

2024

Source
SCS CSHB 226(L&C)

Chapter No.
_____

AN ACT

Relating to insurance; relating to pharmacy benefits managers; relating to dispensing fees; and providing for an effective date.

_____

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

THE ACT FOLLOWS ON PAGE 1

AN ACT

Relating to insurance; relating to pharmacy benefits managers; relating to dispensing fees; and providing for an effective date.

*** Section 1.** AS 08.80.297(d)(2) is amended to read:

(2) "pharmacy benefits manager" has the meaning given in **AS 21.27.975** [AS 21.27.955].

*** Sec. 2.** AS 21.27.901 is amended to read:

Sec. 21.27.901. Registration of pharmacy benefits managers; scope of business practice. (a) A person may not conduct business in the state as a pharmacy benefits manager unless the person is registered with the director [AS A THIRD-PARTY ADMINISTRATOR UNDER AS 21.27.630].

(b) A pharmacy benefits manager registered under **this section** [AS 21.27.630] may

(1) contract with an insurer to administer or manage pharmacy benefits

provided by an insurer for a covered person, including claims processing services for and audits of payments for prescription drugs and medical devices and supplies; **and**

(2) contract with network pharmacies [;

(3) SET THE COST OF MULTI-SOURCE GENERIC DRUGS UNDER AS 21.27.945; AND

(4) ADJUDICATE APPEALS RELATED TO MULTI-SOURCE GENERIC DRUG REIMBURSEMENT].

*** Sec. 3.** AS 21.27.901 is amended by adding new subsections to read:

(c) A pharmacy benefits manager

(1) shall apply for registration following the same procedures for licensure set out in AS 21.27.040;

(2) is subject to hearings and orders on violations; denial, nonrenewal, suspension, or revocation of registration; penalties; and surrender of registration under the procedures set out in AS 21.27.405 - 21.27.460.

(d) Each day that a pharmacy benefits manager conducts business in the state as a pharmacy benefits manager without being registered is a separate violation of this section, and each separate violation is subject to the maximum civil penalty under AS 21.97.020.

*** Sec. 4.** AS 21.27.905(a) is amended to read:

(a) A pharmacy benefits manager shall biennially renew a registration with the director **following the procedures for license renewal in AS 21.27.380**.

*** Sec. 5.** AS 21.27 is amended by adding a new section to read:

Sec. 21.27.907. Duty of care. (a) A pharmacy benefits manager owes a duty of care to a plan sponsor, benefits administrator, and covered person. A pharmacy benefits manager shall adhere to the practices set out in this section.

(b) A pharmacy benefits manager shall

(1) perform the manager's duties with care, skill, prudence, diligence, fairness, transparency, and professionalism and in the best interest of the plan sponsor, benefits administrator, and covered person as required by this section; and

(2) notify the plan sponsor in writing of any activity, policy, or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of

interest with the duties imposed by this chapter.

(c) The duty of care owed to a covered person under this section takes precedence over the duty of care owed to any other person.

(d) A pharmacy benefits manager that receives from a drug manufacturer or labeler a payment or benefit of any kind in connection with the use of a prescription drug by a covered person, including a payment or benefit based on volume of sales or market share, shall pass that payment or benefit on in full to the plan sponsor.

(e) Upon request by a plan sponsor, a pharmacy benefits manager shall

(1) provide information showing the quantity of drugs purchased by the covered person and the net cost to the covered person for the drugs; the information must include all rebates, discounts, and other similar payments; if requested by the plan sponsor, the pharmacy benefits manager shall provide the quantity and net cost information on a drug-by-drug basis by national drug code registration number rather than on an aggregated basis; and

(2) disclose to the plan sponsor all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefits manager and a prescription drug manufacturer or labeler, including formulary management and drug-substitution programs, educational support, claims processing, and data sales fees.

(f) A pharmacy benefits manager providing information to a plan sponsor under (e) of this section may designate that information as confidential. Information designated as confidential may not be disclosed by the plan sponsor to another person without the consent of the pharmacy benefits manager, unless ordered by a court.

(g) If a pharmacy dispenses a substitute prescription drug for a prescribed drug to a covered person and the substitute prescription drug costs more than the prescribed drug, the pharmacy benefits manager shall disclose to the plan sponsor the cost of both drugs and any benefit or payment directly or indirectly accruing to the pharmacy benefits manager as a result of the substitution. The pharmacy benefits manager shall transfer in full to the plan sponsor a benefit or payment received in any form by the pharmacy benefits manager as a result of a prescription drug substitution.

*** Sec. 6.** AS 21.27.940 is amended to read:

Sec. 21.27.940. Pharmacy audits; restrictions. The requirements of

AS 21.27.901 - **21.27.975** [21.27.955] do not apply to an audit

(1) in which suspected fraudulent activity or other intentional or wilful misrepresentation is evidenced by a physical review, a review of claims data, a statement, or another investigative method; or

(2) of claims paid for under the medical assistance program under AS 47.07.

*** Sec. 7.** AS 21.27.945(a) is amended to read:

(a) A pharmacy benefits manager shall

(1) **provide** [MAKE AVAILABLE] to each network pharmacy at the beginning of the term of the network pharmacy's contract, and upon renewal of the contract, the methodology and sources used to determine the [DRUG PRICING] list;

(2) provide the list to a network pharmacy without charge;

(3) [(2)] provide **and keep current** a telephone number at which a network pharmacy may contact an employee of a pharmacy benefits manager [TO DISCUSS THE PHARMACY'S APPEAL];

(4) [(3)] provide a process for a network pharmacy to have ready access to the list specific to that pharmacy;

(5) [(4)] review and update applicable list information at least once every seven business days to reflect modification of list pricing;

(6) [(5)] update list prices within one business day after a significant price update or modification provided by the pharmacy benefits manager's national drug database provider; and

(7) [(6)] ensure that dispensing fees are not included in the calculation of the list pricing.

*** Sec. 8.** AS 21.27.945(b) is repealed and reenacted to read:

(b) Before placing or maintaining a specific drug on the list, a pharmacy benefits manager shall ensure that

(1) if the drug is therapeutically equivalent and pharmaceutically equivalent to a prescribed drug, the drug is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the most recent edition or supplement of the United States Food and Drug Administration's Approved Drug Products with

Therapeutic Equivalence Evaluations, also known as the Orange Book;

(2) if the drug is a different biological product than a prescribed drug, the drug is an interchangeable biological product;

(3) the drug is readily available for purchase from national or regional wholesalers operating in the state; and

(4) the drug is not obsolete or temporarily unavailable.

*** Sec. 9.** AS 21.27.945 is amended by adding new subsections to read:

(c) The list a pharmacy benefits manager provides to a network pharmacy under (a) of this section must

(1) be maintained in a searchable electronic format that is accessible with a computer;

(2) identify each drug for which a reimbursement amount is established;

(3) specify for each drug

(A) the national drug code;

(B) the national average drug acquisition cost, if available;

(C) the wholesale acquisition cost, if available; and

(D) the reimbursement amount; and

(4) specify the date on which a drug is added to or removed from the list.

(d) In this section,

(1) "interchangeable biological product" has the meaning given in AS 08.80.480;

(2) "pharmaceutically equivalent" means a drug has identical amounts of the same active chemical ingredients in the same dosage form and meets the standards of strength, quality, and purity according to the United States Pharmacopeia published by the United States Pharmacopeial Convention or another similar nationally recognized publication;

(3) "significant price update or modification" means

(A) an increase or decrease of 10 percent or more in the pharmacy acquisition cost;

(B) a change in the methodology in which the maximum allowable cost for a drug is determined; or

(C) a change in the value of a variable involved in the methodology used to determine the maximum allowable cost for a drug;

(4) "therapeutically equivalent" means a drug is from the same therapeutic class as another drug and, when administered in an appropriate amount, provides the same therapeutic effect as, and is identical in duration and intensity to, the other drug;

(5) "therapeutic class" means a group of similar drug products that have the same or similar mechanisms of action and are used to treat a specific condition.

*** Sec. 10.** AS 21.27 is amended by adding new sections to read:

Sec. 21.27.951. Patient access to clinician-administered drugs. (a) An insurer or its pharmacy benefits manager may not

(1) refuse to authorize, approve, or pay a provider for providing covered clinician-administered drugs and related services to a covered person if the provider has agreed to participate in the insurer's health care insurance policy according to the terms offered by the insurer or its pharmacy benefits manager;

(2) if the criteria for medical necessity are met, condition, deny, restrict, or refuse to authorize or approve a provider for a clinician-administered drug because the provider obtained the clinician-administered drug from a pharmacy that is not a network pharmacy in the insurer's or its pharmacy benefits manager's network;

(3) require a pharmacy to dispense a clinician-administered drug directly to a covered person or agent of the insured with the intention that the covered person or the agent of the insured will transport the medication to a provider for administration;

(4) require or encourage the dispensing of a clinician-administered drug to a covered person in a manner that is inconsistent with the supply chain security controls and chain of distribution set by 21 U.S.C. 360eee - 360eee-4 (Drug Supply Chain Security Act);

(5) require that a clinician-administered drug be dispensed or

administered to a covered person in the residence of the covered person or require use of an infusion site external to the office, department, or clinic of the provider of the covered person; nothing in this paragraph prohibits the insurer or its pharmacy benefits manager, or an agent of the insurer or its pharmacy benefits manager, from offering the use of a home infusion pharmacy or external infusion site.

(b) If a health insurance policy provides in-network and out-of-network benefits and there is not an in-network health care provider or health care facility within a 50-mile radius of the primary residence of a covered person, the health insurance policy must provide coverage to the covered person for clinician-administered drugs at the minimum in-network benefit level.

(c) In this section, "clinician-administered drug" means a drug, other than a vaccine, that requires administration by a provider and that the United States Food and Drug Administration or the drug's manufacturer has not approved for self-administration.

Sec. 21.27.952. Penalties. In addition to any other penalty provided by law, if a person violates AS 21.27.945 - 21.27.975, the director may, after notice and hearing, impose a penalty in accordance with AS 21.27.440.

Sec. 21.27.953. Regulations relating to pharmacy benefits manager claims, grievances, activities, and appeals. The director shall adopt regulations that provide standards and criteria for

(1) the structure and operation of pharmacy benefits manager reimbursement of pharmacy claims under this chapter;

(2) procedures maintained by a pharmacy benefits manager to ensure that a pharmacy has the opportunity for appropriate resolution of grievances;

(3) an independent review of pharmacy benefits manager activities under this title; and

(4) requiring a pharmacy benefits manager to hear pricing appeals.

*** Sec. 11.** AS 21.27 is amended by adding a new section to article 9 to read:

Sec. 21.27.975. Definitions. In AS 21.27.901 - 21.27.975,

(1) "affiliate" means a business, pharmacy, pharmacist, or provider who, directly or indirectly through one or more intermediaries, controls, is controlled

by, or is under common control with a pharmacy benefits manager;

(2) "audit" means an official examination and verification of accounts and records;

(3) "claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device;

(4) "covered person" means an individual receiving medication coverage or reimbursement provided by an insurer or its pharmacy benefits manager under a health care insurance policy;

(5) "drug" means a prescription drug;

(6) "extrapolation" means the practice of inferring a frequency or dollar amount of overpayments, underpayments, invalid claims, or other errors on any portion of claims submitted, based on the frequency or dollar amount of overpayments, underpayments, invalid claims, or other errors actually measured in a sample of claims;

(7) "insurer" has the meaning given to "health care insurer" in AS 21.54.500;

(8) "list" means a list of drugs for which a pharmacy benefits manager has established predetermined reimbursement amounts, or methods for determining reimbursement amounts, to be paid to a network pharmacy or pharmacist for pharmacy services, such as a maximum allowable cost or maximum allowable cost list or any other list of prices used by a pharmacy benefits manager;

(9) "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a drug;

(10) "national average drug acquisition cost" means the average acquisition cost for outpatient drugs covered by Medicaid, as determined by a monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services;

(11) "network" means an entity that, through contracts or agreements with providers, provides or arranges for access by groups of covered persons to health care services by providers who are not otherwise or individually contracted directly

with an insurer or its pharmacy benefits manager;

(12) "network pharmacy" means a pharmacy that provides covered health care services or supplies to an insured or a member under a contract with a network plan to act as a participating provider;

(13) "pharmacy" has the meaning given in AS 08.80.480;

(14) "pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler or distributor charges for a pharmaceutical product as listed on the pharmacy's invoice;

(15) "pharmacy benefits manager" means a person that contracts with a pharmacy on behalf of an insurer to process claims or pay pharmacies for prescription drugs or medical devices and supplies or provide network management for pharmacies;

(16) "plan sponsor" has the meaning given in AS 21.54.500;

(17) "provider" means a physician, pharmacist, hospital, clinic, hospital outpatient department, pharmacy, or other person licensed or otherwise authorized in this state to furnish health care services;

(18) "recoupment" means the amount that a pharmacy must remit to a pharmacy benefits manager when the pharmacy benefits manager has determined that an overpayment to the pharmacy has occurred;

(19) "wholesale acquisition cost" has the meaning given in 42 U.S.C. 1395w-3a(c)(6)(B).

*** Sec. 12.** AS 21.36 is amended by adding a new section to article 5 to read:

Sec. 21.36.520. Unfair trade practices. (a) An insurer providing a health care insurance policy or its pharmacy benefits manager may not

(1) interfere with a covered person's right to choose a pharmacy or provider;

(2) interfere with a covered person's right of access to a clinician-administered drug;

(3) interfere with the right of a pharmacy or pharmacist to participate as a network pharmacy;

(4) reimburse a pharmacy or pharmacist an amount less than the

amount the pharmacy benefits manager reimburses an affiliate for providing the same pharmacy services, calculated on a per-unit basis using the same generic product identifier or generic code number;

(5) impose a reduction in reimbursement for pharmacy services because of the person's choice among pharmacies that have agreed to participate in the plan according to the terms offered by the insurer or its pharmacy benefits manager;

(6) use a covered person's pharmacy services data collected under the provision of claims processing services for the purpose of soliciting, marketing, or referring the person to an affiliate of the pharmacy benefits manager;

(7) prohibit or limit a pharmacy from mailing, shipping, or delivering drugs to a patient as an ancillary service; however, the insurer or its pharmacy benefits manager

(A) is not required to reimburse a delivery fee charged by a pharmacy unless the fee is specified in the contract between the pharmacy benefits manager and the pharmacy;

(B) may not require a patient signature as proof of delivery of a mailed or shipped drug if the pharmacy

(i) maintains a mailing or shipping log signed by a representative of the pharmacy or keeps a record of each notification of delivery provided by the United States mail or a package delivery service; and

(ii) is responsible for the cost of mailing, shipping, or delivering a replacement for a drug that was mailed or shipped but not received by the covered person;

(8) prohibit or limit a network pharmacy from informing an insured person of the difference between the out-of-pocket cost to the covered person to purchase a drug, medical device, or supply using the covered person's pharmacy benefits and the pharmacy's usual and customary charge for the drug, medical device, or supply;

(9) conduct or participate in spread pricing in the state;

(10) assess, charge, or collect a form of remuneration that passes from

a pharmacy or a pharmacist in a pharmacy network to the pharmacy benefits manager, including claim processing fees, performance-based fees, network participation fees, or accreditation fees;

(11) reverse and resubmit the claim of a pharmacy more than 90 days after the date the claim was first adjudicated, and may not reverse and resubmit the claim of a pharmacy unless the insurer or pharmacy benefits manager

(A) provides prior written notification to the pharmacy;

(B) has just cause;

(C) first attempts to reconcile the claim with the pharmacy; and

(D) provides to the pharmacy, at the time of the reversal and resubmittal, a written description that includes details of and justification for the reversal and resubmittal.

(b) A provision of a contract between a pharmacy benefits manager and a pharmacy or pharmacist that is contrary to a requirement of this section is null, void, and unenforceable in this state.

(c) A violation of this section or a regulation adopted under this section is an unfair trade practice and subject to penalty under this chapter.

(d) For purposes of this section, a violation has occurred each time a prohibited act is committed.

(e) Nothing in this section may interfere with or violate a patient's right under AS 08.80.297 to know where the patient may have access to the lowest-cost drugs or the requirement that a patient must receive notice of a change to a pharmacy network, including the addition of a new pharmacy or removal of an existing pharmacy from a pharmacy network.

(f) The director may adopt regulations to provide an appeals process for claims adjudicated under this section.

(g) In this section,

(1) "affiliate" has the meaning given in AS 21.27.975;

(2) "clinician-administered drug" has the meaning given in AS 21.27.951(c);

(3) "covered person" has the meaning given in AS 21.27.975;

(4) "drug" has the meaning given in AS 21.27.975;

(5) "insurer" has the meaning given to "health care insurer" in AS 21.54.500;

(6) "network pharmacy" has the meaning given in AS 21.27.975;

(7) "out-of-pocket cost" means a deductible, coinsurance, copayment, or similar expense owed by a covered person under the terms of the covered person's health care insurance policy;

(8) "provider" has the meaning given in AS 21.27.975;

(9) "spread pricing" means the method of pricing a drug in which the contracted price for a drug that a pharmacy benefits manager charges a health care insurance policy differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

*** Sec. 13.** AS 21.27.950 and 21.27.955 are repealed.

*** Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to an insurance policy or contract, including a contract between a pharmacy benefits manager and a pharmacy or pharmacist, issued, delivered, entered into, renewed, or amended on or after the effective date of secs. 1 - 13 of this Act.

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The director of the division of insurance may adopt regulations necessary to implement the changes made by this Act under AS 21.06.090. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law implemented by the regulation.

*** Sec. 16.** Section 15 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 17.** Except as provided in sec. 16 of this Act, this Act takes effect January 1, 2025.