PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2019 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 241

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 24.5. Pharmacy Benefit Managers

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 2. As used in this chapter, "effective rate of reimbursement" includes the following:

(1) Generic effective rates.

(2) Brand effective rates.

(3) Direct and indirect remuneration fees.

(4) Any other reduction or aggregate reduction of payment.

Sec. 3. As used in this chapter, "equal access and incentives" means that a pharmacy benefit manager allows any willing pharmacy provider to participate as part of any of the pharmacy benefit manager's networks as long as the pharmacy provider agrees to the terms and conditions of the relevant contract applicable to any other pharmacy provider within that network.

Sec. 4. As used in this chapter, "generic drug" means a drug product that is identified by the drug's chemical name and that is:

(1) accepted by the federal Food and Drug Administration;

(2) available from at least three (3) sources; and

(3) therapeutically equivalent to an originating brand name

drug.

Sec. 5. As used in this chapter, "health plan" means the following:

(1) A state employee health plan (as defined in IC 5-10-8-6.7).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

Sec. 6. As used in this chapter, "independent pharmacies" means pharmacies that are not a pharmacy benefit manager affiliate.

Sec. 7. As used in this chapter, "maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a generic prescription drug. The term does not include a dispensing fee or professional fee.

Sec. 8. As used in this chapter, "maximum allowable cost list" means a list of drugs that is used:

(1) by a pharmacy benefit manager; and

(2) to set the maximum amount that may be reimbursed to a pharmacy or pharmacist for a drug.

Sec. 9. As used in this chapter, "pharmacist" means an individual licensed as a pharmacist under IC 25-26.

Sec. 10. As used in this chapter, "pharmacist services" means products, goods, and services provided as part of the practice of pharmacy.

Sec. 11. As used in this chapter, "pharmacy" means the physical location:

(1) that is licensed under IC 25-26; and

(2) at which drugs, chemicals, medicines, prescriptions, and poisons are compounded, dispensed, or sold at retail.

Sec. 12. (a) As used in this chapter, "pharmacy benefit manager" means an entity that, on behalf of a health benefits plan, state agency, insurer, managed care organization, or other third party payor:

(1) contracts directly or indirectly with pharmacies to provide prescription drugs to individuals;

(2) administers a prescription drug benefit;

(3) processes or pays pharmacy claims;

(4) creates or updates prescription drug formularies;

(5) makes or assists in making prior authorization determinations on prescription drugs;

(6) administers rebates on prescription drugs; or

(7) establishes a pharmacy network.

(b) The term does not include the following:

(1) A person licensed under IC 16.

(2) A health provider who is:

(A) described in IC 25-0.5-1; and

(B) licensed or registered under IC 25.

(3) A consultant who only provides advice concerning the selection or performance of a pharmacy benefit manager.

Sec. 13. As used in this chapter, "pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries:

(1) owns or controls;

(2) is owned or controlled by; or

(3) is under common ownership or control with;

a pharmacy benefit manager.

Sec. 14. As used in this chapter, "pharmacy benefit manager network" means a group of pharmacies or pharmacists that is offered:

(1) through an agreement or health plan contract; and

(2) to provide pharmacist services for health plans.

Sec. 15. As used in this chapter, "pharmacy services administrative organization" means an organization that assists independent pharmacies and pharmacy benefit managers or health plans to achieve administrative efficiencies, including contracting and payment efficiencies.

Sec. 16. (a) As used in this chapter, "rebate" means a discount or other price concession that is:

(1) based on use of a prescription drug; and

(2) paid by a manufacturer or third party to a pharmacy benefit manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.

(b) The term includes an incentive and a disbursement.

Sec. 17. As used in this chapter, "third party" means a person other than a:

(1) pharmacy benefit manager; or

(2) covered individual.

Sec. 18. A person shall, before establishing or operating as a pharmacy benefit manager, apply to and obtain a license from the

commissioner under this chapter.

Sec. 19. (a) A pharmacy benefit manager shall provide equal access and incentives to all pharmacies within the pharmacy benefit network.

(b) A pharmacy benefit manager may not do any of the following:

(1) Condition participation in any network on accreditation, credentialing, or licensing of a pharmacy provider that, other than a license or permit required by the Indiana board of pharmacy or other state or federal regulatory authority for the services provided by the pharmacy. However, nothing in this subdivision precludes the department from providing credentialing or accreditation standards for pharmacies.

(2) Discriminate against any pharmacy provider.

(3) Directly or indirectly retroactively deny a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless any of the following apply:

(A) The original claim was submitted fraudulently.

(B) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the drug.

(C) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

(4) Reduce, directly or indirectly, payment to a pharmacy for pharmacist services to an effective rate of reimbursement, including permitting an insurer or plan sponsor to make such a reduction.

(5) Reimburse a pharmacy that is affiliated with the pharmacy benefit manager, other than solely being included in the pharmacy benefit manager's network, at a greater reimbursement rate than other pharmacies in the same network.

A violation of this subsection by a pharmacy benefit manager constitutes an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

Sec. 20. (a) The commissioner shall do the following:

(1) Prescribe an application for use in applying for a license to operate as a pharmacy benefit manager.

(2) Adopt rules under IC 4-22-2 to establish the following:

(A) Pharmacy benefit manager licensing requirements.

(B) Licensing fees.

(C) A license application.

(D) Financial standards for pharmacy benefit managers.

(E) Reporting requirements described in section 21 of this chapter.

(F) The time frame for the resolution of an appeal under section 22 of this chapter.

(b) The commissioner may do the following:

(1) Charge a license application fee and renewal fees established under subsection (a)(2) in an amount not to exceed five hundred dollars ($500) to be deposited in the department of insurance fund established by IC 27-1-3-28.

(2) Examine or audit the books and records of a pharmacy benefit manager one (1) time per year to determine if the pharmacy benefit manager is in compliance with this chapter.

(3) Adopt rules under IC 4-22-2 to:

(A) implement this chapter; and

(B) specify requirements for the following:

(i) Prohibited market conduct practices.

(ii) Data reporting in connection with violations of state law.

(iii) Maximum allowable cost list compliance and enforcement requirements, including the requirements of sections 22 and 23 of this chapter.

(iv) Prohibitions and limits on pharmacy benefit manager practices that require licensure under IC 25-22.5.

(v) Pharmacy benefit manager affiliate information sharing.

(vi) Lists of health plans administered by a pharmacy benefit manager in Indiana.

(c) Financial information and proprietary information submitted by a pharmacy benefit manager to the department is confidential.

Sec. 21. (a) Beginning June 1, 2021, and annually thereafter, a pharmacy benefit manager shall submit a report containing data from the immediately preceding calendar year to the commissioner. The commissioner shall determine what must be included in the report and consider the following information to be included in the report:

(1) The aggregate amount of all rebates that the pharmacy benefit manager received from all pharmaceutical manufacturers for:

(A) all insurers; and

(B) each insurer;

with which the pharmacy benefit manager contracted during the immediately preceding calendar year.

(2) The aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers for:

(A) all insurers; and

(B) each insurer;

with which the pharmacy benefit manager contracted during the immediately preceding calendar year.

(3) The aggregate amount of retained rebates that the pharmacy benefit manager received from all pharmaceutical manufacturers and did not pass through to insurers with which the pharmacy benefit manager contracted during the immediately preceding calendar year.

(4) The highest, lowest, and mean aggregate retained rebate for:

(A) all insurers; and

(B) each insurer;

with which the pharmacy benefit manager contracted during the immediately preceding calendar year.

(b) A pharmacy benefit manager that provides information under this section may designate the information as a trade secret (as defined in IC 24-2-3-2). Information designated as a trade secret under this subsection must not be published unless required under subsection (c).

(c) Disclosure of information designated as a trade secret under subsection (b) may be ordered by a court of Indiana for good cause shown or made in a court filing.

Sec. 22. (a) A pharmacy benefit manager shall do the following:

(1) Identify to contracted:

(A) pharmacy service administration organizations; or

(B) pharmacies if the pharmacy benefit manager contracts directly with pharmacies;

the sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the pharmacy benefit manager.

(2) Establish an appeal process for contracted pharmacies, pharmacy services administrative organizations, or group purchasing organizations to appeal and resolve disputes concerning the maximum allowable cost pricing.

(3) Update and make available to pharmacies:

(A) at least every forty-five (45) days; or

(B) in a different time frame if contracted between a pharmacy benefit manager and a pharmacy;

the pharmacy benefit manager's maximum allowable cost list.

(b) The appeal process required by subsection (a)(2) must include the following:

(1) The right to appeal a claim not to exceed sixty (60) days following the initial filing of the claim.

(2) The investigation and resolution of a filed appeal by the pharmacy benefit manager in a time frame determined by the commissioner.

(3) If an appeal is denied, a requirement that the pharmacy benefit manager provide the reason for the denial.

(4) If an appeal is approved, a requirement that the pharmacy benefit manager do the following:

(A) Change the maximum allowable cost of the drug for the pharmacy that filed the appeal as of the initial date of service that the appealed drug was dispensed.

(B) Adjust the maximum allowable cost of the drug for the appealing pharmacy and for all other contracted pharmacies in the same network of the pharmacy benefit manager that filled a prescription for patients covered under the same health benefit plan beginning on the initial date of service the appealed drug was dispensed.

(C) Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable.

(D) Allow the appealing pharmacy and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health benefit plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed.

(E) Make retroactive price adjustments in the next payment cycle unless otherwise agreed to by the pharmacy.

(5) The establishment of procedures for auditing submitted claims by a contract pharmacy in a manner established by administrative rules under IC 4-22-2 by the department. The auditing procedures:

(A) may not use extrapolation or any similar methodology;

(B) may not allow for recovery by a pharmacy benefit

manager of a submitted claim due to clerical or other error where the patient has received the drug for which the claim was submitted;

(C) must allow for recovery by a contract pharmacy for underpayments by the pharmacy benefit manager; and

(D) may only allow for the pharmacy benefit manager to recover overpayments on claims that are actually audited and discovered to include a recoverable error.

(c) The department must approve the manner in which a pharmacy benefit manager may respond to an appeal filed under this section. The department shall establish a process for a pharmacy benefit manager to obtain approval from the department under this section.

Sec. 23. (a) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to a contracted pharmacy services administration organization to make available to the pharmacies, or to a pharmacy if the pharmacy benefit manager contracts directly with a pharmacy, in a manner established by the department by administrative rule described in subsection (b) the following:

(1) Information identifying the national drug pricing compendia or sources used to obtain the drug price data.

(2) The comprehensive list of drugs subject to maximum allowable cost and the actual maximum allowable cost for each drug.

(b) The department shall adopt rules under IC 4-22-2 concerning the manner in which a pharmacy benefit manager shall communicate the following to contracted pharmacy services administration organizations:

(1) Drug price data should be used to establish drug reimbursements by pharmacy benefit managers as described in subsection (a)(1).

(2) The comprehensive list of drugs described in subsection (a)(2).

(c) The department may, concerning a maximum allowable cost list, consider whether a drug is:

(1) obsolete;

(2) temporary unavailable;

(3) to be included on a drug shortage list; or

(4) unable to be lawfully substituted.

Sec. 24. (a) For every drug for which a pharmacy benefit

manager establishes a maximum allowable cost to determine reimbursement for the drug product, the pharmacy benefit manager shall make available to the department, upon request of the department, information that is needed to resolve an appeal.

(b) If the pharmacy benefit manager fails to promptly make available to the department the information as required in subsection (a), the department shall consider the appeal granted in favor of the appealing pharmacy.

Sec. 25. (a) A party that has contracted with a pharmacy benefit manager to provide services may, at least one (1) time in a calendar year, request an audit of compliance with the contract. The audit may include full disclosure of rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer and any other revenue and fees derived by the pharmacy benefit manager from the contract. A contract may not contain provisions that impose unreasonable fees or conditions that would severely restrict a party's right to conduct an audit under this subsection.

(b) A pharmacy benefit manager shall disclose, upon request from a party that has contracted with a pharmacy benefit manager, to the party the actual amounts paid by the pharmacy benefit manager to any pharmacy.

(c) A pharmacy benefit manager shall provide notice to a party contracting with the pharmacy benefit manager any consideration that the pharmacy benefit manager receives from a pharmacy manufacturer for any name brand dispensing of a prescription when a generic or biologically similar product is available for the prescription.

(d) The commissioner may establish a procedure to release information from an audit performed by the department to a party that has requested an audit under this section in a manner that does not violate confidential or proprietary information laws.

(e) Any provision of a contract entered into, issued, or renewed after June 30, 2020, that violates this section is unenforceable.

Sec. 26. A person or entity that has contracted with a pharmacy benefit manager for the performance of services described in section 12(a) of this chapter is entitled to full disclosure from the pharmacy benefit manager of the terms of a contract between the pharmacy benefit manager and any other person or entity within the same network concerning the performance of the services described in section 12(a) of this chapter, including:

(1) the purchase price for prescription drugs within the same

network and set by a contract entered into by the pharmacy benefit manager; and

(2) the amount of any rebate provided in connection with the purchase of prescription drugs within the same network by a contract entered into by the pharmacy benefit manager.

Sec. 27. A pharmacy services administrative organization shall, upon request, fully disclose to an independent pharmacy on whose behalf the pharmacy services administrative organization acts the terms of a contract between the pharmacy services administrative organization and any other person or entity concerning the actions taken by the pharmacy services administrative organization on behalf of the independent pharmacy.

Sec. 28. (a) A violation of this chapter is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(b) The department may also adopt rules under IC 4-22-2 to set forth fines for a violation under this chapter.

SECTION 2. IC 27-1-24.8 IS REPEALED [EFFECTIVE JULY 1, 2020]. (Pharmacy Benefit Managers).

SECTION 3. [EFFECTIVE JULY 1, 2020] **(a) Notwithstanding IC 27-1-24.5, as added by this act, a pharmacy benefit manager must be licensed by the department of insurance not later than December 31, 2020, in order to do business in Indiana and provide services for any health provider contract (as defined in IC 27-1-37-3) that is in effect beginning or after January 1, 2021.**

(b) This SECTION expires December 31, 2021.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____