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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

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A N A C T

RELATING TO INSURANCE -- PRESCRIPTION DRUG BENEFITS

Introduced By: Senators Walaska, and McCaffrey

Date Introduced: February 27, 2014

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
19 subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms,

1 conditions and price that the carrier may require for its preferred pharmacy providers.

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

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

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

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

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

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

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

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

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

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

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

34 (6) A preliminary audit report must be delivered to the pharmacy provider within sixty

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

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

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

16 (j) Maximum allowable cost provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 SECTION 2. Section 27-19-26 of the General Laws in Chapter 27-19 entitled "Nonprofit

1 Hospital Service Corporations" is hereby amended to read as follows:

2 **27-19-26. Drug coverage.** -- (a) No group health insurer subject to the provisions of this
3 chapter that provides coverage for prescription drugs under a group plan master contract
4 delivered, issued for delivery, or renewed in this state may require any person covered under the
5 contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining
6 benefits for the drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (8) A pharmacy provider has the right to request mediation by a private mediator, agreed

1 upon by the pharmacy and the listed entity, to resolve any disagreement. A request for mediation
2 does not waive any existing rights of appeal available to a pharmacy provider.

3 (j) Maximum allowable cost provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 managed by the insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (j) Maximum allowable cost provisions:

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

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

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

32 (4) A pharmacy benefits manager may not place a prescription drug on a maximum
33 allowable cost pricing index or create for a prescription drug a maximum allowable cost rate if
34 the prescription drug does not have three (3) or more nationally available and therapeutically

1 equivalent drug substitutes.

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

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

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

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

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

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

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

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

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

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

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

33 (iii) Not later than twenty-one (21) business days after implementing the practice, the
34 utilization of a maximum allowable cost pricing index or maximum allowable cost rates for

1 prescription drugs dispensed at a retail community pharmacy; and

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

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

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

10 **27-41-38. Drug coverage.** -- (a) No group health insurer subject to the provisions of this
11 chapter that provides coverage for prescription drugs under a group plan master contract
12 delivered, issued for delivery, or renewed in this state may require any person covered under the
13 contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining
14 benefits for the drugs.

15 (b) No health maintenance organization shall refuse to contract with a qualified pharmacy
16 provider willing to meet the terms and conditions of the health maintenance organization for
17 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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LC004021
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO 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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LC004021
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