L.D. 1116

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HEALTH AND HUMAN SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 828, L.D. 1116, Bill, "An Act To Restore Market-based Competition for Pharmacy Benefits Management Services"

Amend the bill by striking out the title and substituting the following:

'**An Act To Protect Pharmacies and Continue Regulation of Pharmacy Benefits Management**'

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'**Sec. 1. 22 MRSA §2699, sub-§1, ¶¶A-1 and A-2** are enacted to read:

A-1. "Applicable number of calendar days" means:

(1) With respect to claims submitted electronically, 21 days; and

(2) With respect to claims submitted otherwise, 30 days.

A-2. "Clean claim" means a claim that has no defect or impropriety, including a lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents payment within the applicable number of calendar days from being made on the claim under this section.

Sec. 2. 22 MRSA §2699-A is enacted to read:

§2699-A. Processing of clean claims; audits

1. Payment of claims. A pharmacy benefits manager shall pay or deny a clean claim pursuant to this subsection.

A. A pharmacy benefits manager shall pay or deny a clean claim submitted by a pharmacy within the applicable number of calendar days.

A pharmacy benefits manager that fails to pay or deny a clean claim in accordance with this subsection shall pay a penalty to the Department of Professional and Financial Regulation, Bureau of Insurance for the delinquent payment period, which

is the period beginning on the 45th day after receipt of the clean claim and ending on the clean claim payment date. The penalty is calculated as follows: the amount of the clean claim payment multiplied by 10% per annum multiplied by the number of days in the delinquent payment period divided by 365.

B. A contract entered into by a pharmacy benefits manager with a pharmacy with respect to a prescription drug plan offered by a pharmacy benefits manager must provide that payment be issued, mailed or otherwise transmitted with respect to all clean claims submitted by a pharmacy, other than a pharmacy that dispenses drugs by mail order only or a pharmacy located in, or under contract with, a long-term care facility, within the applicable number of calendar days after the date on which the claim is received. For purposes of this subsection, a claim is considered to have been received:

(1) With respect to claims submitted electronically, on the date on which the claim is transferred; and

(2) With respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission of the claim.

C. If payment is not issued, mailed or otherwise transmitted by the pharmacy benefits manager within the applicable number of calendar days after a clean claim is received, the pharmacy benefits manager shall pay interest to the pharmacy at the rate of 18% per annum.

D. A claim is considered to be a clean claim if the pharmacy benefits manager involved does not provide notice to the pharmacy of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received.

E. If a pharmacy benefits manager determines that a submitted claim is not a clean claim, the pharmacy benefits manager shall immediately notify the pharmacy of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy receives notice from a pharmacy benefits manager that a claim has been determined not to be a clean claim, the pharmacy shall take steps to correct that claim and then resubmit the claim to the pharmacy benefits manager for payment.

F. A claim resubmitted to a pharmacy benefits manager with additional information pursuant to paragraph E is considered to be a clean claim if the pharmacy benefits manager does not provide notice to the pharmacy of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise.

G. A claim submitted to a pharmacy benefits manager that is not paid by the pharmacy benefits manager or contested by the covered entity within the applicable number of calendar days after the date on which the claim is received by the

pharmacy benefits manager is considered to be a clean claim and must be paid by the pharmacy benefits manager.

H. Payment of a clean claim under this subsection is considered to have been made on the date on which the payment is transferred with respect to claims paid electronically and on the date on which the payment is submitted to the United States Postal Service or a common carrier for delivery with respect to claims paid otherwise.

I. A pharmacy benefits manager shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy so requests or has so requested previously.

J. Beginning October 1, 2015, the Department of Professional and Financial Regulation, Bureau of Insurance shall adopt rules that outline the collection procedures for the outstanding interest from claims under paragraph A. The bureau shall also adopt rules that transfer the remaining interest to the General Fund. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

2. Exception. This section does not apply to any medical assistance or public health programs administered by the department, including, but not limited to, the MaineCare program and the elderly low-cost drug program under section 254-D.

3. Adjustment of payments. Within 24 hours of a price increase notification by a pharmaceutical manufacturer or supplier, a pharmacy benefits manager shall adjust its payments to pharmacists or pharmacies consistent with the price increase.

4. Retroactive denial of claims prohibited. A claim paid by a pharmacy benefits manager may not be retroactively denied or adjusted after 7 days from payment of the claim except as provided in subsection 5. In no case may an acknowledgement of eligibility be retroactively reversed.

5. Retroactive denial or adjustment allowed. A pharmacy benefits manager may retroactively deny or adjust a claim if:

A. The original claim was submitted fraudulently;

B. The original claim payment was incorrect because the pharmacist or pharmacy was already paid for services rendered; or

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

6. Audits. A pharmacy benefits manager's books and records relating to rebates and other information must be made available for audit by a covered entity or its agent. The auditor shall comply with the following requirements.

A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

B. Calculations of overpayments may not include dispensing fees.

C. The auditor may not use extrapolation in calculating recoupments or penalties.

D. The auditor may not receive payment based on a percentage of the amount recovered.

E. Interest may not accrue during the audit period.

F. To the extent that an audit results in the identification of any clerical or record-keeping errors in a document or record required by the auditor, the pharmacy is not subject to recoupment of funds by the pharmacy benefits manager unless the pharmacy benefits manager can provide proof of intent to commit fraud or such error results in actual financial harm to the pharmacy benefits manager, a covered entity or a covered individual.

7. Audit information and reports. A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 6. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeals process established by rule by the Department of Professional and Financial Regulation, Bureau of Insurance has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 3. 24-A MRSA §4301-A, sub-§§14-A and 14-B are enacted to read:

14-A. Pharmacy benefits management. "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this State to covered individuals, the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals or any of the following services provided with regard to the administration of pharmacy benefits:

A. Mail service pharmacy;

B. Claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals;

C. Clinical formulary development and management services;

D. Rebate contracting and administration;

E. Certain patient compliance, therapeutic intervention and generic substitution programs; and

F. Disease management programs.

14-B. Pharmacy benefits manager. "Pharmacy benefits manager" means an entity that performs pharmacy benefits management. "Pharmacy benefits manager" includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity and includes mail service pharmacy.

Sec. 4. 24-A MRSA §4317, sub-§3, as enacted by PL 2009, c. 519, §1 and affected by §2, is amended to read:

3. Exception. ~~This section does~~ Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254-D.

Sec. 5. 24-A MRSA §4317, sub-§§4 to 11 is enacted to read:

4. Participation in contracts. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.

5. Prohibition. The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.

6. Pharmacy benefits manager duties. All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in Title 22, section 2699-A.

7. Complaints, grievances and appeals. A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.

8. Denial or limitation of benefits. A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.

9. Written notice required. At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or

B. A finding of fraud.

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.

10. Audits. Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

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

B. The auditor may not use extrapolation in calculating recoupments or penalties.

C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist.

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse.

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

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment is the minority report of the committee. This amendment strikes and replaces the bill. This amendment adds to the bill provisions on the processing of clean claims by a pharmacy benefits manager and audits of the books and records of the pharmacy benefits manager by the entity that contracts for the services of the pharmacy benefits manager. This amendment adds to the bill provisions that relate to the business relationship between a pharmacy and a pharmacy benefits manager. The provisions address the contract between the 2 entities, pharmacy benefits manager duties, complaints, grievances and appeals, denial or limitation of benefits, written notice and audits of the records of the pharmacy.