HB238

8JMSH22-1

By Representative Rigsby

RFD: Insurance

First Read: 27-Feb-24

SYNOPSIS:

Pharmacy benefits managers are third-party administrators of prescription drug benefits in a health insurance plan. They are primarily responsible for processing and paying prescription drug claims. They typically negotiate price discounts and rebates from manufacturers and determine how pharmacies get reimbursed for dispensing prescriptions. Under state law, pharmacy benefits managers are licensed and regulated by the Department of Insurance.

This bill would prohibit pharmacy benefits managers from reimbursing a pharmacy less than the actual acquisition cost paid by the pharmacy or from contracting with a health insurer to receive payment amounts for prescription drug benefits that are different from the amounts the pharmacy benefits managers pay pharmacies. This bill would also prohibit pharmacy benefits manufacturers from starting an investigation against a pharmacy for fraud, waste, or abuse without reasonable suspicion.

This bill would further specify the powers that the Commissioner of Insurance may use to investigate pharmacy benefits managers and would make pharmacy benefits managers subject to the Pharmacy Audit Integrity Act in cases involving fraud, waste, or

abuse.

This bill would require pharmacy benefits managers to pass on 100 percent of the rebates that they receive from pharmaceutical manufacturers and would provide reporting requirements on rebates received by pharmacy benefits managers to both the commissioner and health insurers.

This bill would also prohibit pharmacy benefits managers from penalizing health insurers when they transfer claims processing services and related functions to a different pharmacy benefits manager.

A BILL

TO BE ENTITLED

AN ACT

Relating to pharmacy benefits managers; to amend Sections 27-45A-3, 27-45A-4, 27-45A-5, 27-45A-6, 27-45A-7, 27-45A-8, 27-45A-9, and 27-45A-10, Code of Alabama 1975; to further provide for regulation of pharmacy benefits managers in relation to third-party payors and pharmacies; to prohibit pharmacy benefits managers from paying pharmacies less than the actual acquisition cost for prescription drugs and from paying to pharmacies less than the amounts reimbursed by third-party payors; to permit pharmacists to discuss drug prices with covered individuals; to prohibit pharmacy benefits managers from charging pharmacies certain fees or from

initiating a fraud, waste, or abuse investigation without reasonable suspicion; to require pharmacy benefits managers to report rebate amounts received to the Commissioner of Insurance and to third-party payors; to provide for examination of pharmacy benefits managers by the Commissioner of Insurance; to add Section 27-45A-13 to the Code of Alabama 1975, to require pharmacy benefits managers to pass on 100 percent of the rebates received from pharmaceutical manufacturers to third-party payors and to prohibit pharmacy benefits managers from penalizing third-party payors for switching pharmacy benefits managers; and to amend Section 34-23-187, Code of Alabama 1975, to provide that an investigation into fraud, waste, or abuse by a pharmacy benefits manager falls under the Pharmacy Audit Integrity Act.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 27-45A-3, 27-45A-4, 27-45A-5, 27-45A-6, 27-45A-7, 27-45A-8, 27-45A-9, and 27-45A-10, Code of Alabama 1975, are amended to read as follows:

"§27-45A-3

For purposes of this chapter, the following words shall have the following meanings:

(1) ACTUAL ACQUISITION COST. The Average Acquisition Cost (AAC) of a drug for the State of Alabama, as published by the Alabama Medicaid Agency. If no AAC is available, the term means the wholesale acquisition cost (WAC + 0%).

(2) CLAIMS PROCESSING SERVICES. The administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that

include any of the following:

a. Receiving payments for pharmacist services.

b. Making payments to pharmacists or pharmacies for pharmacist services.

c. Both paragraphs a. and b.

~~(2)~~ (3) COVERED INDIVIDUAL. A member, policyholder, subscriber, enrollee, beneficiary, dependent, or other individual participating in a health benefit plan.

~~(3)~~ (4) HEALTH BENEFIT PLAN. A policy, contract, certificate, or agreement entered into, offered, or issued by a payor or health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services, including pharmacist services.

~~(4)~~ (5) HEALTH INSURER. An entity subject to the insurance laws of this state and rules of the department, or subject to the jurisdiction of the department, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, but not limited to, a sickness and accident insurance company, a health maintenance organization operating pursuant to Chapter 21A, a nonprofit hospital or health service corporation, a health care service plan organized pursuant to Article 6, Chapter 20 of Title 10A, or any other entity providing a plan of health insurance, health benefits, or health services.

(6) IN-NETWORK or NETWORK. A network of pharmacists or pharmacies that are paid for pharmacist services pursuant to

an agreement with a health benefit plan or a pharmacy benefits manager.

~~(5)~~ (7) OTHER PRESCRIPTION DRUG OR DEVICE SERVICES. Services, other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to, any of the following:

a. Negotiating rebates~~, discounts, or other financial incentives and arrangements~~ with drug companies.

b. Disbursing or distributing rebates.

c. Managing or participating in incentive programs or arrangements for pharmacist services.

d. Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both.

e. Developing formularies.

f. Designing prescription benefit programs.

g. Advertising or promoting services.

(8) PAYOR. Any entity other than a health insurer involved in the financing or payment of pharmacist services.

(9) PBM AFFILIATE. An entity, including, but not limited to, a pharmacy, health insurer, or group purchasing organization that directly or indirectly, through one or more intermediaries, has one of the following affiliations:

a. Owns, controls, or has an investment interest in a pharmacy benefits manager.

b. Is owned, controlled by, or has an investment interest holder who is a pharmacy benefits manager.

c. Is under common ownership or corporate control with

a pharmacy benefits manager.

~~(6)~~ (10) PHARMACIST. As defined in Section 34-23-1.

~~(7)~~ (11) PHARMACIST SERVICES. Products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

~~(8)~~ (12) PHARMACY. As defined in Section 34-23-1.

~~(9)~~ (13) PHARMACY BENEFITS MANAGER. a. A person, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that provides claims processing services or other prescription drug or device services, or both, to covered individuals who are employed in or are residents of this state, for health benefit plans. The term includes any person that administers a prescription discount program directly or on behalf of a pharmacy benefits manager or health benefit plan for drugs to covered individuals which are not reimbursed by a pharmacy benefits manager or are not covered by a health benefit plan.

b. Pharmacy benefits manager does not include any of the following:

1. A ~~healthcare~~ health care facility licensed in this state.

2. A ~~healthcare~~ health care professional licensed in this state.

3. A consultant who only provides advice as to the selection or performance of a pharmacy benefits manager.

~~(10) PBM AFFILIATE. A pharmacy or pharmacist that, directly or indirectly, through one or more intermediaries, is owned or controlled by, or is under common control by, a~~

~~pharmacy benefits manager.~~

(14) PRESCRIPTION DRUG FILE. Any electronic and computer data files maintained by a pharmacy benefits manager in connection with administering prescription drug benefits on behalf of a health benefit plan, including, but not limited to, claims history files, drug utilization review files, prior authorization files, EDI 834 eligibility files, accumulator files, step therapy files, and other records pertaining to covered individuals.

~~(11)~~(15) PRESCRIPTION DRUGS. Includes, but is not limited to, certain infusion, compounded, ~~and~~ long-term care, and specialty prescription drugs~~. The term does not include specialty drugs~~.

(16) REBATE. Any payments or price concessions that accrue to a pharmacy benefits manager or its health benefit plan client, directly or indirectly, including through its PBM affiliate or its subsidiary, third party, or intermediary, including an off-shore group purchasing organization, from a pharmaceutical manufacturer or its affiliate, subsidiary, third party, or intermediary. The term includes, but is not limited to, payments, discounts, administration fees, credits, incentives, or penalties associated, directly or indirectly, in any way with claims administered on behalf of a health benefit plan.

~~(12)~~(17) SPECIALTY DRUGS. Prescription medications that require special handling, administration, or monitoring and are used for the treatment of patients with serious health conditions requiring complex therapies, and that are eligible

for specialty tier placement by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. § 423.560.

(18) SPREAD PRICING. A prescription drug pricing model used by a pharmacy benefits manager in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs that differs from the amount the pharmacy benefits manager pays the pharmacy for the prescription drug, including any post-sale or post-adjudication fees, discounts, or adjustments where not prohibited by law."

"§27-45A-4

(a) A person may not establish or operate as a pharmacy benefits manager in this state without first obtaining a license from the commissioner.

(b) Effective through December 31, 2021, to initially obtain a license or renew a license, a pharmacy benefits manager shall submit all of the following:

(1) A nonrefundable fee not to exceed five hundred dollars ($500).

(2) A copy of the licensee's corporate charter, articles of incorporation, or other charter document.

(3) A completed licensure form adopted by the commissioner containing:

a. The name and address of the licensee.

b. The name, address, and official position of an employee who will serve as the primary contact for the Department of Insurance.

c. Any additional contact information deemed

appropriate by the commissioner or reasonably necessary to verify the information contained in the application.

(c) Not later than January 1, 2022, the commissioner shall adopt rules for licensure of pharmacy benefits managers to operate in this state. The rules shall establish all of the following:

(1) The licensing procedure and application form.

(2) Requirements for licensure.

(3) Reporting requirements.

(4) A fee schedule for a nonrefundable application fee and a nonrefundable license renewal fee, set to allow the regulation and oversight activities of the department to be self-supporting.

(d) On and after January 1, 2022, a person applying for a pharmacy benefits manager license shall submit an application for licensure in the form and manner prescribed by the commissioner by rule, along with the application fee.

(e) The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant has been found to have violated this chapter, Article 8 of Chapter 23 of Title 34, or the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

(f) Unless denied licensure pursuant to subsection (e), a person who meets the requirements of this chapter and rules adopted by the commissioner shall be issued a pharmacy benefits manager license. The license may be in paper or

electronic form and shall clearly indicate the expiration date of the license. Licenses are nontransferable. Notwithstanding any provision of law to the contrary, the application and license shall be public records.

(g) The license shall be initially renewed in accordance with a schedule prescribed by the commissioner and shall thereafter be subject to renewal on an annual basis along with the nonrefundable license renewal fee.

(h) A licensee shall inform the commissioner by any means acceptable to the commissioner of any material change in the information required by this section or rules adopted pursuant to this section within 30 days of the change. Failure to timely inform the commissioner of a change shall result in a penalty against the licensee in the amount of fifty dollars ($50).

(i) The commissioner may suspend or revoke a license or may impose civil penalties for a violation of this chapter, Article 8 of Chapter 23 of Title 34, or the insurance laws of this state or any other jurisdiction, as determined by the commissioner in accordance with rules adopted by the commissioner, provided a pharmacy benefits manager shall have the same rights as insurers to request a hearing in accordance with Sections 27-2-28, et seq., and to appeal as provided in Section 27-2-32.

(j) Unless surrendered, suspended, or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefits manager continues to do business in this state and remains in compliance with this

chapter and applicable rules, including the payment of an annual license renewal fee as set forth in subsection (g).

(k) All documents, materials, or other information, and copies thereof, in the possession or control of the department that are obtained by or disclosed to the commissioner or any other person in the course of an application, examination, or investigation made pursuant to this chapter shall be confidential by law and privileged, shall not be subject to any open records, freedom of information, sunshine, or other public record disclosure laws, and shall not be subject to subpoena or discovery. This ~~subdivision~~ subsection only applies to disclosure of confidential documents by the department and does not create any privilege in favor of any other party.

(l)(1) Fees collected pursuant to this section shall be deposited in the State Treasury to the credit of the Insurance Department Fund.

(2) Civil penalties collected pursuant to this chapter shall be deposited in the State Treasury to the credit of the ~~state~~ State General Fund.

(m) Commencing January 1, 2022, a pharmacy benefits manager licensed by the commissioner prior to January 1, 2022, shall submit an application for a new license in accordance with subsection (d). The pharmacy benefits manager's previous license shall expire on the date the commissioner issues a new license or April 1, 2022, whichever occurs earlier."

"§27-45A-5

(a) The commissioner may adopt rules necessary to

implement this chapter and Article 8 of Chapter 23 of Title 34.

(b) The powers and duties set forth in this chapter shall be in addition to all other authority of the commissioner.

(c) The commissioner shall enforce compliance with the requirements of this chapter and rules adopted thereunder.

(d) The commissioner shall require the pharmacy benefits manager to submit a report for each health insurer, on a periodic basis, which may include, but not be limited to, the following information:

(1) The aggregate amount of rebates received by the pharmacy benefits manager.

(2) The aggregate amount of rebates distributed to the health insurer.

(3) The aggregate amount of rebates the health insurer passed on to the insurer's covered individuals which reduced applicable cost-sharing amounts at the point-of-sale, including deductibles, copayments, and coinsurance.

(4) The aggregate amount paid to the pharmacy benefits manager for pharmacist services in categories for pharmacy, drug product, medical devices, and other products, goods, or services.

(5) The aggregate amount paid to a pharmacy for pharmacist services in categories for drug product, medical devices, and other products, goods, or services.

~~(d)~~(e)(1) The commissioner may examine or audit any books and records of a pharmacy benefits manager providing

claims processing services or other prescription drug or device services for a health benefit plan as may be deemed relevant and necessary by the commissioner to determine compliance with this chapter.

(2) Examinations conducted by the commissioner shall be pursuant to the same examination authority of the commissioner relative to insurers as provided in Chapter 2, including, but not limited to, the confidentiality of documents and information submitted as provided in Section 27-2-24; examination expenses shall be processed in accordance with Section 27-2-25; and pharmacy benefits managers shall have the same rights as insurers to request a hearing in accordance with Sections 27-2-28, et seq., and to appeal as provided in Section 27-2-32.

(3) Any examination or audit by the commissioner may include production by the pharmacy benefits manager of the following:

a. Contracts with any pharmaceutical manufacturers, health insurers, payors, and pharmacies.

b. Data on plan utilization, plan pricing, pharmacy utilization, and pharmacy pricing.

c. Documents created pursuant to network development, including contract negotiations, and decisions on network membership.

~~(e)~~(f) The commissioner's examination expenses shall be collected from pharmacy benefits managers in the same manner as those collected from insurers."

"§27-45A-6

~~(a)~~ Nothing in this chapter is intended or shall be construed to do ~~any~~ either of the following:

(1) Be in conflict with existing relevant federal law.

~~(2) Apply to any specialty drug.~~

~~(3)~~ (2) Impact the ability of a hospital to mandate its employees' use of a hospital-owned pharmacy.

~~(b) The following provisions shall not apply to the administration by a person of any term, including prescription drug benefits, of a self-funded health benefit plan that is governed by the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et. seq.:~~

~~(1) Subdivisions (1) and (5) of Section 27-45A-8.~~

~~(2) Subdivisions (2), (3), (6), and (7) of Section 27-45A-10.~~"

"§27-45A-7

~~Reserved.~~ (a) A pharmacy benefits manager shall do all of the following:

(1) Designate the pharmacy benefits manager's point of contact for any in-network pharmacist and pharmacy.

(2) Respond to a request from an in-network pharmacist or pharmacy within two business days.

(b) A pharmacy benefits manager may establish a process whereby a pharmacist or pharmacy may appeal a reimbursement decision that fails to pay the actual acquisition cost for any prescription drug or device, provided that nothing herein shall be construed to prohibit a pharmacy from filing a complaint with the commissioner if the pharmacy is not reimbursed in accordance with Section 27-45A-10."

"§27-45A-8

With respect to a covered individual, ~~A~~a pharmacy benefits manager, directly or through an affiliate or a contracted third party, may not do any of the following:

(1) Require a covered individual, as a condition of payment or reimbursement, to purchase pharmacist services, including, but not limited to, prescription drugs, exclusively through a mail-order pharmacy or pharmacy benefits manager affiliate.

(2) Prohibit or limit any covered individual from selecting an in-network pharmacy or pharmacist of his or her choice who meets and agrees to the terms and conditions, including reimbursements, in the pharmacy benefits manager's contract.

(3) Impose a monetary advantage or penalty under a health benefit plan that would affect a covered individual's choice of pharmacy among those pharmacies that have chosen to contract with the pharmacy benefits manager under the same terms and conditions, including reimbursements. For purposes of this subdivision, "monetary advantage or penalty" includes, but is not limited to, a higher copayment, a waiver of a copayment, a reduction in reimbursement services, a requirement or limit on the number of days of a drug supply for which reimbursement will be allowed, or a promotion of one participating pharmacy over another by these methods.

(4)a. Use a covered individual's pharmacy services data collected pursuant to the provision of claims processing services for the purpose of soliciting, marketing, or

referring the covered individual to a mail-order pharmacy or PBM affiliate.

b. This subdivision shall not limit a health benefit plan's use of pharmacy services data for the purpose of administering the health benefit plan.

c. This subdivision shall not prohibit a pharmacy benefits manager from notifying a covered individual that a less costly option for a specific prescription drug is available through a mail-order pharmacy or PBM affiliate, provided the notification shall state that switching to the less costly option is not mandatory. The commissioner, by rule, may determine the language of the notification authorized under this paragraph made by a pharmacy benefits manager to a covered individual.

(5) Require a covered individual to make a payment for a prescription drug at the point of sale in an amount that exceeds the ~~lessor~~lesser of the following:

a. The contracted cost share amount.

b. An amount an individual would pay for a prescription if that individual were paying without insurance.

(6) Charge a covered individual a copayment or a cost-sharing amount that is greater than the amount paid to the pharmacy that dispenses the prescription drug."

"§27-45A-9

(a) For purposes of this section, ~~client~~ "client" means a health insurer, payor, or health benefit plan.

(b) If requested by a client under subsection (d), a pharmacy benefits manager shall prepare an annual report by

June 1 which discloses ~~all of the following with respect to that client:~~

~~(1) The~~the aggregate amount of all rebates that the pharmacy benefits manager received from pharmaceutical manufacturers on behalf of the client.

~~(2) The aggregate amount of the rebates the pharmacy benefits manager received from pharmaceutical manufacturers that did not pass through to the client.~~

~~(3) If a pharmacy benefits manager or any consultant providing pharmacy benefits management services engages in spread pricing, the aggregated amount of the difference between the amount paid by the client for prescription drugs and the actual amount paid to the pharmacy or pharmacist for pharmacist services. For purposes of this subdivision, "spread pricing" means the model of prescription drug reimbursement in which a pharmacy benefits manager charges a client a contracted price for prescription drugs, and the contract price for the prescription drugs differs from the amount the pharmacy benefits manager, directly or indirectly, pays the pharmacy or pharmacist for pharmacist services.~~

(c) Confidentiality of a report submitted under this section shall be governed by contract between the pharmacy benefits manager and the client.

(d) A pharmacy benefits manager shall annually notify all its clients in a timely manner that a report described in subsection (b) will be made available to the client by the pharmacy benefits manager if requested by the client."

"§27-45A-10

(a) With respect to a pharmacist or pharmacy, ~~A~~a pharmacy benefits manager, directly or through an affiliate or a contracted third party, may not do any of the following:

(1) Reimburse an in-network pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a similarly situated PBM affiliate for providing the same pharmacist services to covered individuals in the same health benefit plan.

(2) Reimburse an in-network pharmacy for a prescription drug in an amount that is less than or exceeds the actual acquisition cost to the pharmacy for the prescription drug plus a professional dispensing fee that is equal to the professional dispensing fee paid by the state under Title XIX of the Social Security Act.

(3) Practice spread pricing in this state.

~~(2)~~(4) Deny a pharmacy or pharmacist the right to participate as a ~~contract~~network provider if the pharmacy or pharmacist meets and agrees to the terms and conditions, including reimbursements, in the pharmacy benefits manager's contract.

~~(3)~~(5) Impose credentialing standards on a pharmacist or pharmacy beyond or more onerous than the licensing standards set by the Alabama State Board of Pharmacy or charge a pharmacy a fee in connection with network enrollment, provided this subdivision shall not prohibit a pharmacy benefits manager from setting minimum requirements for participating in a pharmacy network.

~~(4)~~(6) Prohibit a pharmacist or pharmacy from providing

a covered individual specific information on the amount of the covered individual's cost share for the covered individual's prescription drug, the acquisition cost and reimbursement amount for the prescription drug, and the clinical efficacy of a more affordable alternative drug or therapy if one is available, or penalize a pharmacist or pharmacy for disclosing this information to a covered individual as deemed necessary in the professional judgment of the pharmacist or for selling to a covered individual a more affordable alternative if one is available in the completion of a business transaction.

~~(5)~~ (7) Prohibit a pharmacist or pharmacy from offering and providing delivery services to a covered individual as an ancillary service of the pharmacy, provided all of the following requirements are met:

a. The pharmacist or pharmacy can demonstrate quality, stability, and safety standards during delivery.

b. The pharmacist or pharmacy does not charge any delivery or service fee to a pharmacy benefits manager or health insurer.

c. The pharmacist or pharmacy alerts the covered individual that he or she will be responsible for any delivery service fee associated with the delivery service, and that the pharmacy benefits manager or health insurer will not reimburse the delivery service fee.

~~(6)~~ (8) Charge or hold a pharmacist or pharmacy responsible for a fee or penalty relating to an audit conducted pursuant to ~~The Pharmacy Audit Integrity Act,~~ Article 8 of Chapter 23 of Title 34, provided this prohibition

does not restrict recoupments made in accordance with ~~the Pharmacy Audit Integrity Act~~that article.

~~(7)~~(9) Charge a pharmacist or pharmacy a point-of-sale or retroactive fee or otherwise recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid, unless the recoupment is made pursuant to an audit conducted in accordance with ~~the Pharmacy Audit Integrity Act~~Article 8 of Chapter 23 of Title 34.

(10) Charge a pharmacy a fee in regard to enrollment, credentialing or re-credentialing, change of ownership, submission of claims, adjudication of claims, or otherwise if not in conjunction with an audit conducted pursuant to Article 8 of Chapter 23 of Title 34.

(11) Initiate a fraud, waste, or abuse investigation without first notifying the pharmacist or pharmacy and receiving approval from the commissioner on the basis of information that supports an articulable suspicion of fraud, waste, or abuse by the pharmacist or pharmacy to be investigated.

(12) Impose additional terms on a pharmacy unless the pharmacy or its representative agrees to the terms in writing.

~~(8)~~(b)(1) Except for a drug reimbursed, directly or indirectly, by the Medicaid program, a pharmacy benefits manager may not vary the amount ~~a~~the pharmacy benefits manager reimburses an entity for a drug, including each and every prescription medication that is eligible for specialty tier placement by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. § 423.560, regardless of any provision

of law to the contrary, on the basis of whether:

a. The drug is subject to an agreement under 42 U.S.C. § 256b; or

b. The entity participates in the program set forth in 42 U.S.C. § 256b.

~~(9)~~ (2) If an entity participates, directly or indirectly, in the program set forth in 42 U.S.C. § 256b, a pharmacy benefits manager may not do any of the following:

a. Assess a fee, charge-back, or other adjustment on the entity.

b. Restrict access to the pharmacy benefits manager's pharmacy network.

c. Require the entity to enter into a contract with a specific pharmacy to participate in the pharmacy benefits manager's pharmacy network.

d. Create a restriction or an additional charge on a patient who chooses to receive drugs from the entity.

e. Create any additional requirements or restrictions on the entity.

~~(10)~~ (3) A pharmacy benefits manager may not ~~Require~~require a claim for a drug to include a modifier to indicate that the drug is subject to an agreement under 42 U.S.C. § 256b.

~~(11)~~ (c) A pharmacy benefits manager may not ~~Penalize~~penalize or retaliate against a pharmacist or pharmacy for exercising rights under this chapter or ~~the Pharmacy Audit Integrity Act~~Article 8 of Chapter 23 of Title 34."

Section 2. Section 27-45A-13 is added to the Code of

Alabama 1975, to read as follows:

§27-45A-13

(a) For the purposes of this section, the following terms have the following meanings:

(1) CLIENT. A health insurer or a payor.

(2) PHARMACY BENEFIT. The part of a health benefit plan that reimburses for pharmacist services, including prescription drugs and devices.

(b) A pharmacy benefits manager, directly or through an affiliate or contracted third party, shall pass on to a client 100 percent of all rebates the pharmacy benefits manager receives, directly or indirectly, from pharmaceutical manufacturers in connection with claims the pharmacy benefits manager administers on behalf of the client's health benefit plan unless the client directs the pharmacy benefits manager to apply the rebates to purchases of prescription drugs by covered individuals at the point-of-sale. Notwithstanding the foregoing, nothing shall be construed to allow a rebate from a pharmaceutical manufacturer, directly or indirectly, to a pharmacy benefits manager, or its PBM affiliate, or its client where otherwise prohibited by law.

(c) When a client makes a written request to a pharmacy benefits manager to reassign or transfer a pharmacy benefit to another pharmacy benefits manager, within 30 days, the pharmacy benefits manager, directly or through an affiliate or contracted third party, shall do both of the following:

(1) Provide the client with the prescription drug file.

(2) Establish all electronic data interchange (EDI)

connections necessary for the client to transfer the pharmacy benefit to the new pharmacy benefits manager and maintain the EDI for the six-month period following the transfer of the pharmacy benefit.

(d) A pharmacy benefits manager, directly or through a PBM affiliate or contracted party, may not do any of the following:

(1) Engage in spread pricing.

(2) Charge a client more for a drug at a pharmacy affiliated with the pharmacy benefits manager than the actual acquisition cost for the ingredient cost of the drug.

(3) Enter into any agreement with a client which defines "rebate" more narrowly than the definition in this article or that in any way circumvents the requirement of this section to pass 100 percent of the rebates back to the client.

(4) Enter into any agreement with a pharmaceutical manufacturer that, directly or indirectly, allocates rebates earned under one health benefit plan to a different health benefit plan.

(5) Enter any agreement with a pharmaceutical manufacturer for a rebate that is not attributable to a specific drug covered under a specific health benefit plan.

(6) Charge a client a fee for access to a prescription drug file that exceeds the pharmacy benefits manager's reasonable cost of providing access.

(7) Deny or delay or take any action calculated to inhibit the transfer of a prescription drug file to a client when the client requests the transfer of the file.

(8) Take any action calculated to penalize a client for switching to a new pharmacy benefits manager, including, but not limited to, charging the prospective pharmacy benefits manager a fee to access the prescription drug file or withholding rebates due to a client which are earned during the period before an agreement with the new pharmacy benefits manager takes effect.

(9) Contract with any party, including a health insurer or third-party administrator, that engages in any of the practices prohibited in this section.

Section 3. Section 34-23-187, Code of Alabama 1975, is amended to read as follows:

"§34-23-187

This article ~~does not~~ shall apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or waste abuse that is initiated by a pharmacy benefits manager."

Section 4. This act shall become effective on October 1, 2024.