

# MAINE STATE LEGISLATURE

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# 126th MAINE LEGISLATURE

## SECOND REGULAR SESSION-2014

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Legislative Document

No. 1624

H.P. 1196

House of Representatives, December 30, 2013

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### **An Act Concerning Pricing Disclosure Requirements and Oversight of Pharmacy Benefits Managers**

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Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Received by the Clerk of the House on December 23, 2013. Referred to the Committee on Labor, Commerce, Research and Economic Development pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

*Millicent M. MacFarland*  
MILLICENT M. MacFARLAND  
Clerk

Presented by Representative BECK of Waterville.

Cosponsored by Representatives: COOPER of Yarmouth, GILBERT of Jay, LONGSTAFF of Waterville, NADEAU of Winslow, RANKIN of Hiram, THERIAULT of Madawaska, TREAT of Hallowell.

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 22 MRSA §1711-E, sub-§1, ¶G,** as amended by PL 2011, c. 443, §1, is  
3 further amended to read:

4 G. "Pharmacy benefits manager" has the same meaning as in Title ~~24-A~~ 32, section  
5 ~~4913~~ 13800, subsection 1, paragraph ~~A~~ C.

6 **Sec. 2. 22 MRSA §8702, sub-§8-B,** as amended by PL 2011, c. 443, §3, is  
7 further amended to read:

8 **8-B. Pharmacy benefits manager.** "Pharmacy benefits manager" has the same  
9 meaning as in Title ~~24-A~~ 32, section ~~4913~~ 13800, subsection 1, paragraph ~~A~~ C.

10 **Sec. 3. 22 MRSA §8706, sub-§2, ¶C,** as amended by PL 2007, c. 136, §5, is  
11 further amended to read:

12 C. The operations of the organization must be supported from 3 sources as provided  
13 in this paragraph:

14 (1) Fees collected pursuant to paragraphs A and B;

15 (2) Annual assessments of not less than \$100 assessed against the following  
16 entities licensed under Titles 24 ~~and~~, 24-A and 32: nonprofit hospital and medical  
17 service organizations, health insurance carriers and health maintenance  
18 organizations on the basis of the total annual health care premium; and 3rd-party  
19 administrators, carriers that provide only administrative services for a plan  
20 sponsor and pharmacy benefits managers that process and pay claims on the basis  
21 of claims processed or paid for each plan sponsor. The assessments are to be  
22 determined on an annual basis by the board. Health care policies issued for  
23 specified disease, accident, injury, hospital indemnity, disability, long-term care  
24 or other limited benefit health insurance policies are not subject to assessment  
25 under this subparagraph. For purposes of this subparagraph, policies issued for  
26 dental services are not considered to be limited benefit health insurance policies.  
27 The total dollar amount of assessments under this subparagraph must equal the  
28 assessments under subparagraph (3); and

29 (3) Annual assessments of not less than \$100 assessed by the organization  
30 against providers. The assessments are to be determined on an annual basis by  
31 the board. The total dollar amount of assessments under this subparagraph must  
32 equal the assessments under subparagraph (2).

33 The aggregate level of annual assessments under subparagraphs (2) and (3) must be  
34 an amount sufficient to meet the organization's expenditures authorized in the state  
35 budget established under Title 5, chapter 149. The annual assessment may not  
36 exceed \$1,346,904 in fiscal year 2002-03. In subsequent fiscal years, the annual  
37 assessment may increase above \$1,346,904 by an amount not to exceed 5% per fiscal  
38 year. The board may waive assessments otherwise due under subparagraphs (2) and  
39 (3) when a waiver is determined to be in the interests of the organization and the  
40 parties to be assessed.

1           **Sec. 4. 24-A MRSA §601, sub-§28**, as enacted by PL 2009, c. 581, §3, is  
2 repealed.

3           **Sec. 5. 24-A MRSA §1913**, as repealed and replaced by PL 2011, c. 443, §4, is  
4 repealed.

5           **Sec. 6. 24-A MRSA §4317, sub-§12** is enacted to read:

6           **12. Maximum allowable cost.** This subsection governs the maximum allowable  
7 cost for a drug as determined by a pharmacy benefits manager.

8           A. As used in this subsection, unless the context otherwise indicates, the following  
9 terms have the following meanings.

10           (1) "Maximum allowable cost" means the maximum amount that a pharmacy  
11 benefits manager pays toward the cost of a drug.

12           (2) "Nationally available" means available to all pharmacies in this State for  
13 purchase, without limitation, from regional or national wholesalers and not  
14 obsolete or temporarily available.

15           (3) "Therapeutically equivalent drug substitute" means a drug identified as  
16 therapeutically or pharmaceutically equivalent to another drug by the United  
17 States Food and Drug Administration.

18           B. A pharmacy benefits manager may not set a maximum allowable cost for a  
19 prescription drug if that prescription drug does not have 3 or more nationally  
20 available therapeutically equivalent drug substitutes.

21           C. A pharmacy benefits manager shall remove a maximum allowable cost for a  
22 prescription drug or modify the maximum allowable cost as necessary for the cost of  
23 the prescription drug to remain consistent with changes in the national marketplace  
24 for prescription drugs. A removal or modification made under this paragraph must be  
25 made in a timely fashion.

26           D. A pharmacy benefits manager shall disclose to a pharmacy for which the  
27 pharmacy benefits manager processes claims, makes payment of claims or procures  
28 drugs:

29           (1) At the beginning of each calendar year, the basis of the methodology and the  
30 sources used to establish the maximum allowable costs used by the pharmacy  
31 benefits manager. A pharmacy benefits manager shall give prompt written  
32 notification to a pharmacy of any change made to a maximum allowable cost;  
33 and

34           (2) At least once every 7 business days, the maximum allowable costs used by  
35 the pharmacy benefits manager.

36           E. A pharmacy benefits manager shall establish a procedure by which a pharmacy  
37 may contest a maximum allowable cost. A procedure established under this  
38 paragraph must require a pharmacy benefits manager to respond to a pharmacy that  
39 has contested a maximum allowable cost within 15 calendar days. If the pharmacy  
40 benefits manager changes the maximum allowable cost, the change must:

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

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

5                   F. A pharmacy benefits manager shall disclose to a carrier with which the pharmacy  
6                   benefits manager has entered into a contract:

7                   (1) At the beginning of each calendar year, the basis of the methodology and the  
8                   sources used to establish the maximum allowable costs used by the pharmacy  
9                   benefits manager;

10                  (2) As soon as practicable, any change made to a maximum allowable cost;

11                  (3) The maximum allowable costs for prescription drugs dispensed at a retail  
12                  community pharmacy not later than 21 business days after these costs are set; and

13                  (4) Whether the pharmacy benefits manager used the same maximum allowable  
14                  cost for billing the carrier and for reimbursing a pharmacy and, if the pharmacy  
15                  benefits manager did not use the same maximum allowable cost, the difference  
16                  between the amount billed and the amount reimbursed.

17                  **Sec. 7. 32 MRSA §13800** is enacted to read:

18                  **§13800. Registration of pharmacy benefits managers**

19                  A person may not act as a pharmacy benefits manager in this State without first  
20                  paying the registration fee established by the board by rule.

21                  **1. Definitions.** As used in this section, the following terms have the following  
22                  meanings.

23                  A. "Administrator" has the same meaning as in Title 24-A, section 1901, subsection  
24                  1.

25                  B. "Health maintenance organization" has the same meaning as in Title 24-A, section  
26                  4202-A, subsection 10.

27                  C. "Pharmacy benefits manager" means a person or entity that contracts with a plan  
28                  sponsor, health care service plan, health maintenance organization or insurer to  
29                  manage or administer a contract, agreement or arrangement between a carrier or  
30                  administrator and a pharmacy, as defined in Title 32, section 13702-A, subsection 24,  
31                  in which the pharmacy agrees to provide services to a health plan enrollee whose plan  
32                  benefits include incentives for the enrollee to use the services of that pharmacy.

33                  D. "Plan sponsor" has the same meaning as in Title 24-A, section 1901, subsection 8.

34                  **2. Rules.** The board may adopt routine technical rules pursuant to Title 5, chapter  
35                  375, subchapter 2-A to administer and enforce the registration requirements of this  
36                  section. Pharmacy benefits manager registration fees established by the board may not  
37                  exceed \$100 for an original registration or an annual renewal registration.

38                  **3. Enforcement.** The board may enforce this section.

