# 2024

## STATE WINS FOR COMMUNITY PHARMACY

### MEDICAID MANAGED CARE REFORM LEGISLATION

Nebraska LB 204: Creates a managed Medicaid reimbursement floor for independent pharmacies with six or less locations based on the state's Medicaid fee-for-service methodology of NADAC plus a professional dispensing fee. The professional dispensing fee will be $10.38 until the Department of Insurance completes an initial cost of dispensing survey. The law requires a survey every two years.

New Mexico HB 165: Creates a reimbursement floor in the managed Medicaid program for community-based pharmacy providers using the state's Medicaid fee-for-service methodology of NADAC plus a professional dispensing fee of $10.30. Community-based pharmacies are defined, in part, as not: 1) government-owned; 2) hospital-owned; 3) owned by a corporation that owns hospitals; 4) an extension of a medical practice or special facility; 5) owned by a corporate chain of pharmacies with stores outside of the state; or 6) a mail-order pharmacy.

### PBM REGULATION AND ENFORCEMENT

The National Association of Insurance Commissioners' (NAIC) PBM Regulatory Issues Subgroup adopted its 2024 charges, setting its direction for the upcoming year and beyond. Among other things, the subgroup will monitor, facilitate, and coordinate with the states and federal agencies regarding PBM compliance and enforcement. In addition, the subgroup will draft a new chapter for the NAIC market conduct manual with standards for examinations of PBMs.

Arkansas: The office of Gov. Sarah Huckabee Sanders (R) announced the Arkansas Insurance Department (AID) brought penalties and hearings against Caremark, Express Scripts, Magellan, and MedImpact. According to the press release, it was the state's largest penalty in a pharmaceutical enforcement action ever, with $1.47 million in possible penalties. In June, AID issued a bulletin advising PBMs to stop unfairly paying Arkansas pharmacies less than the national average drug acquisition cost in violation of state law. It's seeking $5,000 per violation for each payment made under NADAC amounts. Arkansas is alleging 19 violations by Express Scripts, 50 by Magellan, and a stunning 217 by Caremark.

Arkansas: Emergency Rule 128 requires PBMs to reimburse pharmacies at "fair and reasonable rates" that are approved by the Department of Insurance. Authorizes the insurance commissioner to review and either approve or deny cost to dispense calculations. Requires the insurance commissioner to issue a bulletin with procedures, timing, and other needed information. Efforts to make the rule permanent are in process.

New York: The New York State Department of Financial Services' Pharmacy Benefits Bureau adopted new PBM market conduct rule languagee. The new rules, the second of a series of expected PBM regulations, address several key issues for NCPA members. Among the provisions, the rules prohibit reimbursing PBM-owned or affiliated pharmacies more than non-owned or affiliated pharmacies; prohibit retroactive claims adjustments; allow pharmacies to voice complaints to government officials and elected officials with prohibitions on retaliation; and prohibit patient steering. The rules also strengthen audit protections and give the superintendent of Financial Services approval authority for PBM mergers and acquisitions.

Louisiana: Gov. Jeff Landry (R-La.) announced approval of an emergency contract to bolster patient access and pharmacy reimbursement within its Office of Group Benefits (OGB) health plans serving active and retired state employees. Being the third year of three-year contract with CVS Caremark, independent pharmacies can opt into the one-year emergency contract and receive NADAC reimbursement for drugs and a $9 dispensing fee. The emergency contract aligns with aspects of two recently enacted laws in Louisiana, HB 172 addressing OGB contracts and SB 444 prohibiting reimbursement below acquisition cost.

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West Virginia: The office of the West Virginia Insurance Commissioner Allan McVey announced a consent order as part of administrative proceedings against CVS Caremark with an initial settlement of over $1 million for violations of the state's reimbursement statute requiring a minimum of NADAC plus a professional dispensing fee of $10.49. The administrative proceedings looked at claims of ERISA plans from out of state serving patients in West Viriginia since Jan. 1, 2023. As part of the consent order, CVS Caremark will review all claims and report findings to the Office of the Insurance Commissioner, paying identified under-reimbursed claims with interest, and submitting a Corrective Action Plan. CVS Caremark had previously represented that computer software challenges were to blame for not being able to identify all impacted claims, so the above-mentioned proceedings may identify additional violations and result in additional fines.

**PBM LEGISLATION**

Alaska HB 226: Establishes PBM duty of care to plan sponsors, benefits administrators, and covered persons. Adds transparency and disclosure requirements. Enables patients to choose their pharmacy, limits patient steering, prohibits fees, and requires equal reimbursement between PBM-affiliated pharmacies and those not affiliated with PBMs. Requires the director of the Division of Insurance to adopt regulations that provide standards and criteria for reimbursement, grievances, and appeals.

Arizona HB 165: Creates pharmacy audit protections, including limiting claim reversals when dispensed quantities are correct during wholesale invoice audits and limiting retroactive fees to claims that are fraudulent, duplicative, or incorrectly resulting in overpayment.

Idaho HB 596: Requires passthrough pricing and network adequacy standards at or above Medicare, limits patient steering, prohibits arbitrary accreditation standards, defines specialty drugs, and establishes reimbursement appeals processes.

Iowa HF 2099: Addresses PBM retaliation against pharmacies, prohibits fees such as claim processing fees, performance-based fees, network participation fees or accreditation fees, and updates MAC list policies.

Kentucky SB 188 and HB 190: Require pharmacy reimbursement in the commercial market and in most state employee plans of NADAC plus a professional dispensing fee effective Jan. 1, 2025 for independent pharmacies. Address network adequacy, limit mail order, prohibit retroactive fees, prohibit lower reimbursement to non-PBM owned or affiliated pharmacies, and limit what PBMs can deem specialty drugs.

Louisiana HB 603: Expands the definition of health insurance issuers to include PBMs and provides the Office of the Insurance Commissioner authority to promulgate standards for audits and reviews of pharmacies.

Louisiana HB 172: Creates transparency and reporting requirements for PBMs serving Office of Group Benefits enrollees.

Louisiana SB 444: Prohibits PBMs from reimbursing pharmacies or pharmacists less than the acquisition cost for the drug, device, or service. This applies to pharmacies and pharmacists that do not own more than five shares or five percent interest in a pharmaceutical wholesale purchasing group or vendor of covered drugs, devices, or services.

New Hampshire SB 555: Creates additional PBM transparency and reporting requirements.

New Mexico HB 33: Creates additional PBM transparency and reporting requirements.

New York S 9040: Prohibits PBM gag clauses.

Oklahoma SB 1670 and HB 3376: Establish additional PBM oversight and enforcement authority within the Office of the Attorney General.

Oregon HB 4149: Requires PBM licensure, transparency and reporting to identify spread pricing, adds audit protections, strengthens appeals processes, and prohibits reimbursement discrimination against 340b covered entities. Requires the Department of Consumer and Business Services to hire at least one additional full-time employee to assist in PBM regulation. Provides oversight of pharmacy services administrative organizations.

Pennsylvania HB 1993: For plans not subject to ERISA, addresses patient steering and reimbursement parity with PBM-owned or affiliated pharmacies, ensures network adequacy, limits audit error recoupment, strengthens PBM reporting, and provides broad oversight and enforcement authority to the Pennsylvania Department of Insurance.

Vermont H 233: Requires PBM certification; prohibits spread pricing, gag clauses, and making classifications of drugs beyond what is established by state and federal governments and the Board of Pharmacy; and creates fiduciary responsibility for the PBM to the payer. Broader authority for enforcement and rulemaking is given to the commissioner of the Department of Financial Regulation.

Virginia HB 1402 and SB 660: Require PBM licensure and rebate reporting and allow for examinations of PBMs.

Washington SB 5213: Creates network access protections, facilitates the Office of the Insurance Commissioner investigations of complaints against PBMs, and adds protections for pharmacies and pharmacists against retaliation if they disclose information when they believe there have been violations of state or federal law.

West Virginia SB 453: Creates transparency in the Public Employees Insurance Agency by requiring pharmacy reimbursement of NADAC plus a professional dispensing fee based on West Virginia's Medicaid pharmacy reimbursement.

## DRUG PRICING AND REIMBURSEMENT

Maine: NCPA opposed LD 1829, which proposed to make it a violation for a pharmacy to purchase for sale or seek reimbursement for a prescription drug at a higher rate than the reference rate established by Medicare. The bill did not advance.

Rhode Island: NCPA joined coalition efforts to defeat S. 2013 and H 7443, which would have prohibited pharmacy reimbursement above a maximum fair price benchmark regardless of the price a pharmacy paid to obtain the drug. The coalition also defeated S. 2719 and H 8220, legislation to create a Rhode Island Drug Cost Review Commission that would have had powers to set reimbursement rate limits.

Virginia: NCPA joined coalition efforts to successful secure a veto by Gov. Glenn Youngkin (R) of SB 274, legislation to create a Prescription Drug Affordability Board with the power to create upper payment limits without regard to the price paid by the pharmacy to obtain the drug.

## PREP ACT

Connecticut SB 133: Authorizes pharmacists to prescribe and administer all FDA-approved, CDC-recommended vaccines to individuals 12 years of age and older pursuant to the age-appropriate immunization schedule; allows pharmacists to delegate vaccine administration authority to an advanced pharmacy technician.

DC B 25-0545: Authorizes pharmacists to administer all CDC-recommended immunizations to patients 3 years and older and allows pharmacists to delegate vaccine administration to a pharmacy technician or intern; authorizes pharmacists to order, perform, and interpret CLIA-waived tests as part of conducting health screenings.

Hawaii HB 2553: Authorizes licensed pharmacists to order and administer all FDA-approved and ACIP-recommended vaccines to patients 3 years and older without a prescription.

Kentucky HB 274: Allows licensed pharmacists to administer ACIP-recommended immunizations to individuals 5 years and older.

Maryland HB 76: Allows licensed pharmacists to order and administer flu and COVID-19 vaccines to patients 3 years old and up, and all other ACIP-recommended vaccines to patients 6 years old and up.

Minnesota HF 5247: Allows pharmacists to administer COVID-19 and flu vaccinations to patients 3 and older; allows pharmacists to order and administer CLIA-waived tests without a statewide protocol.

New Hampshire SB 402: Authorizes pharmacists to administer all FDA-approved vaccines to individuals 18 years or older.

New York S 8920: Extends pharmacists' authority to administer COVID-19 and influenza tests to 2026.

Ohio SB 144: Allows licensed pharmacists and pharmacy technicians to administer immunizations to patients 5 years of age.

Oregon SB 1506: Authorizes pharmacists to test and treat for SARS-CoV-2.

Pennsylvania HB 1993: Authorizes pharmacists to administer all ACIP-recommended vaccines to patients 8 years and older and COVID-19 and influenza vaccines to patients 5 years and older; permits pharmacy technicians to administer COVID-19 and flu vaccines to patients 13 years and older; authorizes pharmacists to order and perform CLIA-waived tests for COVID-19, influenza, RSV, and streptococcal infections.

South Carolina H 3988: Authorizes pharmacists to administer vaccines to individuals 16 years of age and older pursuant to a statewide protocol authorized by the Board of Medical Examiners without an order or prescription of a provider; authorizes pharmacists to initiate, order, and administer flu and COVID tests.

Tennessee SB 869: Allows pharmacists to independently prescribe flu and COVID-19 vaccines for ages 3 and older; allows for all other immunizations for patients 18 and older.

## SCOPE OF PRACTICE

DC B 25-0545: Authorizes pharmacists to initiate HIV PEP/PrEP pursuant to a board-approved protocol.

Delaware SB 194: Authorizes pharmacists to initiate and administer HIV PrEP/PEP via statewide protocol approved by the state's Division of Public Health.

Florida HB 159: Permits licensed pharmacists to screen adults for HIV exposure and provide results and creates a process for pharmacists to be certified to order and dispense PEP under a collaborative practice agreement with a physician.

Idaho H 527: Authorizes pharmacists to prescribe, distribute, dispense, and administer emergency medications including opioid antagonists and epinephrine auto injectors.

Iowa HF 555: Authorizes pharmacists to independently order and administer prescription drugs and biological products in accordance with pharmacists' standard of care pursuant to a statewide board-approved protocol.

Louisiana HB 579: Authorizes pharmacists to perform and order rapid HIV tests for patients at least 17 years old and allows pharmacists to administer up to a 30-day supply of PrEP and/or 28-day supply of PEP.

Maryland HB 127: Authorizes pharmacists to dispense non-occupational PEP pursuant to a standing order.

Minnesota HF 5247: Permits pharmacists to prescribe and administer HIV PEP/PrEP after completing an accredited training program.

Tennessee SB 869: Authorizes pharmacists to dispense the following under certain conditions: opioid antagonists, epinephrine auto injectors, PEP for exposure to HIV infection, and hormonal contraception.

**PAYMENT FOR NON-DISPENSING SERVICES**

California SB 339: Requires health plans to cover HIV PrEP administered by a pharmacist, including related services and tests ordered by the pharmacist.

Delaware SB 272: Requires all insurers and health plans to reimburse pharmacists within their scope of practice at no lesser rate than non-physician practitioners.

Illinois SB 3268: Prohibits health benefit plans from denying reimbursement for testing, screening, and treatment ordered by a pharmacist within their scope of practice if the services were otherwise covered if performed by other practitioners.

Minnesota HF 5247: Mandates coverage from health plans for pharmacist-provided services within their scope of practice if the health plan covers the same service if provided by a physician.

Oregon SB 1506: Requires health benefit plans to provide payment to pharmacists the same way as for other health care providers testing for SARS-CoV-2 and administering treatments.

**MISCELLANEOUS**

Arkansas: The U.S. Court of Appeals for the Eighth Circuit ruled that Arkansas' law preventing reimbursement discrimination against contract pharmacies serving 340b covered entities was not preempted by federal law. The Pharmaceutical Research and Manufacturers of America sued Arkansas Insurance Commissioner Alan McClain after the enactment of Act 1103 in 2021. With this ruling, the insurance commissioner can continue enforcing these anti-discrimination provisions as authorized in the 2021 law.

Mississippi: The Mississippi Board of Pharmacy announced the completion of an audit of Optum's 2022 commercial claims. Several potential violations of state law were identified. Among the apparent violations, more than 75,000 claims were reimbursed at higher rates to PBM-owned or affiliated pharmacies during the study period. In reviewing the 49 MAC lists used by Optum, 22 were exclusive to chain pharmacies and 15 were specific to independent pharmacies. Within these lists, the board found the average independent MAC rates were 74 percent less than those of chains, with 97.7 percent of generics on MAC lists for independents versus 88 percent for chains. Meanwhile, more than 98 percent of MAC appeals were denied, many of which the board views as in conflict with statute.

Montana: Troy Downing, Montana state auditor and commissioner of securities and insurance, issued the state's annual "Pharmacy Benefit Manager Aggregated Rebate and Fee Transparency Report" as required by state law. Reviewing 2022 data, the report identified 3.1 percent of Montana's drug spend as spread pricing. While spread pricing is not against state law at this time, the spread amounted to nearly $9 million that was potentially uncompensated to pharmacies.

South Carolina: Attorney General Alan Wilson announced a settlement with Centene for $25,898,070, making it the 18th state to be compensated for Centene overcharges. The settlement agreement also resolves allegations that Centene misrepresented the true cost of pharmacy services, failed to disclose discounts to the state, and filed improper reporting to the state about its pharmacy benefit services. In the last 2 years, Centene's settlements with those states total almost $1 billion for overcharges to taxpayer-funded state Medicaid programs.

Texas: The Texas Office of the Inspector General has released several reports sharing findings of its audits of PBMs operating within the Medicaid managed care program. In an audit of Navitus, the OIG found Navitus out of compliance with its combination of product reimbursement and dispensing fees, obscuring the amount it paid to pharmacies in its Medicaid and the Children's Health Insurance programs. Meanwhile, the audits of Caremark found that, in its service to both Aetna and Wellpoint Medicaid plans, Caremark broke compliance by using effective rates that resulted in spread pricing, with massive funds not being passed back to the health plans. In turn, the health plans overrepresented drug expenditures in their reports to the Texas Health and Human Services Commission.