EMERGENCY RULE 128

PHARMACY BENEFITS MANAGER COMPENSATION REQUIREMENTS FOR NETWORK ADEQUACY

I. AUTHORITY & PUBLIC EMERGENCY

II. DEFINITIONS

III. COMPENSATION REQUIREMENTS FOR NETWORK ADEQUACY

IV. APPLICABILITY

V. VIOLATIONS

VI. DURATION OF THIS EMERGENCY RULE

VII. INCREASED COST EXEMPTION

VIII. EFFECTIVE DATE

I. AUTHORITY & PUBLIC EMERGENCY

This Emergency Rule is issued by the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-92-509(a)(2)(I), § 23-92-509(a)(2)(D) and § 23-92-509(b)(2)(A). Specifically, under the permissive rule authority of these code provisions, the Commissioner is authorized to adopt rules without limitation to implement the Arkansas Pharmacy Benefits Manager Licensure Act ("PBMLA"), Ark. Code Ann. §§ 23-92-501 et seq., for compensation and pharmacy benefits manager network adequacy.

Statement of Public Emergency. The Commissioner hereby finds under Ark. Code Ann. § 25-15-204(c) **that a public emergency exists to require changes to pharmacy reimbursement standards with pharmacy benefits managers in order to ensure reasonably sustainable network adequacy for health benefit plans in this State.**

II. DEFINITIONS

Unless otherwise defined in this section, the definitions in the PBMLA shall apply to the provisions in this Rule.

III. COMPENSATION REQUIREMENTS FOR NETWORK ADEQUACY

A. Pursuant to Ark. Code Ann. § 23-92-506(a)(1), the Commissioner may review and approve the compensation program of a pharmacy benefits manager ("PBM") with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan. The provisions of this Rule are specifically issued related to cost processes, and not plan benefit design, to help ensure the subject of network adequacy or reasonably sustainable network adequacy of pharmacy services for health benefit plans.

B. To ensure an adequate network of pharmacist or pharmacy services for a health benefit plan, or to ensure a reasonably sustainable adequate network for such services, a health benefit plan, and a pharmacy benefits plan or program, shall compensate or reimburse a pharmacy or pharmacist for prescription drug or device services no less than 110% of the current National Average Drug Acquisition Cost ("NADAC") **plus a $10.50 dispensing fee for all generic and branded drug transactions** or services, if a NADAC price is available, at the time of claim submission by the pharmacy or pharmacist. For drugs, drug services, or medications in which there is no NADAC price set by the Centers of Medicare and Medicaid Services ("CMS"), the minimum reimbursement shall be the wholesale acquisition cost ("WAC"), plus 10% and a $10.50 dispensing fee for all generic and branded drug transactions at the time of claim submission by the pharmacy or pharmacist services. The requirements in this Section shall apply on a per transaction basis. A PBM shall not be deemed to be in compliance with this section because it averages compliance with this section over any compiled or set averaged period of time with pharmacists or pharmacies.

C. Any provision in a pharmacy benefits plan or program, including but not limited to any provision in a contract between a PBM and a pharmacy services administrative organization ("PSAO") that is in conflict or inconsistent with Section III B of this Rule shall be unenforceable in this State, as to its Arkansas subscribers, for PBM and PSAO contracts in which an Arkansas licensed pharmacy or pharmacist has subscribed, endorsed or authorized in contracts or arrangements with a PBM through a PSAO. In the event of such conflicts, the compensation requirements of Section III B of this Rule shall apply.

D. Appeals. Every PBM shall create an electronic system or process to receive or process from an Arkansas licensed pharmacist or pharmacy an electronic appeal request on a claim for reimbursement failing to comply with Section III B of this Rule. An appeal by a pharmacist or pharmacy under this section shall state the amount of the NADAC or WAC percentage plus the dispensing fee, which was not paid, or not fully paid, by the PBM, not in compliance with Section III B of this Rule. A pharmacist or pharmacy shall have twenty (20) calendar days to submit such appeal to the PBM from the date of the drug reimbursement payment or non-payment. The PBM shall then have ten (10) calendar days to review the claim, and, if valid, electronically transfer to the pharmacist or pharmacy a corrected amount for the claim. Appeals not timely

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processed under this section, after thirty (30) days from the receipt of the appeal, shall additionally pay to the pharmacist or pharmacy a penalty of twelve percent (12%) interest per annum, included with the required amount of the claim under Ark. Code Ann. § 23-66-215(b)(2)(B).

E. Reports. Every PBM shall provide a written report to the Arkansas Insurance Department PBM Director, on a quarterly basis, on a form developed by the Department, that details the number of appeals presented to the PBM for compensation appeals under this Rule, and total payment adjustments made by the PBM as required under Section III D of this Rule for each quarter.

F. Complaints to the Arkansas Insurance Department. The Arkansas Insurance Department shall not review compensation complaints from pharmacists or pharmacies under Section III B of this Rule unless or until the pharmacist or pharmacy has exhausted its appeal(s) with the PBM under Section III D of this Rule. If the Department however reviews a complaint, after an appeal, and later determines that an appeal was not correctly paid or adjusted by the PBM, the PBM shall pay a fine of $5,000.00 to the Department for each drug reimbursement violation under Section VI of this Rule. In the event such violations develop into a pattern or trade practice of violations, the PBM shall additionally be subject to a $50,000.00 fine and other sanctions as permitted under Ark. Code Ann. § 23-66-210.

IV. APPLICABILITY

The requirements in this Rule shall apply to all pharmacy benefits plans or programs, limited to provision(s) in PSAO contracts with PBMs that govern, or relate to, compensation rates paid to Arkansas licensed pharmacists or pharmacy subscribers or contract holders, and to health benefit plan contracts issued in this State with PBMs, that are issued, delivered, extended or materially modified after the effective date of this Rule. However, in no event shall such past plans or contracts avoid the requirements of this Rule on or after September 30, 2024.

V. VIOLATIONS

Violations of any provision of this Rule shall be subject to the fines, penalties or sanctions permitted under Ark. Code Ann. § 23-92-508. Repeated violations by a PBM of this Rule shall result in the suspension or revocation of the PBM's license under Ark. Code Ann. § 23-66-210(a)(2).

VI. DURATION OF THIS EMERGENCY RULE

This Emergency Rule, and provisions therein, shall expire 120 days from the effective date of this Rule under Section VIII unless earlier replaced by a permanent rule adopting such standards, or similar standards.

VII. INCREASED COST EXEMPTION.

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A. The provisions of this Rule shall not apply to a health benefit plan if the application of this rule results in an increase to the actual and total costs of drug coverage in a health benefit plan such that these increases may actuarially result in an annual premium rate increase that exceeds 2%.

B. A determination under this section of increases to the actual drug costs of coverage of a health benefit plan, resulting in premium impact above 2%, shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. The determination shall be in a written report prepared by the actuary and submitted to the Arkansas Insurance Department for approval ninety (90) days prior to any effective date of such exemption. The exemption request must be significantly evidenced and itemized by verifiable data from the submitting actuary, and such request must be reviewed and approved by the Arkansas Insurance Department. The report and all underlying data relating to the exemption shall be retained by the healthcare insurer for six (6) years from the date of the request for an exemption.

C. To obtain an exemption under this section, a healthcare insurer shall make the increased cost determination required by this section after the health benefit plan has complied with this Rule for the first six (6) months of the health benefit plan year.

VIII. EFFECTIVE DATE

This Rule is effective ten (10) days after review and approval by the Arkansas Legislative Council.

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ALAN MCCLAIN

INSURANCE COMMISSIONER

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