AN ACT concerning insurance; relating to the oversight and regulation of pharmacy benefits managers; the pharmacy benefits managers licensure act; amending K.S.A. 2019 Supp. 40-3821, 40-3822, 40-3823, 40-3824, 40-3825, 40-3826, 40-3827, 40-3829 and 40-3830 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) A pharmacy benefits manager's license may be revoked, suspended or limited, or the licensee may be censured or placed under probationary conditions, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any the following grounds:

(1) The applicant or licensee committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated license;
(2) the licensee has violated any lawful rule and regulation promulgated by the commissioner or violated any lawful order or directive of the commissioner previously entered by the commissioner;
(3) the PBM has engaged in fraudulent activity that constitutes a violation of state or federal law;
(4) the commissioner has received consumer complaints that justify an action under this section to protect the safety and interest of consumers;
(5) the licensee has failed to furnish the commissioner, or the commissioner's investigators or representatives, any information legally requested by the commissioner;
(6) the PBM has been determined by the commissioner to be in violation or noncompliance with state or federal law; or
(7) the PBM has failed to timely submit a renewal application and the information required under K.S.A. 40-3824, and amendments thereto. In lieu of a denial of a renewal application, the commissioner may permit the PBM to submit to the commissioner a corrective action plan to correct or cure any deficiencies.

(b) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 2. (a) In addition to any fines or other penalties that the commissioner may establish through rules and regulations, the commissioner may enforce the provisions of this act as provided by K.S.A.
(b) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 3. (a) All compensation remitted by, or on behalf of, a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier or to a PBM under contract with a covered entity or plan sponsor, related to its prescription drug benefits shall be:

(1) Remitted directly to the covered person at the point of sale to reduce the covered person's out-of-pocket cost associated with a particular prescription drug; or

(2) remitted to and retained by the covered entity or plan sponsor. Compensation remitted to the covered entity shall be utilized by such covered entity or plan sponsor in its plan design in future plan years to offset premiums for covered persons.

(b) Beginning with the second quarter of a contract between a PBM and a covered entity or plan sponsor, the PBM shall prepare a quarterly transparency report summarizing data relating to prescription drug benefits for the previous quarter. Such transparency report shall be submitted to the covered entity or plan sponsor before the end of the calendar quarter and shall include the following information with respect to prescription drug benefits specific to the covered entity or plan sponsor:

(1) The aggregate paid claims count and aggregate dollar amount of payments made by the PBM to all pharmacies for all prescription drugs dispensed to the covered entity's or plan sponsor's covered persons during the previous calendar quarter;

(2) the aggregate dollar amount of rebates that the PBM expects to receive for all prescription drugs dispensed to the covered entity's or plan sponsor's covered persons during the previous calendar quarter;

(3) the aggregate dollar amount of any other fees or other compensation the PBM has received from a drug manufacturer or wholesale drug distributor related to the management or dispensing of prescription drugs to plan sponsor's enrollees exclusive of prescription drug rebates required in paragraph (2);

(4) if the PBM has a contract, agreement or other arrangement with a drug manufacturer to exclusively dispense or provide a drug to a covered entity's or plan sponsor's covered persons, and the application of all consideration or economic benefits collected or received pursuant to any such arrangement;

(5) prescription drug utilization information for the covered entity's or plan sponsor's covered persons;

(6) de-identified claims level information in an electronic format that allows the covered entity or plan sponsor to sort and analyze the following information for each claim:
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(A) If the claim required prior authorization;
(B) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
(C) any spread between the net amount paid to the pharmacy in subparagraph (B) and the amount charged to the covered entity or plan sponsor;
(D) if the pharmacy is under common control or ownership with the PBM;
(E) if the pharmacy is a preferred pharmacy under the plan;
(F) if the pharmacy is a mail order pharmacy; and
(G) if covered entity's or plan sponsor's covered persons are required by the plan to use the pharmacy;
(7) the aggregate paid claims count and aggregate dollar amount of payments made by the PBM to pharmacies owned or controlled by the PBM on behalf of the sponsor's plan;
(8) the aggregate paid claims amount and aggregate dollar amount of payments made by the PBM to pharmacies not owned or controlled by the PBM on behalf of the sponsor's plan; and
(9) the aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments made against network pharmacies, including point-of-sale fees and retroactive charges and the application of those amounts collected pursuant to the contract with the plan sponsor.

c) A PBM may require a covered entity or plan sponsor to agree to a nondisclosure agreement that specifies that the information reported under this section is confidential and proprietary information. The PBM shall not be required to disclose the information to the plan sponsor until the plan sponsor has executed the nondisclosure agreement, if so required by the PBM.

d) (1) On or before the 15th day of each month, a PBM shall provide each covered person with a full explanation of benefits for all claims processed during the previous calendar month for the covered person. This explanation of benefits shall be provided in a format approved by the commissioner and, at a minimum for each prescription claim during the covered month, contain:
(A) The plan ID;
(B) the beneficiary ID;
(C) the national drug code number;
(D) the drug name;
(E) the quantity;
(F) the claim amount;
(G) plan write-off amount;
(H) fees and adjustments including any applied rebates;
(I) the covered person's cost-sharing amount;
(J) ingredient reimbursement paid to the pharmacy;
(K) the professional dispensing fee paid to pharmacy; and
(L) any fee charged by the PBM to the pharmacy related to that
specific claim.

(2) Each report furnished to a covered person under this subsection
may be delivered either by electronic mail or by United States postal
service delivery.

(e) On and after July 1, 2021, and annually thereafter, each PBM shall
submit to the commissioner a transparency report containing data from the
prior calendar year as it pertains to covered entities and plan sponsors
doing business in Kansas. The report shall contain the following
information:

(1) The aggregate paid claims count and aggregate dollar amount of
payments made by the PBM to all pharmacies for each therapeutic
category of prescription drugs for all of the PBM's covered entity and plan
sponsor clients, and such payments net of all rebates and other fees and
payments, direct or indirect, that were credited against such payments
from all sources;

(2) the aggregate dollar amount of all rebates that the PBM received
from all drug manufacturers for all of the PBM's covered entity and plan
sponsor clients. The aggregate dollar amount of all rebates shall include
any utilization discounts that the PBM received from a drug manufacturer
or wholesale drug distributor;

(3) the aggregate dollar amount of all fees from all sources, direct or
indirect, that the PBM received for all the PBM's covered entity and plan
sponsor clients;

(4) the aggregate dollar amount of all retained rebates and other fees,
as described in paragraphs (2) and (3), that the PBM received from all
sources, direct or indirect, that were not passed through to plan sponsors;

(5) the percentage of the aggregate dollar amount of all rebates that
the retained rebate and fees represents;

(6) the highest, lowest and mean aggregate retained rebate and fees
percentage for all of the PBM's plan sponsor clients; and

(7) de-identified claims level information in an electronic format that
allows the commissioner to sort and analyze the following information for
each claim:

(A) The drug and quantity for each prescription;
(B) if the claim required prior authorization;
(C) the patient's cost-sharing paid on each prescription. This data is
classified pursuant to subsection (g);
(D) the amount paid to the pharmacy for each prescription, net of the
aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges. This data is classified pursuant to subsection (g);

(E) any spread between the net amount paid to the pharmacy in subparagraph (D) and the amount charged to the plan sponsor. This data is classified pursuant to subsection (g);

(F) the identity of the pharmacy for each prescription;

(G) if the pharmacy is under common control or ownership with the PBM;

(H) if the pharmacy is a preferred pharmacy under the plan;

(I) if the pharmacy is a mail order pharmacy; and

(J) if the covered entity's or plan sponsor's covered persons are required by the plan to use the pharmacy.

(f) The aggregate retained rebate and fee percentage shall be calculated for each plan sponsor for rebates and fees in the previous calendar year as follows: The total dollar amount of rebates and fees from all drug manufacturers for all utilization by covered persons of a covered entity or plan sponsor that were not passed through to the plan sponsor divided by the sum total dollar amount of all rebates and fees received from all sources, direct or indirect, for covered persons of a covered entity or plan sponsor.

(g) Data, documents, materials or other information in the possession or control of the commissioner of insurance that are obtained by, created by or disclosed to the commissioner pursuant to this section shall be considered confidential and privileged. Such data, documents, materials or other information are not subject to subpoena and are not subject to discovery or admissible in evidence in any private civil action. The commissioner may use the data, documents, materials or other information in the furtherance of a regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the data, documents, materials or other information public without the prior written consent of the PBM. Neither the commissioner nor any person who received data, documents, materials or other information while acting under the authority of the commissioner are permitted or required to testify in any private civil action concerning data, documents, materials, or information subject to this subsection that are classified as confidential, protected nonpublic, or both. The provisions of this subsection shall expire on July 1, 2025, unless the legislature reviews and reenacts this provision pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2025.

(h) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 4. (a) A PBM has a fiduciary duty to a health carrier client and shall discharge that duty in accordance with all applicable provisions
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of state and federal law.

(b) A PBM shall exercise good faith and fair dealing in the performance of its contractual duties. Any provision in a contract between a PBM and a covered entity or a network pharmacy that attempts to waive or limit this obligation is void.

(c) A PBM shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:

(1) The submission of a claim;
(2) enrollment or participation in a retail pharmacy network; or
(3) the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network.

(d) A PBM shall not deny, limit or terminate a pharmacy's contract based on the employment status of any employee who has an active license to dispense, despite probation status, with the state board of pharmacy.

(e) A PBM shall notify a covered entity in writing of any of its activities, policies or practices that may directly or indirectly present a conflict of interest with the duties imposed in this section.

(f) A PBM shall not impose pharmacy accreditation standards or recertification requirements for a pharmacy to participate in a network that are inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state unless authorized under this act.

(g) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 5. (a) A PBM shall provide an adequate and accessible retail pharmacy network for the provision of prescription drugs. Retail pharmacy networks shall comply with the following access standards:

(1) At least 90% of covered persons in the health benefit plan's urban service area live within two miles of a retail pharmacy participating in the health benefit plan's retail pharmacy network;

(2) at least 90% of covered persons in the health benefit plan's urban service area live within five miles of a retail pharmacy designated as a preferred participating pharmacy in the health benefit plan's retail pharmacy network;

(3) at least 90% of covered persons in the health benefit plan's suburban service area live within five miles of a retail pharmacy participating in the health benefit plan's retail pharmacy network;

(4) at least 90% of covered persons in the health benefit plan's suburban service area live within seven miles of a retail pharmacy designated as a preferred participating pharmacy in the health benefit plan's retail pharmacy network;
(5) at least 70% of covered persons in the health benefit plan's rural service area live within 15 miles of a retail pharmacy participating in the health benefit plan's retail pharmacy network;

(6) at least 70% of covered persons in the health benefit plan's rural service area live within 18 miles of a retail pharmacy designated as a preferred participating pharmacy in the health benefit plan's retail pharmacy network; and

(7) mail order pharmacies shall not be used to meet access standards for retail pharmacy networks.

(b) A PBM shall submit an annual pharmacy network adequacy report to the commissioner describing the pharmacy network and pharmacy accessibility in this state, with the PBM's license application and renewal, in a manner prescribed by the commissioner.

(c) A PBM may apply for a waiver from the commissioner if the PBM is unable to meet the network adequacy requirements under subsection (a). A waiver application shall be submitted to the commissioner on a form prescribed by the commissioner and shall:

(1) Demonstrate with specific data why the PBM is not able to meet the requirements; and

(2) include a detailed action plan describing the steps that were and will be taken to address network adequacy.

(d) If a waiver is granted by the commissioner, the waiver shall automatically expire after one year. If a renewal of the waiver is sought, the commissioner shall consider what steps the PBM has taken and how the PBM has addressed network adequacy over the past three-year period.

(e) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 6. (a) A PBM that has a direct or indirect ownership interest or an ownership interest through an affiliate or subsidiary in a pharmacy shall disclose to its covered entity or plan sponsor client any difference between the amount paid to that pharmacy and the amount charged to its covered entity or plan sponsor client.

(b) Except as provided in subsection (c), a PBM or covered entity or plan sponsor is prohibited from penalizing, requiring or providing financial incentives, including variations in premiums, deductibles, co-payments or coinsurance to incentivize a covered person to use a specific retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy provider in which a PBM has an ownership interest or in which the pharmacy provider has an ownership interest in the PBM.

(c) Subsection (b) shall not apply if the PBM or covered entity or plan sponsor offers a covered person the same financial incentives for using a retail pharmacy, mail order pharmacy, specialty pharmacy or other network pharmacy provider in which the PBM has no ownership interest.
(d) A PBM or covered entity or plan sponsor is prohibited from imposing limits, including quantity or refill frequency limits, on a covered person's access to medication that differ based solely on whether the health carrier or PBM has an ownership interest in a pharmacy or whether the pharmacy has an ownership interest in the PBM.

(e) Nothing in subsection (d) is construed to prohibit a PBM from imposing different limits, including quantity or refill frequency limits, on a covered person's access to medication based on whether the enrollee uses a mail order pharmacy or retail pharmacy so long as the covered person has the option to use a mail order pharmacy or retail pharmacy in which the PBM or health carrier does not have an ownership interest with the same limits imposed.

(f) A PBM shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy.

(g) A PBM or health insurer shall not prohibit a pharmacy authorized to participate in the federal 340B drug pricing program under section 340B of the public health service act, 42 U.S.C. 6A § 340B, or a pharmacy under contract with an entity authorized to participate in the program to provide pharmacy services, from participating in the PBM's or health insurer's provider network. A PBM or health insurer shall not reimburse a pharmacy authorized to participate in the program or a pharmacy under contract with an entity participating in the federal 340B drug pricing program differently from other similarly situated pharmacies.

(h) (1) Any pharmacy that has a contract or pharmacist who has a contract, either directly or indirectly through a pharmacy services administration organization, with a PBM administering any type of drug or pharmacy benefit plan to provide covered drugs, devices or services at a contractual reimbursement rate may decline to provide a covered drug, device or service if the pharmacy or pharmacist is currently reimbursed or will be reimbursed at less than the acquisition cost for the covered drug, device or service.

(2) If the pharmacy or pharmacist declines to provide the drug, device or service as authorized in this subsection, then the pharmacy or pharmacist shall provide the customer with adequate information for the customer to determine where the prescription for the drug, device or service may be filled.

(i) A PBM, pharmacy services administration organization or any person acting for, or on behalf of, a PBM or pharmacy services
administration organization shall not cancel any contract with a pharmacy
or pharmacist, sue for breach of contract, use the decision to decline as a
cause for not renewing the contract or retaliate against or penalize the
pharmacy or pharmacist in any way for exercising the pharmacy's or
pharmacist's rights under this section.

(j) This section shall be a part of and supplemental to article 38 of
chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 7. (a) A PBM or health carrier shall not require or
demonstrate a preference for a pharmacy to dispense a therapeutically
equivalent or therapeutically alternative drug that costs the enrollee more
out-of-pocket than the prescribed drug, unless the substitution is made for
medical reasons that benefit the patient. Substitution made under this
section shall comply with the pharmacy act of the state of Kansas.

(b) This section shall be a part of and supplemental to article 38 of
chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 8. (a) A PBM that contracts with a specialty pharmacy shall
disclose to a covered person, upon such covered person's request, the
covered person's out-of-pocket cost at the specialty pharmacy and the
covered person's out-of-pocket cost at a retail pharmacy identified by the
covered person as being an in-network pharmacy with the covered person's
health plan, for the prescription drug referenced by the covered person.

(b) A PBM is required to allow any pharmacy that can legally obtain
medications defined as specialty medications within a given health plan to
provide those medications to a covered person upon such covered person's
request.

(c) This section shall be a part of and supplemental to article 38 of
chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 9. (a) A PBM that uses a preferred network of pharmacies
shall disclose to a covered person, upon such covered person's request, the
covered person's out-of-pocket cost at the preferred pharmacy and the
covered person's out-of-pocket cost at a nonpreferred pharmacy identified
by the covered person as being an in-network provider with the covered
person's health plan, for the prescription drug referenced by the covered
person.

(b) A PBM shall not deny any pharmacy in good standing with the
board of pharmacy the opportunity to participate in any pharmacy network
at preferred participation status.

(c) A PBM, or representative of a PBM, shall not cause or knowingly
permit the use of advertisement, promotion, solicitation, representation,
proposal or offer that is untrue, deceptive or misleading to patients or the
general public regarding access to pharmacies in a pharmacy network.

(d) This section shall be a part of and supplemental to article 38 of
chapter 40 of the Kansas Statutes Annotated, and amendments thereto.
New Sec. 10. (a) A PBM shall permit a pharmacy to collect the amount of a covered person's cost share from any source.

(b) Except as provided in subsection (c), a PBM shall not deny or reduce a reimbursement to a pharmacy or a pharmacist after the adjudication of a disputed claim, unless:

(1) The pharmacy or pharmacist fraudulently submitted the original claim;

(2) the original reimbursement was incorrect because:
(A) The pharmacy or pharmacist had already been paid for the pharmacy service; or
(B) an unintentional error resulted in an incorrect reimbursement; or
(3) the pharmacy service was not rendered by the pharmacy or pharmacist.

(c) Subsection (b) shall not apply if an investigative audit of pharmacy records for fraud, waste, abuse or other intentional misrepresentation indicates that the pharmacy or pharmacist engaged in criminal wrongdoing, fraud or other intentional misrepresentation.

(d) This section shall be a part of and supplemental to article 38 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

Sec. 11. K.S.A. 2019 Supp. 40-3821 is hereby amended to read as follows: 40-3821. (a) K.S.A. 2019 Supp. 40-3821 through 40-3828 and sections 1 through 10, and amendments thereto, shall be known and may be cited as the pharmacy benefits manager registration licensure act.

(b) On and after January 1, 2021, a person shall not perform, act or do business in this state as a PBM unless such person has a valid license issued by the commissioner pursuant to this act.

(c) This act shall apply to any pharmacy benefits manager PBM that provides claims processing services, other prescription drug or device services, or both, to covered persons who are residents of this state.

(e) This act shall not apply to any pharmacy benefits manager PBM that holds a certificate of registration as an administrator pursuant to K.S.A. 40-3810, and amendments thereto.

(e) A license issued in accordance with this act shall be nontransferable.

Sec. 12. K.S.A. 2019 Supp. 40-3822 is hereby amended to read as follows: 40-3822. For purposes of this act:

(a) "Commissioner" means the commissioner of insurance as defined by K.S.A. 40-102, and amendments thereto.

(b) (1) "Covered entity" means:
(A) A nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization; or
(B) a health program administered by a department or the state in the capacity of provider of health coverage; or
(C)—an employer, labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state.

(2) "Covered entity" shall not include any:

(A) Self-funded plan that is exempt from state regulation pursuant to ERISA;

(B) plan issued for coverage for federal employees; or

(C) health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.

(c) "Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

(d) "Department" means the department of insurance.

(e) "Health benefit plan" means the same as defined in K.S.A. 40-4602, and amendments thereto.

(f) "Health insurer" means the same as defined in K.S.A. 40-4602, and amendments thereto.

(g) "Maximum allowable cost" or "MAC" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug.

(h) "Pharmacy benefits management" means:

(1) Any of the following services provided with regard to the administration of the following 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; or

(F) disease management programs involving prescription drug utilization; and

(2) (A) the procurement of prescription drugs by a prescription benefits manager at a negotiated rate for dispensation to covered individuals within this state; or

(B) the administration or management of prescription drug benefits provided by a covered insurance entity for the benefit of covered individuals.

(e)(i) "Pharmacy benefits manager" or "PBM" means a person, business or other entity that performs pharmacy benefits management.
"Pharmacy benefits manager" includes any person or entity acting in a contractual or employment relationship for a pharmacy benefits manager in the performance of pharmacy benefits management for a covered entity. The term "Pharmacy benefits manager" shall not include a covered insurance entity.

(f)(j) "Person" means an individual, partnership, corporation, organization or other business entity.

Sec. 13. K.S.A. 2019 Supp. 40-3823 is hereby amended to read as follows: 40-3823. Registration requirement

(a) No person shall act or operate as a pharmacy benefits manager (PBM) without first obtaining a valid certificate of registration issued by the commissioner.

(b) Each person seeking a certificate of registration to act as a pharmacy benefits manager (PBM) shall file with the commissioner an application for a certificate of registration upon a form to be furnished by the commissioner. At a minimum, the application form shall include the following information:

(1) The name, address and telephone number of the PBM.

(2) The name, address, official position and professional qualifications of each individual who is responsible for the conduct of the affairs of the pharmacy benefits manager (PBM), including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager (PBM).

(2)(3) The name and address of the applicant's agent for service of process in the state.

(4) The name, address, phone number, email address, official position and professional qualifications of each person responsible for setting MAC prices, including all persons with authority to modify MAC prices in response to MAC appeals.

(3)(5) A nonrefundable application fee of $2,500.

(c) (1) Upon receipt of an application, the commissioner may require additional documentation or information necessary to verify the information contained in the application. Within 30 days of receiving an application, the commissioner may request additional information or submissions from an applicant for licensure and shall obtain any document or information reasonably necessary to verify the information contained in the application.

(2) Within 90 days after receipt of a completed application, the network adequacy report and the applicable license fee, the commissioner
shall review the application and issue a license if the applicant is deemed qualified under this section. If the commissioner determines the applicant is not qualified, the commissioner shall notify the applicant and shall specify the reason for the denial.

Sec. 14. K.S.A. 2019 Supp. 40-3824 is hereby amended to read as follows: 40-3824. (a) Each pharmacy benefits manager registration license shall expire on March 31 each year and may be renewed annually on the request of the registrant licensee. The application for renewal shall be submitted on a form furnished by the commissioner and accompanied by a renewal fee of $140 $2,500. The application for renewal shall be in such form and contain such matters as the commissioner prescribes.

(b) If a registration license renewal fee is not paid by the prescribed date, the amount of the fee, plus a penalty fee of $140 $2,500 shall be paid. The pharmacy benefits manager registration license may be revoked or suspended by the commissioner until the renewal fee and any penalty assessed has been paid.

(c) Any person who performs or is performing any pharmacy benefits management service on the effective date of this act must obtain a certificate of registration. July 1, 2020, shall be required to obtain a license as a pharmacy benefits manager from the commissioner within 90 days after the effective date of this act by October 1, 2020, in order to continue to do business in Kansas.

Sec. 15. K.S.A. 2019 Supp. 40-3825 is hereby amended to read as follows: 40-3825. In accordance with the provisions of the rules and regulations filing act, K.S.A. 77-415 et seq., and amendments thereto, (a) The commissioner may adopt, amend and revoke rules and regulations governing the administration and enforcement of this act, including, but not limited to:

(1) The content of the application form;
(2) the content of any other form or report required to implement this act; and
(3) such other rules and regulations as the commissioner may deem necessary to carry out implement and administer the provisions of this act.

(b) The commissioner shall adopt, amend and revoke all such necessary rules and regulations not later than July 1, 2022.

Sec. 16. K.S.A. 2019 Supp. 40-3826 is hereby amended to read as follows: 40-3826. Any person who acts as a pharmacy benefits manager PBM without being registered licensed as required by this act shall be subject to a fine of $500 for each $5,000 for the period that the PBM is found to be in violation.

(b) If a PBM is found to be in violation of or non-compliant with any state or federal law, the PBM shall be subject to a fine of $5,000 per violation and $5,000 per occurrence of non-compliance.
Sec. 17. K.S.A. 2019 Supp. 40-3827 is hereby amended to read as follows: 40-3827. There is hereby established in the state treasury the pharmacy benefits manager licensure fund. Such fund shall be administered by the commissioner for costs related to administering the pharmacy benefits manager licensing act. All expenditures from the pharmacy benefits manager licensure fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner or by the commissioner's designee. The commissioner shall remit all moneys received by or for the commissioner under the provisions of this act to the state treasurer at least monthly in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury and such amount shall be credited to the pharmacy benefits manager registration licensure fund.

Sec. 18. K.S.A. 2019 Supp. 40-3829 is hereby amended to read as follows: 40-3829. As used in this act K.S.A. 2019 Supp. 40-3829 and 40-3830, and amendments thereto:

(a) "List" means the list of drugs for which maximum allowable costs have been established;

(b) "Maximum allowable cost" or "MAC"—means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug includes without limitation:

(1) Average acquisition cost, including national average drug acquisition cost;
(2) average manufacture price;
(3) average wholesale price;
(4) brand effective rate or generic effective rate;
(5) discount indexing;
(6) federal upper limits;
(7) wholesale acquisition cost; and
(8) any other term that a pharmacy benefits manager or a healthcare insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services;

(b) "maximum allowable cost list" or "MAC list" means a listing of drugs or other methodology used by a pharmacy benefits manager, directly or indirectly, that sets the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product or other prescription drug;

(c) "network pharmacy" means a pharmacy that contracts with a pharmacy benefits manager; and

(d) "pharmacy benefits manager" or "PBM"—shall have the same meaning as means the same as defined in K.S.A. 2019 Supp. 40-3822(e),
and amendments thereto.

Sec. 19. K.S.A. 2019 Supp. 40-3830 is hereby amended to read as follows: 40-3830. A pharmacy benefits manager shall:

(a) Not pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services in an amount less than:

(1) The pharmacy's usual and customary price;
(2) the national average drug acquisition cost; or
(3) the pharmacy's wholesale acquisition cost if the national average drug acquisition cost is unavailable.

(b) Pay to every pharmacy a professional dispensing fee that is equal to the dispensing fee set in the state program for medical assistance, authorized by K.S.A. 39-709, and amendments thereto.

(c) Use a single MAC list to establish the maximum amount to be paid to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A PBM shall use the same MAC list for each pharmacy provider.

(d) Shall not place a drug on a MAC list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase, without conditions, by network pharmacies from national or regional wholesalers and the national drug code, NDC, for the drug is not obsolete.

(b) Shall(e) Provide to each network pharmacy at the beginning of the term of a contract and upon request thereafter, the sources utilized to determine the maximum allowable cost MAC price.

(e) Shall provide a process for each network pharmacy provider to readily access the maximum allowable price specific to that provider.

(f) Upon request of a network pharmacy, disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list for each plan sponsor and pharmacy network rate schedule that applies to the network pharmacy. A PBM shall make the list of the maximum allowable costs available in its entirety, in a readily accessible format to all contracted pharmacies.

(g) Ensure that the MAC prices are set at sufficient levels to ensure products are readily available to pharmacies to purchase at or below the MAC price established for similarly situated pharmacies within the PBM's preferred network.

(h) Review and update each applicable—maximum—allowable cost MAC list every seven business days, noting any price changes from the previous list, including retroactive MAC adjustments based on successful MAC appeals by a participating pharmacy in a separate section of the list, provide a means by which network pharmacies
may promptly review current prices in an electronic, print or telephonic format and apply the updates to reimbursements no later than one business day at no cost to the pharmacy. Such information shall be available to the pharmacy or the pharmacy's representative in a comprehensive downloadable format that includes all national drug codes, the unit MAC price allowed and an identifying code connecting fee schedules and patients to the respective MAC list used to price claims for reimbursement.

(i) Ensure that the MAC prices are not set below sources utilized by the PBM.

(e) Shall (j) Ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(f) Shall (k) Establish a process by which a network pharmacy may appeal reimbursement for a drug subject to maximum allowable cost as follows:

(1) The network pharmacy must file an appeal no not later than 15 business days after the fill date.

(2) The PBM shall provide a response to the appealing network pharmacy no not later than seven business days after receiving an appeal request containing information sufficient for the PBM to process the appeal as specified by the contract.

(3) If the appeal is upheld, the PBM:

(A) Shall make the adjustment in the drug price effective no later than one business day after the appeal is resolved;

(B) shall make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the plan sponsor or pharmacy benefits manager, as appropriate; and

(C) permit the appealing pharmacy to reverse and rebill the appealed claim.

(4) If the appeal is denied, the PBM shall provide the appealing pharmacy the specific sources utilized for setting the maximum allowable cost, including the national drug code number from a national or regional wholesaler operating in Kansas where the drug is generally available for purchase at a price equal to or less than the maximum allowable cost, and when applicable, may be substituted lawfully.

(5) If an appeal is upheld, the PBM shall:

(A) Make an adjustment to the MAC price not later than one business day after the date of determination and update the MAC price in the adjudication system so that the pharmacy may reverse and reprocess the claim for the increased reimbursement; and

(B) make the determined price adjustment applicable to all similarly situated network pharmacy providers. The PBM shall waive timely filing requirements to allow pharmacies the ability to reverse and reprocess claims to comply with this paragraph.

Sec. 21. This act shall take effect and be in force from and after its publication in the statute book.