



Legislature Could Consider Options to Address Pharmacy Benefit Manager Business Practices

at a glance

Pharmacy benefit managers (PBMs) provide their services to health care sponsors as a way to manage prescription drug benefits and costs. While they emerged in the mid-1980s as entities that processed prescription drug claims, they have expanded to provide a wide range of services, typically including developing and managing drug formularies and pharmacy networks and providing drugs through mail-order and specialty pharmacies. Because PBMs act as intermediaries between health plan sponsors and drug manufacturers and pharmacies, they are sometimes referred to as middlemen in the drug industry.

In recent years, federal and state litigation as well as various stakeholders in the prescription drug industry have alleged that PBMs sometimes engage in unfair business practices. This perception results from the lack of transparency in PBM costs and profits, which occurs because PBMs consider their contract negotiations with drug manufacturers and pharmacies confidential and proprietary. As of December 2006, three states and the District of Columbia have passed legislation that addresses transparency, and another 28 states have considered such measures. In addition, two states have passed legislation to regulate PBMs. Health plan sponsors and PBMs have also responded to these concerns by taking steps to increase transparency. The Legislature could give market forces an opportunity to increase transparency or could consider legislation to regulate PBMs.

Scope

Pursuant to a legislative request, OPPAGA reviewed pharmacy benefit managers. This report addresses four questions.

- What role do PBMs play in the prescription drug industry?
- What concerns exist related to PBM business practices?
- How have states, PBMs, and health plan sponsors addressed these concerns?
- What options could the Legislature consider to address PBM business practices?

Background

Pharmacy benefit managers provide services to health plan sponsors to help manage prescription drug benefits.¹ PBMs initially emerged in the mid-1980s as prescription drug claims processors. In the early 1990s, they began to expand services and currently offer a wide range of services designed to manage pharmacy costs. In addition to processing claims submitted by pharmacies, these services include drug formulary development, pharmacy network development and management, mail-order and specialty pharmacy services, rebate negotiation, therapeutic substitution, disease management, utilization review, and support services for physicians and beneficiaries. See Exhibit 1 for an explanation of each of these services.

¹ Health plan sponsors include health maintenance organizations; self-funded employer plans, including federal, state, and local government employee plans; union health plans; Medicare managed care and Medicare prescription drug plans; and some state Medicaid programs.

**Exhibit 1
Pharmacy Benefit Managers Provide a Variety of Services to Health Plan Sponsors**

Type of Service	Description
Pharmacy Claims Processing	Verifies beneficiary eligibility and plan benefits and pays pharmacies for filling prescriptions.
Drug Formulary Development	Identifies which preferred and non-preferred drugs to include in health plan benefits, develops rules for generic substitutions, and establishes co-payments and/or deductibles.
Pharmacy Network Development and Management	Establishes a network of pharmacies from which beneficiaries can purchase their prescriptions.
Mail-Order and Specialty Pharmacy Services	Provides beneficiaries with the option to obtain prescriptions by mail and at specialty pharmacies for prescriptions to treat complex and chronic diseases that are not dispensed at retail pharmacies.
Rebate Negotiations	Lowers the cost of drugs by negotiating discounts with manufacturers for formulary placement and volume.
Therapeutic Substitution	Ensures that, when clinically appropriate, physicians prescribe drugs that are on health plan sponsors' drug formularies.
Disease Management	Provides health education to beneficiaries to help them better manage specific medical conditions, such as diabetes or asthma.
Utilization Review	Reviews beneficiary drug usage and recommends ways to lower costs, including switching a prescribed brand-name drug to a generic or less expensive brand-name drug.
Support Services for Physicians and Beneficiaries	Provides education to physicians and beneficiaries on appropriate prescribing and prescription use, general health and wellness, and patient compliance.

Source: OPPAGA interviews and analysis of *Pharmacy Benefit Managers (PBMs): Tools for Managing Drug Benefit Costs, Quality, and Safety*; Health Policy Alternatives, Inc.; August 2003.

Health plan sponsors contract with PBMs to provide various services. For example, a large health maintenance organization that prefers to oversee formulary development and disease management in-house may only contract for a few services, such as claims processing and pharmacy network management. Another sponsor might prefer to contract for a full array of services, including most or all of the services described in Exhibit 1.

Payments for these services are established in contracts between health plan sponsors and PBMs. For example, contracts will specify how much health plan sponsors will pay PBMs for brand-name and generic drugs. These prices are typically set as a discount off the Average Wholesale Price for brand-name drugs and at a Maximum Allowable Cost for generic drugs, plus a dispensing fee.² Contracts also generally

include fees for processing claims submitted by pharmacies (usually based on a rate per claim) and fees for providing services such as disease management or utilization review.³ In addition, contracts generally specify whether and how the PBM will pass manufacturer rebates on to the health plan sponsors.⁴ The contracts can also include performance guarantees, such as claims processing accuracy or amount of rebates received.

Currently, approximately 70 PBMs operate in the United States and manage prescription drug benefits for health plan sponsors. One industry stakeholder estimates that PBMs manage prescription drug benefits for approximately 95%

to physicians, pharmacies and others, such as hospitals. The Maximum Allowable Cost, a price set for generic drugs, is the maximum amount that the health plan will pay for a specific drug.

³ If the PBM owns the mail-order or specialty pharmacy, claims processing fees may not be applied.

⁴ Contracts may specify a fixed amount per prescription (such as \$1) or a percentage of the total rebates received by a PBM (which can range up to 100%).

² The Average Wholesale Price is the retail list price (sticker price) or the average price that manufacturers recommend wholesalers sell

of health insurance beneficiaries nationwide. The largest PBMs include Caremark Rx, Inc.; Medco Health Solutions, Inc.; Express Scripts; Walgreens Health Initiatives, Inc.; and PharmaCare.⁵

Although Florida law does not establish a specific licensing or regulatory process for PBMs, both federal and state laws regulate PBM services in Florida. These include federal laws that protect the privacy of health information; prevent abuse and misuse of controlled substances; protect federal employee and self-insured health plans, Medicare, and Medicaid from fraud; and guard against anti-competitive and anti-trust activities.⁶ Florida law requires pharmacies and pharmacists that dispense prescriptions to Floridians to obtain proper permits and licenses whether pharmacies are located in Florida or in another state. These laws apply to PBM mail-order and specialty pharmacies that provide prescriptions to Floridians.⁷ In addition,

PBMs must comply with Florida’s prompt claims payment laws and with the requirements of the state’s Medicaid Third-party Liability Act.^{8,9} Further, Florida law that regulates health insurers and managed care organizations apply to those services that PBMs provide on behalf of these entities.¹⁰

Questions and Answers —

What role do PBMs play in the prescription drug industry?

PBMs are sometimes referred to as the middlemen in the prescription drug market because they act as intermediaries between health plan sponsors and drug manufacturers and pharmacies. As shown in Exhibit 2, PBMs negotiate with drug manufacturers and pharmacies on behalf of plan sponsors.

⁵ Caremark Rx, Inc. serves as the PBM for Florida’s self-insured employee health plan.

⁶ For example, PBMs that process pharmacy claims or dispense prescriptions through mail-order pharmacies must comply with provisions of the federal Health Insurance Portability and Accountability Act that established national standards for the use and disclosure of any patient’s medical information. In addition, as mail-order pharmacies that dispense narcotics, PBMs must comply with record-keeping provisions of the federal Controlled Substance Act.

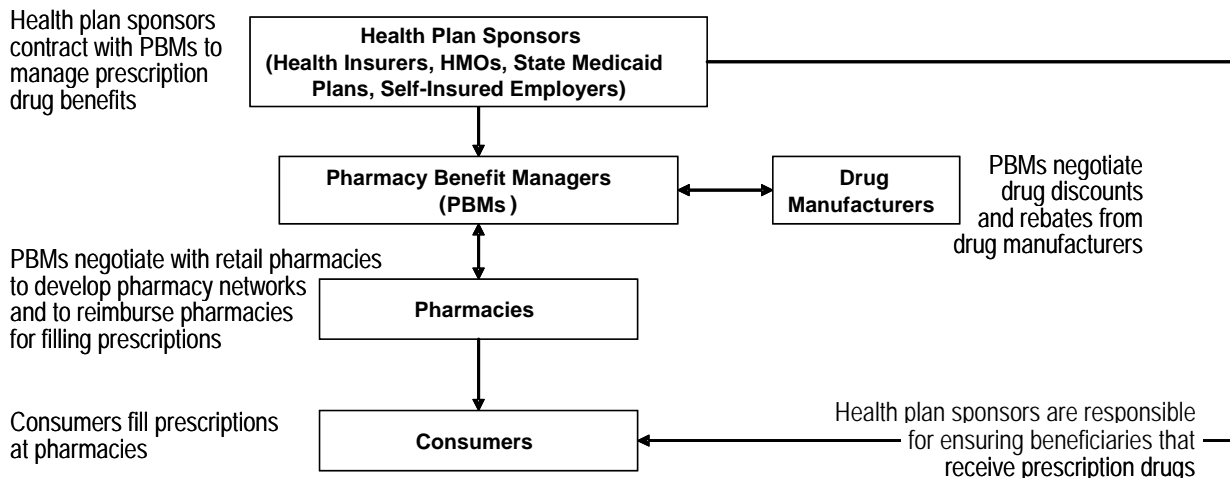
⁷ Florida Pharmacy Act, Ch. 465, F.S.

⁸ Section 641.3155, F.S., requires that a PBM acting on behalf of a health maintenance organization shall pay pharmacy claims that have been submitted or notify the designee that the claim is contested within 30 days of receipt.

⁹ Section 409.910, F.S., creates the Medicaid Third-Party Liability Act which specifies responsibility of payment on behalf of Medicaid-eligible persons.

¹⁰ For example, Florida statute that requires the Agency for Health Care Administration to administer a program for beneficiaries of managed care organizations to file unresolved grievances applies to beneficiaries who receive prescription drug benefits from managed care organizations that contract with PBMs.

Exhibit 2 Pharmacy Benefit Managers Play a Central Role in the Prescription Drug Market



Source: OPPAGA analysis of Pharmacy Benefit Manager industry publications.

These negotiations include provisions for cash rebates that drug manufacturers pay for drugs placed on health plan sponsor formularies (lists of approved drugs for prescribing) and the volume of these drugs that are used by health plan beneficiaries. PBMs also contract with pharmacies on behalf of plan sponsors to establish how pharmacies will be reimbursed for prescriptions they dispense to health plan sponsor beneficiaries.

What concerns exist related to PBM business practices?

In recent years, federal and state litigation as well as various stakeholders in the prescription drug industry have alleged that PBMs sometimes engage in unfair business practices that may not be in health plan sponsors' or their beneficiaries' best interests. These allegations cite unfair business practices that have resulted in excessive profits at the expense of health plan sponsors or pharmacies. The confidential and proprietary nature of PBM contracts and financial arrangements with drug manufacturers and pharmacies creates the opportunity for PBMs to engage in unfair business practices.

Federal and state litigation claims PBMs engage in unfair business practices. In 2003, the United States Department of Justice and 20 state attorneys general, including Florida's, filed complaints against Medco Health Solutions, many under state and federal False Claims Acts.^{11, 12} The cases alleged that Medco defrauded government-funded health insurance programs by accepting payments from manufacturers for influencing physicians to prescribe certain drugs as well as accepting rebates from drug manufacturers for increasing product market share.¹³ In April 2004, this case was settled requiring Medco to follow specific guidelines and pay \$29.1 million in damages to states and individuals. A federal consent order is pending.

¹¹ Federal and state false claims acts protect the federal and state governments from paying or approving false claims.

¹² The 20 states include Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nevada, New York, North Carolina, Oregon, Pennsylvania, Texas, Vermont, Virginia, and Washington.

¹³ These rebates were in addition to those negotiated on behalf of health plan sponsors for placement of drugs on plan formularies.

In another example, New York workers' unions collectively filed a December 2003 lawsuit against Express Scripts for engaging in fraudulent practices by unlawfully withholding discounts and rebates with manufacturers and artificially inflating drug prices. This case is pending before the New York Supreme Court. In addition, lawsuits filed in August and October 2003 by individual pharmacies and the National Community Pharmacists Association allege that three major PBMs set pharmacy reimbursements artificially low (sometimes lower than the actual costs that pharmacies pay for drugs). These cases are pending before the United States District Court for the Eastern District of Pennsylvania.

Claims of unfair business practices generally allege that PBMs have excessively profited at the expense of health plan sponsors or pharmacies. Although PBMs save health plan sponsors money by managing prescription drug costs, litigation, as well as stakeholders representing health plan sponsors, allege that PBMs have excessively profited by illegally accepting secret monetary incentives from drug manufacturers that are not shared with health plan sponsors. To manage prescription drug costs, PBMs negotiate rebates with manufacturers for drugs placed on health plan formularies as well as on the volume of drugs used by beneficiaries of the health plan sponsor. PBMs also manage costs by substituting, when clinically appropriate, a beneficiary's prescription for a more cost-effective drug, i.e., a less expensive but therapeutically equivalent brand-name or generic drug.

However, lawsuits assert that some PBMs have illegally accepted secret rebates or payments from manufacturers that are not shared with health plan sponsors, such as incentives for increasing a manufacturer's drug sales. Also, some stakeholders allege that PBMs have illegally increased rebates by changing patient prescriptions to drugs that receive higher rebates. These business practices are not only illegal but can also increase health plan sponsor costs if PBMs switch beneficiaries to higher cost drugs.¹⁴

¹⁴ Federal and state anti-kickback laws classify payments in exchange for favorable treatment as illegal kickbacks.

Drug switching, for non-clinical reasons, also may not be in the best interest of patients as changed prescriptions can potentially cause them harm or result in higher out-of-pocket payments.

Lawsuits and stakeholders also allege that PBMs have excessively profited from the price spread created by the difference between pharmacy reimbursements and health plan sponsor drug prices. Ideally, health plan sponsors should pay drug prices to the PBMs that are comparable to the prices that PBMs reimburse pharmacies. However, some stakeholders allege that PBMs have realized high profits by charging health plan sponsors significantly higher drug prices than prices at which they reimburse pharmacies. For example, in 2002 one PBM made a profit of \$200 for each prescription of a generic version of Zantac, a drug for acid reflux, it sold on behalf of a health plan sponsor. It did this by charging the health plan sponsor \$215 per prescription while only reimbursing network pharmacies \$15.

Lack of transparency creates opportunity for PBMs to engage in unfair business practices. Many of these issues arise because historically, PBM contracts with health plan sponsors have not provided sponsors access to information on PBM transactions or negotiations with manufacturers and pharmacies. PBMs consider this information to be confidential and proprietary. However, this lack of transparency increases the potential that PBMs may engage in unfair business practices that can prevent health plan sponsors and pharmacies from receiving a fair share of the profits realized by PBMs in their negotiations with drug manufacturers.

How have states, PBMs, and health plan sponsors addressed these concerns?

As of December 2006, three states and the District of Columbia have passed legislation that addresses these issues by requiring contract transparency. Another 28 states, including Florida, have considered but not passed similar legislation. In addition, two states have passed legislation to regulate PBMs by requiring licensure or oversight by state insurance departments or pharmacy boards. PBMs, health plan sponsors, and other

stakeholders have also taken steps to change business practices and increase transparency.

To address the lack of transparency, states have passed or considered legislation to regulate PBMs. In 2003, Maine passed legislation that imposes a fiduciary duty on PBMs, requiring them to act in the best interest of health plan sponsors.¹⁵ Maine's legislation also requires PBMs to fully disclose information related to contracts they have with drug manufacturers and all rebates or other payments related to negotiations with drug manufacturers. The legislation also outlines steps PBMs must take to make drug substitutions. The District of Columbia passed similar legislation imposing a fiduciary duty on PBMs and requiring them to pass on all payments from drug manufacturers.¹⁶ South and North Dakota, in 2004 and 2005, respectively, also passed laws with transparency provisions addressing disclosure, treatment of rebates, and drug substitution guidelines.

Another 28 states, including Florida, have considered but not passed legislation to address transparency issues.¹⁷ In 2004, the Florida Legislature considered but did not pass legislation that would impose a fiduciary duty on PBMs, require them to disclose information on financial arrangements they have with drug manufacturers, and establish guidelines for drug substitution.¹⁸ (See Appendix A for a summary of legislation passed or considered by states.)

¹⁵ A fiduciary duty requires PBMs to place the interest of the health plan sponsor above its own interests.

¹⁶ While federal courts upheld a challenge to the Maine legislation, the legislation passed by the District of Columbia is still in litigation in a U.S. District Court.

¹⁷ Although proposed legislation varies among these states, legislation generally requires PBMs to disclose contractual relationships with drug manufacturers and pass on revenues they receive related to drug purchasing; declares that PBMs have a fiduciary responsibility; and establishes guidelines for PBMs to use for drug substitutions.

¹⁸ House Bill 1347 and Senate Bill 3042.

In addition to legislation that addresses transparency by imposing fiduciary duties and requiring more disclosure, some states have considered legislation to regulate PBMs by requiring licensure, certification, or registration through state insurance regulation offices or pharmacy boards.¹⁹ For example, the 2003 Florida Legislature considered but did not pass legislation that would have required dual regulation of PBMs by the Office of Insurance Regulation and the Board of Pharmacy.²⁰ To date, two states, Maryland and Kansas, have passed this type of legislation. In 2003, Maryland passed legislation requiring PBMs that conduct utilization reviews for health plan sponsors to register with the state's insurance commissioner. Kansas passed legislation in 2006 that requires all PBMs to register with the Commissioner of Insurance.

PBMs, health plan sponsors, and other stakeholders have taken steps to address transparency concerns. To create more transparency in their business practices, PBMs have begun to offer health plan sponsors contracts that provide more transparency than traditional contracts. These contracts give health plan sponsors access to information about contractual and financial arrangements with drug manufacturers and pharmacies. Some PBMs also will negotiate contracts that establish drug prices for health plan sponsors equal to the price at which PBMs reimburse pharmacies. In addition to these voluntary steps, the provisions of settled lawsuits require defendant PBMs to adhere to specific transparency practices.²¹

Health plan sponsors and other stakeholders are working to encourage more transparent business practices. In 2005, the Human Resource Policy Association, a national association of chief human resource officers representing over 250 large employers, formed a coalition to certify PBMs

based on a set of transparent contracting standards. As of January 2006, the coalition had certified 10 PBMs.^{22, 23} In June 2006, URAC, an independent accrediting organization that promotes health care quality, formed a committee to establish benchmarks for accrediting PBMs for Medicare, commercial insurance, and health plan sponsors.²⁴

Some stakeholders claim that over time these efforts combined with the effect of litigation will reduce the need for regulation. However, because the more transparent contracts generally require PBMs to pass on more rebates to health plan sponsors, potentially reducing profits, PBMs have increased their administrative fees for transparent contracts. In addition, the more transparent contracts require health plan sponsors to accept greater risk because these contracts do not guarantee specific amounts of drug rebates. Health plan sponsors could also experience greater administrative costs because of the increased monitoring needed to ensure transparency. As such, some health plan sponsors are reluctant to negotiate more transparent contracts, in part, because they prefer contracts with lower fixed costs and guaranteed rebates.

What options could the Legislature consider to address PBM business practices?

Prior to considering statutory actions, the Legislature may wish to give market forces time to further influence efforts by PBMs, health plan sponsors, and other stakeholders to change PBM business practices and establish more transparent contracts. If the Legislature wishes to enact statutory provisions to regulate PBMs, it could

¹⁹ This type of legislation also includes requirements for financial reporting and establishes standards PBMs must follow in contracting with pharmacies.

²⁰ House Bill 1599 and Senate Bill 2536.

²¹ For example, the settlement between the 20 state attorneys general against Medco prohibits Medco from soliciting drug switches when the net drug cost of the proposed drug exceeds the cost of the prescribed drug. It also requires Medco to disclose financial incentives for switching drugs.

²² The Human Resource Policy Association formed the Pharmaceutical Purchasing Coalition which developed transparency standards for PBMs to use when providing services to Coalition members. The Coalition certifies PBMs annually that complete a request for proposal issued by the association in which the PBM must agree and verify compliance with the standards.

²³ These 10 PBMs are Aetna Pharmacy Management; Blue Cross and Blue Shield of Alabama; Caremark Rx, Inc.; Catalyst Rx, A HealthExtras Company; CIGNA Pharmacy Management; HealthTrans; Medco Health Solutions, Inc.; MedImpact Healthcare Systems, Inc.; RESTAT; and Walgreens Health Initiatives, Inc.

²⁴ URAC, formerly known as Utilization Review Accreditation Commission, also uses the corporate name American Accreditation HealthCare Commission.

consider the following two options that have been adopted by some other states.

- **Establish transparency guidelines.** The Legislature could establish guidelines that impose a fiduciary duty on PBMs, requiring them to act in the best interest of health plan sponsors. Such guidelines could also require PBMs to disclose to health plan sponsors information related to contracts with drug manufacturers and disclose all revenues from drug manufacturers including rebates and other incentives. These guidelines would help to ensure that health plan sponsors are aware of all revenues resulting from manufacturer negotiations. Transparency requirements could facilitate the state taking civil or criminal action through the Attorney General's office.
- **License or certify PBMs.** The Legislature could mandate that PBMs become licensed or certified, which would require these entities to register with the state and adhere to prescribed standards. This approach would also provide the state with information on PBMs operating in Florida, such as corporate ownership and the services they provide. Licensure or certification could also establish minimum quality standards for PBM business practices and reporting requirements for these standards. If the Legislature elects to adopt this approach, it should consider the principles established by the Legislature for regulating professions. Chapter 456.003, *Florida Statutes*, states in part that professions should only be regulated "when their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation."

Appendix A

Thirty-Six States and the District of Columbia Have Recently Introduced Legislation to Regulate Pharmacy Benefit Managers

In response to growing concerns about PBM business and contracting practices, 36 states and the District of Columbia introduced legislation over the last three years to regulate PBMs (see Table A-1). Legislation includes transparency and financial disclosure requirements and licensure and certification by states’ insurance regulation offices or pharmacy boards.

**Table A-1
Legislation to Regulate PBMs Varied Among States**

State	Summary of Proposed Legislation	Passed or Failed?
Alabama	2003 and 2004 – regulation by the pharmacy board; establishes rules for PBM qualifications, co-payment pricing, and disclosure to consumers (House Bill 154). 2006 – licensure by attorney general; establishes pharmacy contract standards (House Bill 171).	Failed
Arkansas	2003 – dual regulation by Department of Insurance and Board of Pharmacy; requires pharmacy contract approval; establishes benchmarks for reimbursement and minimum pharmacy contract standards (Senate Bill 313). 2005 – licensure by Department of Insurance; requires pharmacy contract approval; establishes pharmacy contract standards (House Bill 2845). ¹	Failed
California	2004 – annual registration with Board of Pharmacy; establishes requirements for disclosure, confidentiality of information, and prior authorization (Assembly Bill 1960). 2005 – requires annual disclosure of manufacturer discounts for drug utilization, financial arrangements, and confidentiality of information (Assembly Bill 78).	2005 passed but vetoed by Governor
Colorado	2003 – certification by Board of Pharmacy; establishes pharmacy contract standards; establishes standards for PBMs to substitute drugs (Senate Bill 142). 2005 – establishes fiduciary obligation; establishes requirements for rebates and disclosure; establishes noncompliance as deceptive trade practice and subject to sanctions (House Bill 5-1300). 2006 – establishes requirements for exercising good faith, disclosure, and audit rights; defines covered entities to include programs administered by state that are not self-regulated (Senate Bill 6-164).	Failed
Connecticut	2003 and 2004 – dual regulation by Insurance Department and Board of Pharmacy; establishes requirements for pharmacy contract approval, PBM ownership, and minimum pharmacy contract standards (2003 House Bill 6606 and 2004 Senate Bill 111). 2005 – similar to 2004 legislation; also requires filing of annual financial statements with Insurance Department; specifies conditions for pharmacy payments and arrangements (Senate Bill 6867). 2006 – similar to 2005 legislation; also establishes solvency standards, fiduciary obligation, and disclosure and rebate requirements (Senate Bills 483 and 580).	Failed
District of Columbia	2004 – establishes fiduciary duty, requirements for transparent business practices, disclosure, and drug substitution (D.C. Code Annotated subsection 48-832.01 to 48-832.03).	Passed
Florida	2003 – licensure by Office of Insurance Regulation; certification by Board of Pharmacy; requires the office of Insurance Regulation to establish pharmacy contract standards and ensure solvency compliance; establishes health plan sponsor audit rights (House Bill 1599 and Senate Bill 2536). 2004 – establishes fiduciary duty and requirements for rebates, disclosure, and drug substitution (House Bill 1347 and Senate Bill 3042).	Failed
Hawaii	2003 – requires fiduciary duty (Senate Bill 775 and House Bill 18). 2005 and 2006 – establishes requirements for disclosure, health plan sponsor audit rights, and drug substitutions (Senate Bill 1440 and House Bill 31).	Failed

State	Summary of Proposed Legislation	Passed or Failed?
Illinois	2003 and 2004 – certification by Department of Financial and Professional Regulation, Division of Insurance, and Board of Pharmacy; requires pharmacy contract approval by board(2003 House Bill 520 and 2004 House Bill 6871). 2005 and 2006 – registration with Department of Financial and Professional Regulation, establishes pharmacy contract standards and fiduciary responsibilities (2005 Senate Bill 1828 and 2006 Senate Bill 2779). ¹	Failed
Iowa	2003 – certification by Board of Pharmacy Examiners; requires pharmacy contract approval; establishes conditions for payments to and audits of pharmacies (House Bill 496). 2004 – annual license by Insurance Department; certification by Board of Pharmacy Examiners ; requires pharmacy contract approval; establishes requirements for drug substitution and rebates (House Bill 496). 2004 – licensure as third party administrators; establishes requirements for disclosure, audit rights, and drug substitution (Senate Bill 2283). 2005 and 2006 – similar to 2004 legislation; requires that PBMs exercise good faith (2005 House Bill 160 and House Bill 214; 2006 House Filing 160 and Senate Filing 181).	Failed
Kansas	2003 – certification by Insurance Department; establishes requirements for disclosure (Senate Bill 234). 2006 – registration by Insurance Department (Senate Bill 547).	2006 Passed
Louisiana	2003 – certification by Insurance Department; establishes requirements for pharmacy payments and disclosure (House Bill 1612).	Failed
Maine	2003 – establishes fiduciary duty and requirements for rebates and disclosure (Maine Revenue Statutes Annotated, title 22, section 2699).	Passed
Maryland	2003 – examination by Insurance Department of PBMs that conduct utilization review (Maryland Code Annotated Insurance section 15-10B-20). 2004 – establishes fiduciary duty and requirements for disclosure and drug substitution (House Bill 840); registration by Department of Health and Mental Hygiene (House Bill 397). 2005 and 2006 – registration by Insurance Commissioner as third party administrator; establishes requirements for disclosure and drug substitution; establishes pharmacy contract standards (2005 House Bill 1058 and 2006 House Bill 493). ¹	2003 Passed
Michigan	2004 – certification by Insurance Department; establishes requirements for disclosure; establishes standards for paying and auditing pharmacies (House Bill 5438).	Failed
Minnesota	2005 and 2006 – certification by Insurance Commissioner; establishes requirements for disclosure, audit rights, and drug substitutions. (2005 and 2006 House Bill 1898 and Senate Bill SF 1999).	Failed
Mississippi	2005 – certification by Board of Pharmacy; annual licensure by Insurance Commissioner and pharmacy contract approval; establishes requirements for pharmacy payments, audits rights, and pharmacy contract standards (House Bill 710). ¹ 2006 – certification by Board of Pharmacy; establishes requirements for claims payments and pharmacy contract standards (Senate Bill 2697 and similar legislation in House Bill 542).	Failed
Missouri	2006 – establishes PBM Fair Trade Practice Act; establishes requirements for pharmacy contracts, rebates, disclosure, and audits rights (House Bill 2092).	Failed
New Hampshire	2006 – dual regulation by Department of Insurance and Board of Pharmacy; establishes fiduciary duty; establishes requirements for disclosure, drug substitution; and rebates (House Bill 1247).	Failed
New Jersey	2003 – certification by Department of Law and Public Safety, Division of Consumer Affairs; pharmacy contract approval by Department of Insurance (Senate Bill 1619). 2006 – certification by Insurance Commissioner; establishes financial examinations by Commissioner, requirements for disclosure and drug substitution (Senate Bill 1291and Assembly Bill 320). Additional legislation requires certification by Division of Consumer Affairs and approval of pharmacy contracts (Assembly Bill 1807).	Failed
New Mexico	2003 – certification by Superintendent of Insurance; establishes fiduciary duty (Senate Bill 871). 2005 – licensure by Superintendent of Insurance, establishes pharmacy contract standards and requirements for disclosure and audit rights (House Bill 622 and Senate Bill 532). Additional legislation requires legislative task force to study the need to regulate PBMs (House Joint Memorial 98).	2005 proposal for a study passed
New York	2004 – licensure by Department of Insurance and certification of compliance by Board of Pharmacy ; establishes requirements for disclosure, drug substitution, and pharmacy payments (Senate Bill 6948). ¹ 2006 – establishes regulation of PBMs (Senate Bill 2259).	Failed
North Carolina	2005 and 2006 – annual licensure by Insurance Commissioner; establishes disclosure requirements to commissioner; establishes requirements of disclosure to health plan sponsors, terms for pharmacy participation, requires DOI approval of pharmacy payment and audit arrangements (2005 and 2006 House Bill 1374). ¹	Failed

State	Summary of Proposed Legislation	Passed or Failed?
North Dakota	2005 – licensure as administrators; establishes requirements for disclosure to Insurance Commissioner, disclosure to health plan sponsors, drug substitution, and pharmacy payments (Section 26.1-27 North Dakota Century Code).	Passed
Oklahoma	2006 – establishes fiduciary duty; establishes requirements for disclosure (House Bill 2392).	Failed
Oregon	2003 – dual certification/regulation by Insurance Department and Board of Pharmacy (Senate Bill 629).	Failed
Pennsylvania	2003 and 2004 – dual certification by Insurance Department and Board of Pharmacy; establishes requirements for disclosure to state, drug substitution, and pharmacy contract arrangements (House Bill 1067 and Senate Bill 726). 2005 and 2006 – similar legislation as 2003 and 2004 (2005 and 2006 House Bill 714). ¹	Failed
Rhode Island	2006 – establishes fiduciary duty and requirements for disclosure, rebates, and drug substitution (Senate Bill 2247).	Failed
South Carolina	2006 – certification by Department of Insurance and certification of PBM operation plan by Board of Pharmacy; establishes financial examinations by department; establishes requirements for disclosure to department and health plan sponsors, drug substitution, and pharmacy contract standards (Senate Bill 828).	Failed
South Dakota	2004 – licensure as third party administrator; establishes requirements for disclosure to health plans sponsor, audit rights, and drug substitution (South Dakota Codified Laws subsection 58-29E-1 to 29E-10).	Passed
Tennessee	2003 – licensure as a pharmacy (House Bill 263 and Senate Bill 388). 2006 – establishes fiduciary duty and disclosure requirements (Senate Bill 2847 and House Bill 2971).	Failed
Texas	2003 – certification by Insurance Department, establishes requirements for standard PBM contracts, disclosure to department, drug substitution, and pharmacy contract standards (House Bill 3302/3320 and Senate Bill 1746). 2005 – similar to 2003; also establishes requirements for reporting annual financial statements to Insurance Department, on-site inspections, and drug substitutions (House Bill 1336).	Failed
Vermont	2003 and 2004 – licensure by Insurance Department; establishes fiduciary duty and requirements for contract approval, drug substitution, and disclosure (2003 Senate Bill 116 and 2004 Senate Bill 288). 2006 – licensure by Insurance Department; establishes requirements for disclosure to health plan sponsor, notification of conflict of interest, and drug substitution (Senate Bill 261).	Failed
Virginia	2006 – registration with State Corporation Commission and registration with Department of Health if PBM conducts utilization reviews; establishes requirements for registering contracts with Commission, disclosure to Commission and health plan sponsors, drug substitution, and pharmacy contract standards (House Bill 945). ¹	Failed
Washington	2006 – establishes fiduciary duty; establishes requirements for disclosure to health plan sponsors, drug substitution, and rebates (House Bill 2473).	Failed
West Virginia	2006 – annual licensure by Insurance Commissioner; establishes requirements for reporting and disclosure to Commissioner (House Bill 4656). Additional Legislation requires Joint Committee on Government and Finance to study need for PBM regulation (House Concurrent Resolution 81).	Failed
Wyoming	2003 – certification by Board of Pharmacy; establishes requirements of pharmacy contract approval, reporting annual financial statements, and conducting financial examinations (House Bill 208).	Failed

¹ Legislation included 2005 National Community Pharmacists Association model legislation provisions.

Source: OPPAGA analysis of National Community Pharmacists Association Overview of PBM Legislation Introduced in State Legislative Sessions for 2003, 2004, 2005, and 2006; the National Conference of State Legislatures 2006 Prescription Drug State Legislation, June 2006; the National Conference of State Legislatures Background Brief - 2006: State Legislation Affecting Pharmaceutical Benefit Managers (PBMs), December 2006; *Report for Interim Study Proposal 2005-149 Pharmacy Benefit Managers: Practices and Procedures*, Arkansas Bureau of Legislative Research, Research Project 06-113, November 13, 2006.

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