Senate Bill 313

By: Senators Burke of the 11th, Watson of the 1st, Dugan of the 30th, Kennedy of the 18th, Hufstetler of the 52nd and others

AS PASSED

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 64 of Title 33 of the Official Code of Georgia Annotated, relating to regulation and licensure of pharmacy benefits managers, so as to provide extensive revisions regarding pharmacy benefits managers; to revise definitions; to revise provisions relating to license requirements and filing fees; to revise a provision regarding the prohibition on the practice of medicine by a pharmacy benefits manager; to provide additional authority for the Insurance Commissioner to regulate pharmacy benefits managers; to revise provisions relating to rebates from pharmaceutical manufacturers; to revise provisions relating to administration of claims; to revise provisions relating to prohibited activities; to provide for surcharges on certain practices; to provide for statutory construction; to provide for related matters; to provide for effective dates and applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 64 of Title 33 of the Official Code of Georgia Annotated, relating to regulation and licensure of pharmacy benefits managers, is amended by revising Code Section 33-64-1, relating to definitions, as follows:

"33-64-1.

As used in this chapter, the term:

(1) 'Affiliate pharmacy' means a pharmacy which, either directly or indirectly through one or more intermediaries:

(A) Has an investment or ownership interest in a pharmacy benefits manager licensed under this chapter;

(B) Shares common ownership with a pharmacy benefits manager licensed under this chapter; or

(C) Has an investor or ownership interest holder which is a pharmacy benefits manager licensed under this chapter.

~~(1)~~(2) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

~~(2) 'Covered entity' means an employer, labor union, or other group of persons organized in this state that provides health coverage to covered individuals who are employed or reside in this state.~~

~~(3) 'Covered individual' means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by a covered entity.~~

~~(3.1)~~(3) 'Dispenser' shall have the same meaning as in paragraph (10) of Code Section 16-13-21.

(4) 'Health plan' means an individual or group plan or program which is established by contract, certificate, law, plan, policy, subscriber agreement, or any other method and which is entered into, issued, or offered for the purpose of arranging for, delivering, paying for, providing, or reimbursing any of the costs of health care or medical care, including pharmacy services, drugs, or devices. Such term includes any health care coverage provided under the state health benefit plan pursuant to Article 1 of Chapter 18 of Title 45; the medical assistance program pursuant to Article 7 of Chapter 4 of Title 49; the PeachCare for Kids Program pursuant to Article 13 of Chapter 5 of Title 49; and any other health benefit plan or policy administered by or on behalf of this state.

~~(4)~~(5) 'Health system' means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

(6) 'Insured' means a person who receives prescription drug benefits administered by a pharmacy benefits manager.

~~(5)~~(7) 'Maximum allowable cost' means the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(8) 'National average drug acquisition cost' means the monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services to determine average acquisition cost for Medicaid covered outpatient drugs.

~~(6)~~(9) 'Pharmacy' means a pharmacy or pharmacist licensed pursuant to Chapter 4 of Title 26 or another dispensing provider.

~~(7)~~(10) 'Pharmacy benefits management' means the administration of a plan or program that pays for, reimburses, and covers the cost of drugs, devices, or pharmacy care to insureds on behalf of a health plan. The term shall not include the practice of pharmacy as defined in Code Section 26-4-4. ~~service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be~~

~~dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:~~

~~(A) Mail order pharmacy;~~

~~(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;~~

~~(C) Clinical or other formulary or preferred drug list development or management;~~

~~(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;~~

~~(E) Patient compliance, therapeutic intervention, or generic substitution programs; and~~

~~(F) Disease management.~~

~~(8)~~(11) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a ~~covered entity~~ health plan. The term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. The term also does not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(12) 'Point-of-sale fee' means all or a portion of a drug reimbursement to a pharmacy or other dispenser withheld at the time of adjudication of a claim for any reason.

(13) 'Rebate' means any and all payments that accrue to a pharmacy benefits manager or its health plan client, directly or indirectly, from a pharmaceutical manufacturer, including but not limited to discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered on behalf of a health plan client.

(14) 'Retroactive fee' means all or a portion of a drug reimbursement to a pharmacy or other dispenser recouped or reduced following adjudication of a claim for any reason, except as otherwise permissible as described in Code Section 26-4-118.

(15) 'Steering' means:

(A) Ordering an insured to use its affiliate pharmacy for the filling of a prescription or the provision of pharmacy care;

(B) Ordering an insured to use an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter pursuant to an arrangement or agreement for the filling of a prescription or the provision of pharmacy care;

(C) Offering or implementing plan designs that require an insured to utilize its affiliate pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter or that increases plan or insured costs, including requiring an insured to pay the full cost for a prescription when an insured chooses not to use any affiliate pharmacy; or

(D) Advertising, marketing, or promoting its affiliate pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter to insureds. Subject to the foregoing, a pharmacy benefits manager may include its affiliated pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the pharmacy benefits manager includes information regarding eligible nonaffiliated pharmacies in such communications and that the information provided is accurate.″

SECTION 2.

Said chapter is further amended by revising Code Section 33-64-2, relating to license requirements and filing fees, as follows:

″33-64-2.

(a) No person, business entity, or other entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such person, business entity, or other entity holds a license as a pharmacy benefits manager issued by the Commissioner pursuant to this chapter. The license shall be renewable on an annual basis. Failure to hold such license shall subject such person, business entity, or other entity to the fines and other appropriate penalties as provided in Chapter 2 of this title.

(b) An application for a pharmacy benefits manager's license or an application for renewal of such license shall be accompanied by a filing fee of ~~$500.00~~ $2,000.00 for an initial license and ~~$400.00~~ $1,000.00 for renewal.

(c) A license shall be issued or renewed ~~and shall not be suspended or revoked~~ by the Commissioner unless the Commissioner finds that the applicant for or holder of the license:

(1) Has intentionally misrepresented or concealed any material fact in the application for the license;

(2) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(3) Has committed fraud; ~~or~~

(4) Has failed to obtain for initial licensure or retain for annual licensure renewal a net worth of at least $200,000.00; or

(5) Has violated any provision of this chapter while on probation, if for license renewal.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy benefits manager, the Commissioner shall provide notice of that action to the pharmacy benefits manager, and the pharmacy benefits manager may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this title.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(3) The Commissioner shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period in accordance with rules and regulations.

(h) A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated formulary services to any unlicensed ~~nonaffiliated~~ business entity ~~unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement~~.

(i) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to assess a monetary penalty against any person, business entity, or other entity acting as a pharmacy benefits manager without a license of up to ~~$1,000.00~~ $2,000.00 for each transaction in violation of this chapter, unless such person, business entity, or other entity knew or reasonably should have known it was in violation of this

chapter, in which case the monetary penalty provided for in this subsection may be increased to an amount of up to ~~$5,000.00~~ $10,000.00 for each and every act in violation.

(j) A licensed pharmacy benefits manager shall not market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

(k) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to place any pharmacy benefits manager on probation for a period of time not to exceed one year for each and every act in violation of this chapter and ~~may~~ shall subject such pharmacy benefits manager to a monetary penalty of up to ~~$1,000.00~~ $2,000.00 for each and every act in violation of this chapter, unless the pharmacy benefits manager knew or reasonably should have known he or she was in violation of this chapter, in which case the monetary penalty provided for in this subsection ~~may~~ shall be increased to an amount of up to ~~$5,000.00~~ $10,000.00 for each and every act in violation. In the event a pharmacy benefits manager violates any provision of this chapter while on probation, the Commissioner shall have the authority to suspend the pharmacy benefits manager's license. For purposes of this subsection, a violation shall be considered to have occurred each time an act in violation of this chapter is committed.

~~(l) A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Such health insurer, health care center, or fraternal benefit society shall notify the Commissioner annually, in writing, on a form provided by the Commissioner, that it is affiliated with or operating as a line of business as a pharmacy benefits manager.~~"

SECTION 3.

Said chapter is further amended by revising Code Section 33-64-4, relating to a prohibition on the practice of medicine by a pharmacy benefits manager, as follows:

"33-64-4.

(a) No pharmacy benefits manager shall engage in the practice of medicine, except as otherwise provided in subsection (b) of this Code section.

(b) Any physician employed by or contracted with a pharmacy benefits manager advising on or making determinations specific to a Georgia insured in connection with a prior authorization or step therapy appeal or determination review shall:

(1) Have actively seen patients within the past five years; and

(2) Have practiced in the same specialty area for which he or she is providing advisement within the past five years.

(c) For contracts and amendments entered into with a pharmacy benefits manager on and after the effective date of this Act, the department is encouraged to require the use of a licensed Georgia physician for prior authorization or step therapy appeal or determination reviews."

SECTION 4.

Said chapter is further amended by revising Code Section 33-64-7, relating to a prohibition on the extension of rules and regulations and the enforcement of specific provisions of the chapter and rules and regulations, as follows:

"33-64-7.

(a) The Commissioner ~~may not enlarge upon or extend the specific provisions of this chapter through any act, rule, or regulation; provided, however, that the Commissioner is authorized to~~ shall enforce ~~any specific provision~~ the provisions of this chapter and may promulgate rules and regulations to ~~effectuate the specific~~ implement the provisions of this chapter to ensure the safe and proper operations of pharmacy benefits managers in this state.

(b) In addition to all other authority granted by this title, the Commissioner may:

(1) Conduct financial examinations and compliance audits of pharmacy benefits managers to ensure compliance with the provisions of this chapter and rules and regulations implemented pursuant to this chapter; provided, however, that such authority shall not extend to financial examination and compliance audits of pharmacy benefits managers' conduct in performing services on behalf of the state health benefit plan pursuant to Article 1 of Chapter 18 of Title 45 or the medical assistance program pursuant to Article 7 of Chapter 4 of Title 49. The pharmacy benefits manager subject to a financial examination or compliance audit shall pay all the actual expenses incurred in conducting the examination or audit. When the examination or audit is made by an examiner or auditor who is not a regular employee of the department, the pharmacy benefits manager examined or audited shall pay the proper expenses for the services of the examiner or auditor and his or her assistants and the actual travel and lodging expenses incurred by such examiners, auditors, and assistants in an amount approved by the Commissioner. The examiner or auditor shall file a consolidated accounting of expenses for the examination or audit with the Commissioner. No pharmacy benefits manager shall pay, and no examiner or auditor shall accept, any additional emolument on account of any examination or audit. When the examination or audit is conducted in whole or in part by regular salaried employees of the department, payment for such services and proper expenses shall be made by the pharmacy benefits manager examined or audited to the Commissioner. The Commissioner shall be authorized to keep a portion

of examination or audit fees paid by the pharmacy benefits manager examined or audited to pay for any costs incurred as a result of the examination or audit, and any fees remaining shall be deposited in the state treasury; provided, however, that when a pharmacy benefits manager is examined or audited because of a complaint filed against such pharmacy benefits manager and it is determined by the Commissioner that the complaint was not justified, the expenses incurred as a result of the examination or audit shall not be assessed against the pharmacy benefits manager but shall be borne by the department;

(2) Investigate complaints of alleged violations of this chapter;

(3) Issue cease and desist orders when a pharmacy benefits manager is taking or threatening to take action in violation of this chapter or rules and regulations implemented pursuant to this chapter; and

(4) Order reimbursement to an insured, pharmacy, or dispenser who has incurred a monetary loss as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter as well as order payment of a fine not to exceed $1,000.00 per violation to an insured, pharmacy, or dispenser who has been aggrieved as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter. Such fine shall be in addition to and shall not preclude any other fines imposed pursuant to this title. For purposes of this paragraph, a violation shall be considered to have occurred each time a prohibited act is committed.

(c) A pharmacy benefits manager shall make its records available to the Commissioner, deidentified of any protected health information, upon written demand and provide cooperation in connection with financial examinations, compliance audits, and investigations.

(d) In the event a violation of this chapter or rules and regulations implemented pursuant to this chapter is found following a complaint, the Commissioner may, at his or her discretion, conduct a compliance audit to identify whether any other similar violations have occurred within the state.″

SECTION 5.

Said chapter is further amended by adding a new Code section to read as follows:

″33-64-9.1.

(a)(1) Any methodologies utilized by a pharmacy benefits manager in connection with reimbursement pursuant to Code Section 33-64-9 shall be filed with the Commissioner for use in determining maximum allowable cost appeals; provided, however, that methodologies not otherwise subject to disclosure under Article 4 of Chapter 18 of Title 50 shall be treated as confidential and shall not be subject to disclosure.

(2) A pharmacy benefits manager shall utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the national average drug acquisition cost list and shall produce a report every four months, which shall be provided to the Commissioner and published by the pharmacy benefits manager on a website available to the public for no less than 24 months, of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and above the national average drug acquisition cost. For each drug in the report, a pharmacy benefits manager shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed per unit or dosage, whether the dispensing pharmacy was an affiliate, whether the drug was dispensed pursuant to a state or local government health plan, and the average national average drug acquisition cost for the month the drug was dispensed. Such report shall exclude drugs dispensed pursuant to 42 U.S.C. Section 256b.

(3) This subsection shall not apply to Medicaid under Chapter 4 of Title 49 when the department reimburses providers directly for each covered service; provided, however, that it shall apply to Medicaid managed care programs administered through care management organizations.

(4) This subsection shall take effect on January 1, 2021; provided, however, that prior to July 1, 2021, upon written request, a pharmacy benefits manager shall be granted an extension by the Commissioner of up to six months for its initial filing required pursuant to paragraph (1) of this subsection if the pharmacy benefits manager certifies it is in need of such extension.

(b) On and after July 1, 2021, a pharmacy benefits manager shall not:

(1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy from the pharmacy benefit manager's network on the basis that the pharmacy dispenses drugs subject to an agreement under 42 U.S.C. Section 256b; or

(2) Engage in any practice that:

(A) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores, or metrics; provided, however, that nothing shall prohibit pharmacy reimbursement for pharmacy care, including dispensing fees from being based on patient outcomes, scores, or metrics so long as the patient outcomes, scores, or metrics are disclosed to and agreed to by the pharmacy in advance;

(B) Includes imposing a point-of-sale fee or retroactive fee; or

(C) Derives any revenue from a pharmacy or insured in connection with performing pharmacy benefits management services; provided, however, that this shall not be

construed to prohibit pharmacy benefits managers from receiving deductibles or copayments.

(c) This Code section shall also apply to pharmacy benefits managers' reimbursements to dispensers."

SECTION 6.

Said chapter is further amended by revising Code Section 33-64-10, relating to administration of claims by pharmacy benefits manager, as follows:

"33-64-10.

(a) A pharmacy benefits manager shall administer claims in compliance with Code Section 33-30-4.3 and shall not require insureds to use a mail-order pharmaceutical distributor including a mail-order pharmacy.

(b) A pharmacy benefits manager shall offer a health plan the ability to receive 100 percent of all rebates it receives from pharmaceutical manufacturers. In addition, a pharmacy benefits manager shall report annually to each ~~client, including but not limited to, insurers and payors,~~ health plan and the department the aggregate amount of all rebates and other payments that the pharmacy benefits manager received from pharmaceutical manufacturers in connection with claims if administered on behalf of the ~~client and the aggregate amount of such rebates the pharmacy benefits manager received from pharmaceutical manufacturers that it did not pass through to the client~~ health plan.

(c) A pharmacy benefits manager shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug; provided, however, that a pharmacy benefits manager shall charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, including any county or municipality, the same price for a prescription drug as it pays a pharmacy for the prescription drug.

(d) A pharmacy benefits manager shall report in the aggregate to a health plan the difference between the amount the pharmacy benefits manager reimbursed a pharmacy and the amount the pharmacy benefits manager charged a health plan. Such information shall be confidential and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that such information as it relates to health plans administered by or through the Department of Community Health, including Medicaid care management organizations, or any other state agency shall not be confidential and shall be subject to disclosure under Article 4 of Chapter 18 of Title 50.

(e) When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a pharmacy benefits manager shall include any amount paid by the insured or paid on his or her behalf through a third-party payment, financial

assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. Nothing in this subsection shall be construed to require that a pharmacy benefits manager accept a third-party payment, financial assistance, discount, or product voucher submitted on behalf of an insured.

~~(c)~~(f) This Code section shall not apply to~~:~~

~~(1) A care management organization, as defined in Chapter 21A of this title;~~

~~(2) The Department of Community Health, as defined in Chapter 2 of Title 31;~~

~~(3) The State Health Benefit Plan under Article 1 of Chapter 18 of Title 45; or~~

~~(4) Any~~ any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section ~~26-4-110.1~~ 26-4-110.

(g) As used in this Code section, the term 'generic equivalent':

(1) Means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium, and that, if administered in the same amounts, will provide comparable therapeutic effects; and

(2) Does not include a drug that is listed by the federal Food and Drug Administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.″

SECTION 7.

Said chapter is further amended by revising Code Section 33-64-11, relating to prohibited activities of pharmacy benefits manager, as follows:

″33-64-11.

(a) A pharmacy benefits manager shall be proscribed from:

(1) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from providing an insured individual information on the amount of the insured's cost share for such insured's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available. No pharmacist, pharmacy, or other dispenser or dispenser practice shall be penalized by a pharmacy benefits manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available;

(2) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from offering and providing ~~store direct~~ delivery services to an insured as an ancillary service of the pharmacy or dispenser practice;

(3) Charging or collecting from an insured a copayment that exceeds the total submitted charges by the network pharmacy or other dispenser practice for which the pharmacy or dispenser practice is paid;

(4) Charging or holding a pharmacist or pharmacy or dispenser or dispenser practice responsible for a fee or penalty relating to the adjudication of a claim or an audit conducted pursuant to Code Section 26-4-118, provided that this shall not restrict recoupments made in accordance with Code Section 26-4-118~~ or pay for performance recoupments otherwise permitted by law~~;

(5) Recouping funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements set forth in Code Section 26-4-118, unless such recoupment is otherwise permitted or required by law;

(6) Penalizing or retaliating against a pharmacist or pharmacy for exercising rights under this chapter or Code Section 26-4-118;

(7) Steering. ~~Ordering an insured for the filling of a prescription or the provision of pharmacy care services to an affiliated pharmacy; offering or implementing plan designs that require patients to utilize an affiliated pharmacy; or advertising, marketing, or promoting a pharmacy by an affiliate to patients or prospective patients. Subject to the foregoing, a pharmacy benefits manager may include an affiliated pharmacy in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the pharmacy benefits manager includes information regarding eligible nonaffiliated pharmacies in such communications and the information provided is accurate.~~ This paragraph shall not be construed to prohibit a pharmacy benefits manager from entering into an agreement with an affiliated pharmacy or an affiliated pharmacy of another pharmacy benefits manager licensed pursuant to this chapter to provide pharmacy care to patients~~. The restrictions in this paragraph shall not apply to limited distribution prescription drugs requiring special handling and not commonly carried at retail pharmacies or oncology clinics or practices~~;

(8) Transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review;

(9) Knowingly making a misrepresentation to an insured, pharmacist, pharmacy, dispenser, or dispenser practice; ~~and~~

(10) Taking any action in violation of subparagraphs (a)(21)(D) and (a)(21)(E) of Code Section 26-4-28 or charging a pharmacy a fee in connection with network enrollment;

(11) Withholding coverage or requiring prior authorization for a lower cost therapeutically equivalent drug available to an insured or failing to reduce an insured's cost share when an insured selects a lower cost therapeutically equivalent drug; and

(12) Removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing an insured to seek coverage from a different health plan.

(b) To the extent that any provision of this Code section is inconsistent or conflicts with applicable federal law, rule, or regulation, such applicable federal law, rule, or regulation shall apply.

(c) This Code section shall not apply to~~:~~

~~(1) A care management organization, as defined in Chapter 21A of this title;~~

~~(2) The Department of Community Health, as defined in Chapter 2 of Title 31;~~

~~(3) The State Health Benefit Plan under Article 1 of Chapter 18 of Title 45; or~~

~~(4) Any~~ any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section ~~26-4-110.1~~ 26-4-110.″

SECTION 8.

Said chapter is further amended by adding new Code sections to read as follows:

″33-64-12.

(a) The General Assembly finds that:

(1) The practice of steering by a pharmacy benefits manager represents a conflict of interest;

(2) The practice of imposing point-of-sale fees or retroactive fees obscures the true cost of prescription drugs in this state;

(3) These practices have resulted in harm, including increasing drug prices, overcharging insureds and payors, restricting insureds' choice of pharmacies and other dispensers, underpaying community pharmacies and other dispensers, and fragmenting and creating barriers to care, particularly in rural Georgia and for patients battling life-threatening illnesses and chronic diseases; and

(4) Imposing a surcharge on pharmacy benefits managers that engage in these practices in this state may encourage entities licensed under this title and other payors to use pharmacy benefits managers that are committed to refraining from such practices.

(b)(1) A pharmacy benefits manager that engages in the practices of steering or imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs for Georgia insureds.

(2) Any other person operating a health plan and licensed under this title whose contracted pharmacy benefits manager engages in the practices of steering or imposing point-of-sale fees or retroactive fees in connection with its health plans shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount its pharmacy benefits manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs for Georgia insureds.

(c)(1) By March 1 of each year, a pharmacy benefits manager shall provide a letter to the Commissioner attesting as to whether or not, in the previous calendar year, it engaged in the practices of steering or imposing point-of-sale fees or retroactive fees. The pharmacy benefits manager shall also submit to the Commissioner, in a form and manner and by a date specified by the Commissioner, data detailing all prescription drug claims it administered for Georgia insureds on behalf of each health plan client and any other data the Commissioner deems necessary to evaluate whether a pharmacy benefits manager may be engaged in the practice of steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefits manager on behalf of all health plans in the state along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.

(2) By March 1 of each year, any other person operating a health plan and licensed under this title that utilizes a contracted pharmacy benefits manager shall provide a letter to the Commissioner attesting as to whether or not, in the previous calendar year, its contracted pharmacy benefits manager engaged in the practices of steering or imposing point-of-sale fees or retroactive fees in connection with its health plans. The health plan shall also submit to the Commissioner, in a form and manner and by a date specified by the Commissioner, data detailing all prescription drug claims its contracted pharmacy benefits manager administered for Georgia insureds and any other data the Commissioner deems necessary to evaluate whether a health plan's pharmacy benefits manager may be engaged in the practice of steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting health

plan along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.

(d) By April 1 of each year, a pharmacy benefits manager or other person operating a health plan and licensed under this title shall pay into the general fund of the state treasury the surcharge owed, if any, as contained in the report submitted pursuant to subsection (c) of this Code section.

(e) Nothing in this Code section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

33-64-13.

To the extent that any provision of this chapter is inconsistent or conflicts with applicable federal law, rule, or regulation, such applicable federal law, rule, or regulation shall apply."

SECTION 9.

(a) Except as otherwise provided in subsection (b) of this section, this Act shall become effective on July 1, 2021, and shall apply to all contracts issued, delivered, or issued for delivery in this state on and after such date.

(b) This section and Sections 1, 5, 7, and 10 of this Act shall become effective on January 1, 2021, and shall apply to all contracts issued, delivered, or issued for delivery in this state on and after such date.

SECTION 10.

All laws and parts of laws in conflict with this Act are repealed.