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LEGISLATURE OF NEBRASKA

ONE HUNDRED FOURTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1060

Introduced by Fox, 7; Brasch, 16; Campbell, 25; Davis, 43; Groene, 42; Kintner, 2; Kolterman, 24.

Read first time January 20, 2016

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to pharmacy; to adopt the Pharmacy Benefit Fairness and Transparency Act.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 24 of this act shall be known and may be cited as the Pharmacy Benefit Fairness and Transparency Act.

Sec. 2. For purposes of the Pharmacy Benefit Fairness and Transparency Act:

(1) Affiliate or affiliated means any entity or person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person;

(2) Clean claim means a claim which is received by a pharmacy benefit manager for adjudication and which requires no further information, adjustment, or alteration by the pharmacy or the covered individual in order to be processed and paid by the pharmacy benefit manager. A claim is a clean claim if it has no defect or impropriety, including any lack of substantiating documentation, or no particular circumstance requiring special treatment that prevents timely payment from being made on the claim. A clean claim includes a resubmitted claim with previously identified deficiencies corrected;

(3) Contracted pharmacy means a pharmacy located in this state participating either in the network of a pharmacy benefit manager or in a health care or pharmacy benefits plan through a direct contract or through a contract with a pharmacy services organization, a group purchasing organization, or another contracting agent;

(4) Control has the same meaning as in section 44-2121;

(5)(a) Covered entity means a nonprofit hospital or medical services corporation, health covered entity, health insurer, managed care company, or health maintenance organization; a health program administered by a department of the state in the capacity of provider of health insurance coverage; or an employer, labor union, or other group of persons organized in the state that provides health insurance coverage.

(b) Covered entity does not include a self-funded health insurance coverage plan that is exempt from state regulation pursuant to the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001

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et seq., a plan issued for health insurance coverage for federal employees, or a health plan that provides insurance coverage only for accidental injury, specified disease, hospital indemnity, medicare supplemental, disability income, or long-term care, or other limited benefit health insurance policy or contract;

(6) Covered individual means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a covered entity who is provided health insurance coverage by the covered entity, and includes a dependent or other person provided health insurance coverage through a policy, contract, or plan for a covered individual;

(7) Day means a calendar day unless otherwise defined or limited;

(8) Department means the Department of Insurance;

(9) Director means the Director of Insurance;

(10) Generic drug means a chemically equivalent copy of a brand-name drug with an expired patent;

(11) Insurance or insurance coverage means any coverage offered or provided by a covered entity;

(12)(a) Insurer means any person undertaking to provide life insurance, sickness and accident insurance, workers' compensation insurance, or annuities in this state.

(b) Insurer includes an authorized insurance company, a prepaid hospital or medical care plan, a managed care plan, a health maintenance organization, or any other person providing a plan of insurance subject to state insurance regulation. Insurer also includes an employer who is approved by the Nebraska Workers' Compensation Court as a self-covered entity.

(c) Insurer does not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the federal Employee Retirement Income Security Act of 1974;

(13) Paid means the later of either the day on which the payment is

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mailed by the pharmacy benefit manager or the day on which the electronic payment is processed by the pharmacy benefit manager's bank;

(14) Pharmacist has the same meaning as in section 38-2832;

(15) Pharmacy has the same meaning as in section 71-425;

(16) Pharmacy benefits management means the administration or management of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefit manager and the covered entity;

(17)(a) Pharmacy benefit manager includes a person or entity acting on behalf of a pharmacy benefit manager in a contractual or employment relationship in the performance of pharmacy benefits management services for a covered entity.

(b) Pharmacy benefit manager does not include a health insurer licensed in the state if the health insurer or its subsidiary is providing pharmacy benefits management services exclusively to its own insureds, or a public self-funded pool or a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries;

(18) Prescription has the same meaning as in section 38-2840;

(19) Prescription drug has the same meaning as prescription drug or device or legend drug or device as given in section 38-2841; and

(20) Reimbursement amount means the maximum reimbursement amount for a therapeutically and pharmaceutically equivalent multiple-source prescription drug that is listed in the publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations," published by the federal Food and Drug Administration.

Sec. 3. (1) No person shall act as, offer to act as, or hold himself or herself out to be a pharmacy benefit manager in this state without a valid certificate of authority as a pharmacy benefit manager issued by the director.

(2) An applicant for a certificate of authority as a pharmacy

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benefit manager shall apply to the director upon a form to be furnished by the director. The application shall include or be accompanied by an application fee of two hundred dollars and by the following information and documents:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, articles of organization, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the applicant;

(c) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, limited liability company, or association, shareholders holding directly or indirectly ten percent or more of the voting securities of the applicant, and any other person who exercises control or influence over the affairs of the applicant;

(d) Annual financial statements or reports for the two most recent years which prove that the applicant is solvent and such information as the director may require in order to review the current financial condition of the applicant;

(e) Such other pertinent information as may be required by the director.

(3) The applicant shall make available for inspection by the director copies of all written agreements with covered entities and contracts with other persons utilizing the services of the applicant.

(4) The director may refuse to issue a certificate of authority as a

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pharmacy benefit manager if the director determines that the applicant or any individual responsible for the conduct of affairs of the applicant as described in subdivision (2)(c) of this section is not competent, trustworthy, financially responsible, or of good personal and business reputation or has had an insurance license or certificate of authority or a pharmacy benefit manager license or certificate of authority denied or revoked for cause by any state.

(5) A certificate of authority as a pharmacy benefit manager issued under this section shall remain valid, unless surrendered to or suspended or revoked by the director, for so long as the pharmacy benefit manager continues in business in this state and remains in compliance with the Pharmacy Benefit Fairness and Transparency Act.

(6) A person shall not be required to hold a certificate of authority as a pharmacy benefit manager in this state if the person exclusively provides services to one or more bona fide employee benefit plans each of which is established by an employer or an employee organization, or both, and for which the insurance laws of this state are preempted pursuant to the federal Employee Retirement Income Security Act of 1974. Such person shall register with the director annually and verify his or her status as described in this section.

(7) A pharmacy benefit manager shall immediately notify the director of any material change in its ownership or control or other fact or circumstance affecting its qualification for a certificate of authority as a pharmacy benefit manager in this state.

Sec. 4. (1) No pharmacy benefit manager shall act as such without a written agreement between the pharmacy benefit manager and the covered entity, and such written agreement shall be retained as part of the official records of both the covered entity and the pharmacy benefit manager for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by the Pharmacy Benefit Fairness and Transparency Act except insofar as those provisions

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do not apply to the functions performed by the pharmacy benefit manager.

(2) The written agreement shall include a statement of duties which the pharmacy benefit manager is expected to perform on behalf of the covered entity and the benefits or duties for which the pharmacy benefit manager is to be authorized to administer.

(3) The covered entity or pharmacy benefit manager may, with written notice, terminate the written agreement for cause as provided in the written agreement. The covered entity may suspend the authority of the pharmacy benefit manager during the pendency of any dispute regarding the cause for termination of the written agreement. The covered entity shall fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the covered entity and the pharmacy benefit manager.

Sec. 5. (1) Every pharmacy benefit manager shall maintain and make available to the covered entity complete records of all transactions performed on behalf of the covered entity. The records shall be maintained in accordance with prudent standards of insurance record keeping and shall be maintained for a period of not less than five years from the date of their creation. In the event the covered entity and the pharmacy benefit manager cancel their written agreement, the pharmacy benefit manager may, by written agreement with the covered entity, transfer all records to a new pharmacy benefit manager rather than retain them for five years. In such cases, the new pharmacy benefit manager shall acknowledge, in writing, that it is responsible for retaining the records of the prior pharmacy benefit manager as required in this subsection.

(2)(a) The director shall have access to records maintained by a pharmacy benefit manager for the purposes of examination, audit, and inspection. Any trade secrets contained in such records, including the identity and addresses of policyholders, contract holders, certificate holders, and subscribers, shall be kept confidential, except that the

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director may use such information in any proceeding instituted against the pharmacy benefit manager and as set forth in subdivisions (2)(b) and (c) of this section.

(b) Records relating to a pharmacy benefit manager maintained by the director may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the records.

(c) The director may receive records maintained by a pharmacy benefit manager from other state, federal, foreign, or international regulatory and law enforcement agencies or their affiliates and subsidiaries. The director shall maintain as confidential or privileged records received pursuant to this subdivision with notice or the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

Sec. 6. (1) If a covered entity utilizes the services of a pharmacy benefit manager, the covered entity shall be responsible for determining the benefits to be provided and claims processing and payment procedures.

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The rules pertaining to these matters shall be provided, in writing, by the covered entity to the pharmacy benefit manager. The responsibilities of the pharmacy benefit manager as to any of these matters shall be set forth in the written agreement between the pharmacy benefit manager and the covered entity.

(2) It shall be the sole responsibility of the covered entity to provide for competent administration of its programs.

Sec. 7. All charges, fees, and rebates collected by a pharmacy benefit manager on behalf of or for a covered entity or covered entities shall be held by the pharmacy benefit manager in a fiduciary capacity.

Sec. 8. A pharmacy benefit manager shall not enter into any agreement or understanding with a covered entity in which the effect is to make the amount of the pharmacy benefit manager's commissions, fees, or charges contingent upon savings effected in the adjustment, settlement, audit services, and payment of losses covered by the covered entity's obligations.

Sec. 9. (1) If a covered entity utilizes the services of a pharmacy benefit manager, the pharmacy benefit manager shall provide a written notice approved by the covered entity to contracted pharmacies advising them of the identity of and relationship among the pharmacy benefit manager, the policyholder or contract holder, and the covered entity.

(2) The pharmacy benefit manager shall disclose to the covered entity all charges, fees, and commissions received in connection with the providing of administrative services for the covered entity, including any fees or commissions paid by covered entities.

(3) The pharmacy benefit manager shall disclose to the covered entity any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer.

(4) A pharmacy benefit manager shall notify the director in writing within five business days after any material change in the pharmacy

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benefit manager's ownership.

Sec. 10. (1) Each pharmacy benefit manager shall file an annual report for the preceding calendar year with the director on or before March 1 of each year.

(2) The annual report shall include the complete names and addresses of all covered entities and all contracted pharmacies with which the pharmacy benefit manager had a written agreement during the preceding calendar year.

(3)(a) Within seven business days after the failure of a pharmacy benefit manager to comply with the requirements of this section, the director shall notify the pharmacy benefit manager of such failure.

(b) Subject to subdivision (3)(c) of this section, if a pharmacy benefit manager fails to comply with the requirements of this section, any rules and regulations adopted and promulgated under this section, or any orders issued under this section:

(i) Such pharmacy benefit manager shall forfeit one thousand dollars for each day thereafter that such failure continues and the pharmacy benefit manager continues to transact any business of insurance; and

(ii) In addition to the forfeiture required under subdivision (3)(b)(i) of this section, the director may suspend the certificate of authority of the pharmacy benefit manager until it has complied with the requirements of this section, any rules and regulations adopted and promulgated under this section, and any orders issued under this section. All such forfeitures collected by the director shall be remitted to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(c) For good and sufficient cause shown, the director may grant a reasonable extension of time not to exceed thirty days within which the annual report may be filed as required under this section without the forfeiture required under subdivision (3)(b)(i) of this section and without any suspension authorized under subdivision (3)(b)(ii) of this

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section.

Sec. 11. A pharmacy benefit manager may not require a pharmacist or pharmacy to participate in one contract with a pharmacy benefit manager in order to participate in other contracts with the same pharmacy benefit manager. The pharmacy benefit manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefit manager's contract.

Sec. 12. (1) During an examination of a covered entity as provided for in the Pharmacy Benefit Fairness and Transparency Act, the department shall examine any contract between the covered entity and a pharmacy benefit manager and any related record to determine if the payment received by the pharmacy benefit manager and which the covered entity received from the pharmacy benefit manager has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.

(2) To facilitate the examination, the covered entity shall disclose annually to the department the benefits of the payment received by the pharmacy benefit manager under any contract with a covered entity and shall describe the manner in which the payment received by the pharmacy benefit manager is applied toward reducing rates or is distributed to covered individuals.

(3) Any information disclosed to the director under this section is considered a trade secret under section 84-712.05.

Sec. 13. (1) A pharmacy benefit manager shall offer to a covered entity options for the covered entity to contract for services that must include:

(a) A transaction fee without a sharing of a payment received by the pharmacy benefit manager;

(b) A combination of a transaction fee and a sharing of a payment received by the pharmacy benefit manager; or

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(c) A transaction fee based on the covered entity receiving all the benefits of a payment received by the pharmacy benefit manager.

(2) The agreement between the pharmacy benefit manager and the covered entity must include a provision allowing the covered entity to have audited the pharmacy benefit manager's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the pharmacy benefit manager is being disclosed and shared as required by the contract.

(3) The pharmacy benefit manager must disclose to the covered entity and to the pharmacy the method used to calculate dispensing fees, administration fees, and any other fee payment, including, but not limited to, direct and indirect remuneration fees. Fees must be clearly stated in the agreements between the pharmacy and the pharmacy benefit manager. The pharmacy benefit manager may not charge pharmacy providers transaction-based or claims-processing fees.

Sec. 14. (1) A pharmacy benefit manager shall perform the pharmacy benefit manager’s duties exercising good faith and fair dealing in the performance of its contractual obligations toward the covered entity and toward the contracted pharmacy.

(2) A pharmacy benefit manager shall notify the covered entity in writing of any activity, policy, practice, ownership interest, or affiliation of the pharmacy benefit manager that presents any conflict of interest.

Sec. 15. A pharmacy benefit manager, unless authorized pursuant to the terms of its contract with a covered entity, shall not contact any covered individual without the express written permission of the covered entity. If information is provided by the pharmacy benefit manager about the pharmacy benefit, including contracted pharmacies, that is incorrect or misleading, the pharmacy benefit manager shall mail to the covered individuals within one week corrected and accurate information about the contracted pharmacy network and shall report such activity to the

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department.

Sec. 16. (1) A pharmacy benefit manager shall not mandate to contracted pharmacies basic record keeping that is more stringent than that required by state or federal law or regulation.

(2) If a pharmacy benefit manager receives notice from a covered entity of termination of the covered entity's contract, the pharmacy benefit manager shall notify, within ten working days of the notice, all contracted pharmacies of the effective date of the termination.

(3) Within seven days after a price increase notification by a manufacturer, supplier, or nationally recognized source, a pharmacy benefit manager shall adjust its payment to the contracted pharmacy consistent with the price increase.

(4) A pharmacy benefit manager must accept into its network any pharmacy or pharmacists if the pharmacy or pharmacist is licensed in good standing with the State of Nebraska and accepts the terms and conditions of the contract offered by the pharmacy benefit manager.

(5) A pharmacy benefit manager may not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the pharmacy benefit manager agreement with its specialty pharmacies.

(6) A pharmacy benefit manager may utilize mail-order pharmacies in its network but must not require or incentivize covered individuals to use a mail-order pharmacy, including through different copays or quantities filled. Covered individuals who use this service must not be charged fees to utilize a contracted pharmacy.

(7) A pharmacy benefit manager shall not mandate accreditation for a covered pharmacy as a prerequisite to mailing and being reimbursed for any prescription drug provided to a patient.

Sec. 17. (1) The department must require a pharmacy benefit manager to make readily available information to the director and to each contracted pharmacy related to the pharmacy benefit manager's pricing

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methodology and reimbursement amount for single and multiple-source drugs.

(2) For purposes of the disclosure of pricing methodology, reimbursement amounts shall be:

(a) Established for multiple-source prescription drugs prescribed after the expiration of any generic drug exclusivity period;

(b) Established for any prescription drug with at least two or more therapeutically equivalent, multiple-source prescription drugs; and

(c) Determined using comparable prescription drug prices obtained from multiple nationally recognized comprehensive data sources, including wholesalers, prescription drug file vendors, and pharmaceutical manufacturers for prescription drugs that are nationally available and available for purchase locally by multiple pharmacies in the state.

(3) For those prescription drugs to which reimbursement amount pricing applies, a pharmacy benefit manager shall include in a contract with a contracted pharmacy information regarding which of the national compendia or other source is used to obtain pricing data used in the calculation of the reimbursement amount pricing and shall provide a process to allow a contracted pharmacy to comment on, contest, or appeal the reimbursement amount rates or reimbursement amount list. The right to comment on, contest, or appeal the reimbursement amount rates or reimbursement amount list shall be limited in duration and allow for retroactive payment in the event that it is determined that reimbursement amount pricing has been applied incorrectly. The reimbursement amount shall be updated no less than every seven days by the pharmacy benefit manager.

Sec. 18. All financial benefits the pharmacy benefit manager receives, including, but not limited to, all rebates, discounts, credits, fees, grants, chargebacks, or other payments or financial benefits of any kind, must be disclosed to the covered entity for which it is contracted.

Sec. 19. (1) All benefits payable under a pharmacy benefits

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management plan shall be paid as soon as feasible but within twenty days after receipt of a clean claim when the claim is submitted electronically and shall be paid within thirty days after receipt of a clean claim when the claim is submitted in paper format.

(2) Payments to the contracted pharmacy for clean claims are considered to be overdue and not timely if not paid within twenty or thirty days, whichever is applicable. If any clean claim is not timely paid, the pharmacy benefit manager must pay the contracted pharmacy interest at the rate of ten percent per annum commencing the day after any claim payment or portion thereof was due until the claim is finally settled or adjudicated in full.

(3) A pharmacy benefit manager may demonstrate the date a claim is paid by a mail record or a bank statement.

Sec. 20. (1) An audit of the contracted pharmacy records by a pharmacy benefit manager shall be conducted in accordance with the following:

(a) The pharmacy benefit manager conducting the initial onsite audit must provide the contracted pharmacy written notice at least two weeks prior to conducting any audit;

(b) Any audit which involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;

(c) When a pharmacy benefit manager alleges an overpayment has been made to a contracted pharmacy or pharmacist, the pharmacy benefit manager shall provide the contracted pharmacy or pharmacist sufficient documentation to determine the specific claims included in the alleged overpayment;

(d) A contracted pharmacy may use the records of a hospital, physician, or other licensed health care practitioner for drugs or medical supplies, written or transmitted by any means of communication, for purposes of validating the contracted pharmacy record with respect to orders or refills of a prescription drug;

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(e) Each contracted pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the pharmacy benefit manager;

(f) The period covered by an audit may not exceed two years from the date on which the claim was submitted to or adjudicated by a managed care company, insurance company, third-party payor, or any pharmacy benefit manager that represents such company or third-party payor;

(g) Unless otherwise consented to by the contracted pharmacy, an audit may not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled during that time;

(h) The preliminary audit report must be delivered to the contracted pharmacy within one hundred twenty days after conclusion of the audit. A final written audit report shall be received by the contracted pharmacy within six months after the preliminary audit report or final appeal, whichever is later;

(i) A contracted pharmacy shall be allowed at least thirty days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit; and

(j) The audit criteria set forth in this section shall apply only to audits of claims submitted for payment after January 1, 2010.

(2) Notwithstanding any other provision in this section, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating the recuperation of contractual penalties for audits.

(3) Recuperation of any disputed funds shall occur only after final disposition of the audit, including the appeals process as set forth in subsection (4) of this section.

(4) Each pharmacy benefit manager conducting an audit shall establish an appeals process under which a contracted pharmacy may appeal an unfavorable preliminary audit report to the pharmacy benefit manager.

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If, following the appeal, the pharmacy benefit manager finds that an unfavorable audit report or any portion thereof is unsubstantiated, the pharmacy benefit manager shall dismiss the audit report or the portion without the necessity of any further proceedings.

(5) If, following the final appeal, the pharmacy benefit manager finds that an unfavorable audit report or any portion thereof is found to be substantiated, the pharmacy benefit manager shall have in place a process for an independent third-party review of the final audit findings. As part of the final appeal process of any final adverse decision, the pharmacy benefit manager shall notify the contracted pharmacy in writing of its right to request an independent third-party review of the final audit findings and the process used to request such a review.

(6) Each pharmacy benefit manager conducting an audit shall, after completion of any review process, provide a copy of the final audit report to the plan sponsor.

(7) The pharmacy benefit manager or the entity conducting the audit on its behalf may not receive payment based on a percentage of the amount recovered. The auditing entity may charge the responsible party, directly or indirectly, based on amounts recouped if the covered entity and the entity conducting the audit have a contract and the commission to an agent or employee is based on amounts recouped.

(8) A clerical or record-keeping error in a required document may not be recorded as fraud, however, it may be subject to recoupment. Errors that have no financial harm to a patient or plan may not result in pharmacy benefit manager chargebacks.

(9) Interest may not accrue during the audit period beginning with the audit and ending with the final report.

(10) This section shall not apply to any investigative audit that involves fraud, willful misrepresentation, abuse, or any other statutory provision which authorizes investigations relating to but not limited to

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insurance fraud.

Sec. 21. A pharmacy benefit manager shall mail an explanation of benefits to the patient for each patient’s pharmacy claim for a prescription drug covered or managed by the pharmacy benefit manager. The explanation of benefits shall include the cost of the prescription drug being charged to the covered entity, the pharmacy benefit manager’s payment, the copayment paid by the patient, the fees and other charges deducted from the cost of the drug, and the final payment to the pharmacy. The pharmacy benefit manager shall not prohibit the pharmacist from disclosing the cost of the drug or what the pharmacy was reimbursed to a patient or patient's caregiver.

Sec. 22. A covered entity that contracts with a pharmacy benefit manager to perform the pharmacy benefit manager’s services shall require the pharmacy benefit manager to notify the department of any detection of fraud, including, but not limited to, prescription drug diversion activity.

Sec. 23. (1) The director shall suspend or revoke the certificate of authority of a pharmacy benefit manager if the director finds that the pharmacy benefit manager:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to the covered entity, pharmacies, or the public; or

(c) Has failed to pay any judgment rendered against it in this state within sixty days after the judgment has become final.

(2) The director may, in his or her discretion, suspend or revoke the certificate of authority of a pharmacy benefit manager if the director finds that the pharmacy benefit manager:

(a) Has violated any lawful rule or regulation or order of the director or any provision of the insurance laws of this state;

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(b) Has refused to be examined or to produce its accounts, records, and files for examination or if any of its officers has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to such examination, when required by the director;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered entities, pharmacies, or claimants to accept less than the amount due them or caused covered entities, pharmacies, or claimants to retain attorneys or bring actions against the pharmacy benefit manager to secure full payment or settlement of such claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another pharmacy benefit manager, insurer, or covered entity which unlawfully transacts business in this state without having a certificate of authority as a pharmacy benefit manager;

(e) At any time fails to meet any qualification for which issuance of the certificate of authority as a pharmacy benefit manager could have been refused had such failure then existed and been known to the director;

(f) Has been convicted of or has entered a plea of guilty or nolo contendere to a felony without regard to whether adjudication was withheld; or

(g) Is under suspension or revocation in another state.

(3) The director may, in his or her discretion and without advance notice or hearing thereon, immediately suspend the certificate of authority of a pharmacy benefit manager if the director finds that one or more of the following circumstances exist:

(a) The pharmacy benefit manager is insolvent or impaired;

(b) A proceeding for supervision, rehabilitation, conservation, receivership, or other delinquency proceeding regarding the pharmacy

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benefit manager has been commenced in any state; or

(c) The financial condition or business practices of the pharmacy benefit manager otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(4) If the director finds that one or more grounds exist for the suspension or revocation of a certificate of authority of a pharmacy benefit manager, the director may, in lieu of such suspension or revocation and after notice and hearing, impose an administrative penalty upon the pharmacy benefit manager in an amount not less than five thousand dollars nor more than fifteen thousand dollars.

Sec. 24. The director may adopt and promulgate rules and regulations to carry out the Pharmacy Benefit Fairness and Transparency Act.