EXHIBIT C6

Hugh McDonald
SECRETARY OF COMMERCE

Alan McClain
COMMISSIONER,
ARKANSAS INSURANCE
DEPARTMENT

Bulletin # 18-2024

Date:

TO: All health insurers, health maintenance organizations ("HMOs"), hospital and medical services corporations, self-funded employer health plans, and pharmacy benefits managers ("PBMs"), and other interested organizations and persons

RE: Data Reporting and Arkansas Insurance Department ("AID") Review Processes For Implementation of Arkansas Insurance Department Rule 128: Fair and Reasonable Pharmacy Reimbursements

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The Arkansas Insurance Commissioner ("Commissioner") issues this Bulletin to implement AID Rule 128: Fair and Reasonable Pharmacy Reimbursements. Pursuant to Ark. Code Ann. § 23-92-506(a)(1), the Commissioner may review and approve the compensation program of a PBM with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan. The Commissioner issued Rule 128 under the above statutory mandate to determine if current pharmacy compensation programs by PBMs with health benefit plans are fair and reasonable to provide such networks for health benefit plans, and, if not, to decide whether health benefit plans should be required to pay an additional pharmacy dispensing cost to improve such reimbursement. The purpose of this Bulletin is to set out health benefit plan data filing requirements, filing processes or procedures, and timing deadlines and other requirements in order that plans may submit to the Commissioner such data or information required by this Bulletin, to necessitate review of such pharmacy compensation programs. The overall purpose therefore of this Bulletin is to only address data filing and review processes only to implement AID Rule 128.

I. ~~Fully Insured Health Plans~~. Reporting Requirements, Standards and Procedures.

The filing dates or deadlines in this section apply to health benefit plans that are insured or funded by healthcare payors as defined under Ark. Code Ann. § 23-92-503(2) and (3).

A. Two (2) Year Phase In. The objective of this section is to provide staggered filing dates in 2025 to phase into a regular and repeating March 1 annual filing date for fully insured health benefit plans filing a report under this Bulletin effective for plan year 2027.

The following data reporting for review of pharmacy compensation programs shall apply for plan years 2025 and 2026. For plan year 2025, data as required by this Bulletin may be filed for review by AID beginning on or after November 30, 2024 and received by AID until February 17, 2025. For plan year 2026, the required data from this bulletin shall be reported to AID on or before July 1, 2025.

For health benefit plans filing on November 30, 2024, they may consider the previous plan year to be from 1-1-2024 until 11-30-2024 or until any date in December of 2024 in which the filing is made. Health benefit plans, for plan year 2026, may consider the previous plan year to be from 1-1-2025 until 7-1-2025. Thereafter, for succeeding plan years, health benefit plans shall annually file the data as required by this bulletin for review of pharmacy compensation programs on or before 3-1 each year using the previous full year of plan data.

Transition Filing Dates:
On or before February 17, 2025 for plan year 2025
On or before July 1, 2025 for plan year 2026
Thereafter, for succeeding plan years on or before 3-1

B. Data Required To Be Filed. The following data shall be submitted to AID in writing for review by the Commissioner to determine if a pharmacy compensation is fair and reasonable in reimbursement(s).

- the total annual average percentage of total pharmacy reimbursement above or relative to NADAC pricing (or WAC, wholesale acquisition cost if NADAC is unavailable) in the previous calendar year. Please provide such percentage also separately for generic drugs verses brand name drugs. (please also provide a median and 25th/75th percent calculation for total annual above NADAC pricing, as well as for generic and brand name drugs relative to NADAC pricing).
- the average dispensing fee paid to pharmacies from total pharmacy reimbursement in the previous calendar year. (please provide such averages for generic drugs versus brand name drugs).

- the total number of drug reimbursement claims paid during the prior calendar year for generic, brand and specialty. Please also separately state the total number of generic claims paid.
- pharmacy network retention data in the previous calendar year which may include a report on the number of pharmacies lost or gained by the health benefit plan or PBM, administering the plan for the health benefit plan, in the previous calendar year. Also, please reference the latest or most current network adequacy reports filed by the health benefit plan, if any, filing a network adequacy report with AID as to the number of accessible pharmacies for the plan.
- the total amount of adjustments made during the previous plan year by the health benefit plan's PBM made in response to appeals or complaints filed by pharmacies for payments below NADAC or maximum allowable cost during the previous calendar year.
- for health benefit plans contracting with PBMs with PBM affiliates, the average annual reimbursement percentage of reimbursement to PBM affiliate pharmacies relative to non PBM affiliate pharmacies.
- any additional proposed contribution or increases in pharmacy reimbursement for the filed for plan year that may increase annual average pharmacy reimbursement above NADAC base averages.

The above data, reports or calculations shall only apply to Arkansas issued plans or policies or resident enrollees with Arkansas licensed pharmacy reimbursement(s).

For statistical average calculations as required in this Bulletin, for which this Bulletin does not provide adequate or full clarification at this time, please submit such data explicitly noting or stating assumptions being made in such calculations.

C. Cost Impact Data Required To Be Filed. The following data shall also be submitted in writing with the information required to be filed under Section I. B of this Bulletin. The total annual estimate of the following cost impact(s):

- the total projected increase in drug costs incurred by the health benefit plan if a pharmacy dispensing cost was applied to the plan for drug payment transactions in the following amounts of dispensing costs ($1, $2, $4, $6, $8, and $10.50).
- the projected premium impact incurred by the health benefit plan if a pharmacy dispensing cost was applied to the plan for drug payment transactions in the following amounts of dispensing costs ($1, $2, $4, $6, $8, and $10.50).
- the per member per month projected cost increase in premium if a pharmacy dispensing cost was applied to the plan for drug payment transactions in the following amounts of dispensing costs ($1, $2, $4, $6, $8, and $10.50).

D. Any Other Additional Data Or Certifications. In addition to the data required under Sections I., A & B of this Bulletin, a health benefit plan may submit to the Commissioner any other additional data including but not limited to methodologies, reports, calculations, or actuarial certifications addressing whether the projected plan pharmacy compensation program of the plan already provides and shall provide in the projected plan year fair and reasonable reimbursements to pharmacies to ensure an adequate pharmacy network for the health benefit plan.

E. Review Standards For Data Evaluation. The Commissioner shall review the data required by Section I. B, C and D of this Bulletin to determine first whether a health plan's pharmacy compensation program is already adequate to ensure an adequate pharmacy network or whether a health benefit plan shall be required to pay an additional dispensing cost for the health benefit plan to achieve a fair and reasonable pharmacy compensation program to ensure an adequate and sustainable network of pharmacies for the projected plan year.

In his or her evaluation, the maximum amount of dispensing cost if so required by the Commissioner, after review of the data required by this Bulletin, shall not exceed the Arkansas State Medicaid dispensing cost of $10.50, or as may be later adjusted by Arkansas State Medicaid. After review of the data as required by this Bulletin, the Commissioner may refuse to require an additional dispensing cost pharmacy compensation program is already fair and reasonable to ensure an adequate pharmacy network for the health benefit plan.

F. Confidentiality Of Data Submitted Under This Bulletin or Rule 128.

Pursuant to Ark. Code Ann. § 23-92-506(a)(2) and Rule 128, all data acquired by AID for review of a pharmacy compensation program under Rule 128 or this Bulletin shall be considered proprietary and confidential under Ark. Code Ann. § 23-61-107(a)(4) and § 23-61-207; and shall not be subject to the Arkansas Freedom of Information Act of 1967, § 25-19-101 et seq. However, the average dispensing fee per healthcare payor that is approved will be published annually

G. Fully Insured Reporting Of Data May Be By Product Or Market Type.

Fully insured health benefit plans and fully insured healthcare payors under Ark. Code Ann. § 23-92-503(2) may submit the data or report as required by this Bulletin by product type, e.g., individual market, small group market, or group market.

H. Procedure And Timelines For Review To Review. The Commissioner shall review a health benefit plan's filing of data or reports under this Bulletin within twenty (20) working days of receipt of the information and shall, within that time period, provide a written decision to the health benefit plan whether an additional dispensing

cost, and the amount, is required as evaluated under Section I. E. The Commissioner and health benefit plan may however extend this time period if additional data is needed to finalize the determination. A decision by the Commissioner may be appealable by the health benefit plan, and a health benefit plan shall be considered an aggrieved party under Ark. Code Ann. § 23-61-303(b)(1) and shall be entitled to an administrative hearing on the matter under AID Rule 125.

I. PBM Filing For And On Behalf Of The Health Benefit Plan. A PBM of a health benefit plan may file the data or report for an on behalf of a health benefit plan for which it administers its drug benefits.

J. Format Of Filing Of Data And Report(s) Under This Bulletin. Unless or until AID develops a specific form for submission of data or reports as required under Section 1 of this Bulletin, a health benefit plan, or PBM, on behalf of such plan, may simply submit a cover letter to the AID PBM Director, identifying the health benefit plan, and indicating it is making a filing under this Bulletin, attaching to such cover letter the data required under Section 1 of this Bulletin. This filing may be sent to AID electronically.

H. Exemptions The requirements of this Bulletin shall not apply to health benefit plans or healthcare payors exempted from state regulation under the Pharmacy Benefits Managers Licensure Act, AID Rule 128 or which are specifically exempted from data submission requirements under this Bulletin.

I. Dispensing Costs For Out Of State Pharmacies. Any dispensing costs required by the Commissioner in his or her evaluation under Section I. E of this Rule shall also inure to out of state licensed pharmacies, licensed by the Arkansas Board of Pharmacy.

II. SELF FUNDED HEALTH PLANS

The filing requirements in this section apply to self-funded employer health plans and self-funded government health plans operating as healthcare payors under Ark. Code Ann. § 23-92-503(2) and (3).

A. Exemption For Self-Funded Plans And Self-Funded Government Plans With Less Than 5,000 Arkansas Resident Covered Lives. Except for the data filing requirement under Section 1 B (and first bullet point for data requests) and the two (2) year phase in requirements, the requirements of Rule 128 and data reporting requirements under this Bulletin shall not apply to self -funded health plans with less than 5,000 Arkansas resident covered lives. The Commissioner shall adhere to the

requirements or standards of counting qualified employees, for purposes of this exemption, under its small employer health benefit plan standards.

B. Section I. Provisions Applicable To Self Funded Health Plans. All provisions under Section I of this Bulletin shall apply to all other self-funded health benefit plans not exempt under Section II A. of this Bulletin. However, as to required filing dates, including phased in filing dates, a self-funded health plan may have reasonable extensions for required filing dates granted if the data or report requires information or calculations reasonably not available or in possession of the health plan. In such cases, the AID PBM Division may assist the health benefit plan in locating or contacting the plan's TPA or PBM for the required data, calculations or report.

C. TPA or PBM Filing For And On Behalf Of A Self-Funded Health Benefit Plan. A third party administrator ("TPA") or PBM of a self-funded health benefit plan may file the data or report as required by this Bulletin for an on behalf of a health benefit plan for which it administers its drug benefits.

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ALAN MCCLAIN

INSURANCE COMMISSIONER

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DATE