Updated Summary

This is a summary of changes made to the language in proposed Rule 128 in response to public comments and drafting notes addressing why such language was either added or removed. I will provide the added or removed mark up first and then explain the change in a comment in italics. These changes to the originally filed rule were made largely in response to various public comments.

I. AUTHORITY

This Rule is issued by the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-92-509(a)(2)(I), § 23-92-509(a)(2)(D) and § 23-92-509(b)(2)(A). Specifically, under the permissive rule authority of these code provisions, the Commissioner is authorized to adopt rules without limitation to implement the Arkansas Pharmacy Benefits Manager Licensure Act ("PBMLA") for compensation and pharmacy benefits manager network adequacy. In addition, as it applies to health benefit plans, this Rule is issued under the authority of Ark. Code Ann. § 23-61-108(b)(1) that permits the promulgation of rules necessary for the effective regulation of the business of insurance to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers that include pharmacies.

Comment: Because we are applying these dispensing cost and reviews on "health insurers" or "health benefit plans," who essentially tell PBMS what to pay or not pay, I'm adding additional language supporting the rule authority under our powers to issue rules for "network adequacy" on health plans, which include a network adequacy requirement for pharmacies.

II. DEFINITIONS

Unless otherwise defined in this Section, the definitions in the PBMLA shall apply to the provisions in this Rule.

~~A. "Fair and reasonable cost to dispense" shall mean the Arkansas Insurance Commissioner's determination of an adequate price or amount for the dispensing of a drug by a pharmacy giving due regard for the cost factors of labor, supplies and other administrative costs of a pharmacy associated with the dispensing of a drug to a subscriber of a health benefit plan.~~

A. "Fair and Reasonable Pharmacy Compensation Program" shall mean the Arkansas Insurance Commissioner's determination of whether a current or proposed health benefit plan's pharmacy reimbursements result in an adequate network of pharmacies for a health benefit plan.

B. "Subscriber" shall mean an insured, enrollee or certificate holder of a health benefit plan as defined under Ark. Code Ann. § 23-92-503(2).

Comment: We are requiring an additional dispensing cost here, in actuality, on health benefit plans based on the new underlined A. definition above and not at all related what the total economic costs and administrative overhead is for drug dispensation per transaction. Therefore, we might require a $6 dollar additional cost or $9 etc, for example if the data justifies it, or none, or $10 dollars etc, depending on their data, to raise their overall reimbursement to pharmacies to "ensure an adequate pharmacy network." It really and legally has nothing to do that it costs in any drug transaction at a pharmacy that it costs in each instance, $10.50 cents adjusted for inflation. We simply wanted to make that very clear.

III. APPLICABILTY

This Rule applies to all health benefit plans as defined in Ark. Code Ann. § 23-92-503(2) and healthcare payors as defined in Ark. Code Ann. § 23-92-503(3). The requirements of this Rule shall not apply to federally regulated health benefit programs, restricted from state regulation under federal law or which are exempted from state regulation under state law.

Comment: I would prefer NOT to set out a long laundry list of federal and state plans this rule cannot legally apply to. Because we are issuing this Rule under the PBMLA, essentially the rule only applies to what the PBMLA has jurisdiction over. What happens in my experience when you do provide a list of 20-30 exempt plans, a new one will be required to be added due to federal legislation or litigation, or state law, or its erroneously just not listed, and we have to come back and amend the Rule!. The rule for example may or may not be apply to Medicare Advantage Plans, depending on how you read an 8th Circuit opinion. It will not apply to primary Medicaid, but will apply to Private Option. It will not apply to healthcare ministry plans, direct medical discount plans, boutique medical memberships, and will not appl to the Federal Employees plan, or Tricare for military members, and so on, on out to Tribal Indian Health plans. I would please just leave it with it with the above general exclusions.

IV. FAIR AND REASONABLE REIMBURSEMENTS

A. Pursuant to Ark. Code Ann. § 23-92-506(a)(1), the Commissioner may review and approve the compensation program of a pharmacy benefits manager ("PBM") from 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 provisions of this Rule are specifically issued related to cost processes, and not plan benefit design, to help ensure the subject of network adequacy or reasonably sustainable network adequacy of pharmacy services for health benefit plans.

B. The Commissioner finds that current pharmacy reimbursement minimums under the PBMLA, or payments within a close range to minimums of

National Average Drug Acquisition Cost ("NADAC"), or maximum allowable cost ("MAC"), that do not also include a reasonable cost to dispense to pharmacies may impair the sustainability of network adequacy for pharmacy services for health benefit plans.

Comments: We said before in B. under this section that payments at NADAC minimums without a dispensing cost DO or shall impair network adequacy or pharmacies. The reality it MAY or MAY not depending our review of the pharmacy reimbursement data, so I think we change this to "MAY IMPAIR…"

To ensure an adequate network of pharmacy services for a health benefit plan, or to ensure a reasonably sustainable adequate network for such services, a health benefit plan, through its pharmacy benefits plan or program, may be required to include a fair and reasonable cost to dispense to pharmacies in its administration of drug benefits under its health benefit plan upon and after a review of whether it has a fair and reasonable pharmacy compensation program to ensure an adequate network of pharmacies. For health benefit plans that are required to pay an additional dispensing cost under this Rule, a health benefit plan may not require a subscriber to pay for the dispensing cost outside of the amounts the health benefit plan has designated as the co-pay, co-insurance and deductible.

Comments: again, "may be required," not "shall be" depending on how we review the data.

The next markup is coming here from the health plans and Blue Cross and some of the concerns already from EBD in my #2 point in this comment.

First, our policy on these dispensing costs has been this is not going to be recouped at the counter from the customer. We really have not explored whether the next question of whether it instead can be applied or recovered under co-payment or co-insurance responsibilities. The plans suggest allow providing for it in high deductible health plan cases and very cheap generic RX payment. This is essentially saying it can be in high deductible health plans and very cheap generics if the total pharmacy reimbursement plus the fee IS LESS than a co-payment.

Under IRS rules, for high deductible health plans, members in those plans have to pay dollar for dollar for benefits and all costs, to receive tax deductions until they satisfy their deductible. We believe this covers all provider reimbursement billing including any dispensing costs. Under such plans, it may be required for the member to absorb the total charges up to their deductible to qualify for tax deductibility of that high deductible plan. That's number one. Number 2: this comes somewhat under administrative nightmare but what if the drug ingredient cost plus the dispensing fee is under the required co-payment? The plans will have to modulate their whole drug benefit design to lower co-payment amounts especially on cheap generics. I'm posing that we allow for the collection of the cost in the total reimbursement up to co-payment or co-insurance AND NOT OUTSIDE of it or when it would be IN EXCESS of those cost-sharing minimums.

C. To ensure an adequate network of pharmacy services for a health benefit plan, or to ensure a reasonably sustainable adequate network for such services, a health benefit plan, through its pharmacy benefits plan or program, may be required to shall include a fair and reasonable cost to dispense to pharmacies in its administration of drug benefits under its health benefit plan upon and after a review of whether it has a fair and reasonable pharmacy compensation program to ensure an adequate network of pharmacies. . ~~A fair and reasonable cost to dispense shall be calculated commiserate with the time, labor, supplies, and other administrative costs associated with the dispensing of the drug by the pharmacy. This cost to dispense shall be uniform or equally applied to all pharmacies servicing the health benefit plan.~~ NFor health benefit plans that are required to pay an additional dispensing cost under this Rule, a health benefit plan may not require a subscriber to pay for the dispensing cost outside of the amounts the health benefit plan has designated as the co-pay, co-insurance and deductible. o health insurer, and no pharmacy benefits manager ("PBM") administrating drug benefits for health benefit plans shall recoup or recover any increased costs to dispense from a subscriber at the point of sale through increased cost-sharing requirement ratios or percentages ("co-insurance, co-payment, or deductibles") on the health benefits plan member. Every health benefit plan or healthcare payor subject to the Arkansas Pharmacy Benefits Manager Licensure Act insurer shall file with the Commissioner, beginning on November 30, 2024, and no later than by February 17, 2025, by January 1, 2025, a written report describing each healthcare payor's pharmacy compensation data as required by Bulletin # 18-2024 by AID. calculation amount, and methodology for such calculation, of the cost to dispense as required by this Rule. This requirement shall apply to plan year 2025 and thereafter on such dates March 1 for each succeeding plan year as mandated by the AID implementation Bulletin # 18-2024. Upon receipt of the data as required by AID Bulletin# 18-2024, the Commissioner is authorized to require an additional dispensing cost if the health benefit plan does not already provide a fair and reasonable pharmacy compensation program to ensure an adequate network of pharmacies. The Commissioner shall be authorized to review, approve or deny such dispensing cost requirement, to dispense calculation, in consultation with the actuary for the Arkansas Insurance Department ("AID"). The Commissioner shall make his or her decision to approve or deny such cost calculation within twenty (20) working days of receipt of such report from a healthcare payor and notify the submitting healthcare payor of his or her decision in writing. The Commissioner may extend such time periods for his or her decision in the event that the Commissioner needs additional data from the healthcare payor. The Commissioner shall issue a bulletin with the promulgation of this Rule more specifically addressing the format, procedures and information requirements required for such submissions as required under this Section of this Rule. Bulletin (18-2024) is hereby incorporated as part of this Rule. This Bulletin shall not be amended without filing such amendments as an amended promulgation of this Rule.

Comments: Making quite a few clarifications here in response to public comments. First, we make it clear the rule and reporting requirements in the bulletin apply both to fully-insured plans (insured by health insurers) as well as self-funded employer plans. This is consistent with the definitions in the PBMLA defining what a health benefit plan is and a healthcare payor. Second, we had a lot of comments complaining that the report filing timing requirements were

not clear. We therefore clarified that such reporting timelines will follow AID Bulletin 18-2024 which sets those out in great detail, and we incorporated the bulletin into this rule by reference. No changes will be made by AID to this bulletin without going through full rule-making approval with the legislature.

~~E. To the extent it is feasible, legally permitted and does not excessively and adversely impact health plan premium rates, the Commissioner requests that the health benefit plans and healthcare payors strive to reduce any additional costs, associated with the costs to dispense as required by this Rule, by applying all unused brand name rebates to such costs, remaining after compliance with Act 333 of 2023 under the Healthcare Insurer Share the Savings Act, codified at Ark. Code Ann. § 23-79-2501 et seq., and the Pharmacy Benefits Manager Share the Savings Act, codified at Ark. Code Ann. § 23-92-704 et seq.~~

Comments: we removed the underlined condition in the above, as there have been raised about both the legality of that as well as the cost and feasibility of doing so.

D. Confidentiality of Data Required By AID Bulletin. Pursuant to Ark. Code Ann. § 23-92-506(a)(2), 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.

Comments: this is consistent and already in the insurance code, in the statute in the PBMLA. The last sentence is added however to make it transparent to all of the health benefit plans, what the dispending cost decisions were by the Commissioner for each health benefit plan.