SPONSOR SUBSTITUTE FOR SENATE BILL NO. 121

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-THIRD LEGISLATURE - SECOND SESSION

BY SENATORS GIESSEL BY REQUEST, Bjorkman, Myers, Tobin, Gray-Jackson

Introduced: 2/8/24
Referred: Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Board of Pharmacy; relating to insurance; relating to pharmacies; relating to pharmacists; relating to pharmacy benefits managers; relating to patient choice of pharmacy; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy, including independent monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) license and regulate the qualifications of entities and individuals engaged in the manufacture or distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent prescribing and administration of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board and an epinephrine auto-injector training program under AS 17.22.020(b);

(13) establish standards for the independent prescribing and dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist who dispenses a schedule II, III, or IV controlled substance under federal law to a person in the state register with the controlled substance prescription database under AS 17.30.200(n);

(15) establish the qualifications and duties of the executive

administrator and delegate authority to the executive administrator that is necessary to conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status**;**

(19) prohibit, limit, or provide conditions relating to the dispensing of a prescription drug that the United States Food and Drug Administration or the prescription drug's manufacturer has not approved for self-administration to ensure the effectiveness and security of a prescription drug to be administered by infusion or in a clinical setting.

*** Sec. 2.** AS 21.27.901 is amended to read:

Sec. 21.27.901. Registration of pharmacy benefits managers; scope of business practice. (a) A person may not conduct business in the state as a pharmacy benefits manager unless the person is registered with the director [AS A THIRD-PARTY ADMINISTRATOR UNDER AS 21.27.630].

(b) A pharmacy benefits manager registered under **this section** [AS 21.27.630] may

(1) contract with an insurer to administer or manage pharmacy benefits provided by an insurer for a covered person, including claims processing services for and audits of payments for prescription drugs and medical devices and supplies; **and**

(2) contract with network pharmacies [;

(3) SET THE COST OF MULTI-SOURCE GENERIC DRUGS UNDER AS 21.27.945; AND

(4) ADJUDICATE APPEALS RELATED TO MULTI-SOURCE GENERIC DRUG REIMBURSEMENT].

*** Sec. 3.** AS 21.27.901 is amended by adding new subsections to read:

(c) A pharmacy benefits manager

(1) shall apply for registration following the same procedures for

licensure set out in AS 21.27.040;

(2) is subject to hearings and orders on violations; denial, nonrenewal, suspension, or revocation of registration; penalties; and surrender of registration under the procedures set out in AS 21.27.405 - 21.27.460.

(d) Each day that a pharmacy benefits manager conducts business in the state as a pharmacy benefits manager without being registered is a separate violation of this section, and each separate violation is subject to the maximum civil penalty under AS 21.97.020.

*** Sec. 4.** AS 21.27.905(a) is amended to read:

(a) A pharmacy benefits manager shall biennially renew a registration with the director **following the procedures for license renewal in AS 21.27.380**.

*** Sec. 5.** AS 21.27 is amended by adding a new section to read:

Sec. 21.27.907. Fiduciary duty. (a) A pharmacy benefits manager owes a fiduciary duty to a plan sponsor. A pharmacy benefits manager shall adhere to the practices set out in this section.

(b) A pharmacy benefits manager shall

(1) perform the manager's duties with care, skill, prudence, and diligence and in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims; and

(2) notify the plan sponsor in writing of any activity, policy, or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of interest with the duties imposed by this chapter.

(c) A pharmacy benefits manager that receives from a drug manufacturer or labeler a payment or benefit of any kind in connection with the use of a prescription drug by a covered person, including a payment or benefit based on volume of sales or market share, shall pass that payment or benefit on in full to the plan sponsor. This provision does not prohibit the insurer from agreeing by contract to compensate the pharmacy benefits manager by returning a portion of the benefit or payment to the pharmacy benefits manager.

(d) Upon request by a plan sponsor, a pharmacy benefits manager shall

(1) provide information showing the quantity of drugs purchased by

the covered person and the net cost to the covered person for the drugs; the information must include all rebates, discounts, and other similar payments; if requested by the plan sponsor, the pharmacy benefits manager shall provide the quantity and net cost information on a drug-by-drug basis by National Drug Code registration number rather than on an aggregated basis; and

(2) disclose to the plan sponsor all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefits manager and a prescription drug manufacturer or labeler, including formulary management and drug-substitution programs, educational support, claims processing, and data sales fees.

(e) A pharmacy benefits manager providing information to a plan sponsor under (d) of this section may designate that information as confidential. Information designated as confidential may not be disclosed by the plan sponsor to another person without the consent of the pharmacy benefits manager, unless ordered by a court.

(f) If a pharmacy dispenses a substitute prescription drug for a prescribed drug to a covered person and the substitute prescription drug costs more than the prescribed drug, the pharmacy benefits manager shall disclose to the plan sponsor the cost of both drugs and any benefit or payment directly or indirectly accruing to the pharmacy benefits manager as a result of the substitution. The pharmacy benefits manager shall transfer in full to the plan sponsor a benefit or payment received in any form by the pharmacy benefits manager as a result of a prescription drug substitution.

*** Sec. 6.** AS 21.27.945(a) is amended to read:

(a) A pharmacy benefits manager shall

(1) **provide** [MAKE AVAILABLE] to each network pharmacy at the beginning of the term of the network pharmacy's contract, and upon renewal of the contract, the methodology and sources used to determine the [DRUG PRICING] list;

(2) provide the list to a network pharmacy without charge;

(3) [(2)] provide **and keep current** a telephone number at which a network pharmacy may contact an employee of a pharmacy benefits manager [TO DISCUSS THE PHARMACY'S APPEAL];

(4) [(3)] provide a process for a network pharmacy to have ready access to the list specific to that pharmacy;

(5) [(4)] review and update [APPLICABLE] list information at least once every seven [BUSINESS] days to **ensure** [REFLECT MODIFICATION OF] list pricing **reflects current national drug database pricing**;

(6) [(5)] update list prices within one business day after a significant price update or modification provided by the pharmacy benefits manager's national drug database provider; and

(7) [(6)] ensure that dispensing fees are not included in the calculation of the list pricing.

*** Sec. 7.** AS 21.27.945(b) is repealed and reenacted to read:

(b) Before placing or maintaining a specific drug on the list, a pharmacy benefits manager shall ensure that

(1) if the drug is therapeutically equivalent and pharmaceutically equivalent to a prescribed drug, the drug is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the most recent edition or supplement of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(2) if the drug is a different biological product than a prescribed drug, the drug is an interchangeable biological product;

(3) the drug is readily available for purchase by each pharmacy in the state from national or regional wholesalers operating in the state; and

(4) the drug is not obsolete or temporarily unavailable.

*** Sec. 8.** AS 21.27.945 is amended by adding new subsections to read:

(c) The list a pharmacy benefits manager provides to a network pharmacy under (a) of this section must

(1) be maintained in a searchable electronic format that is accessible with a computer;

(2) identify each drug for which a reimbursement amount is established;

(3) specify for each drug

(A) the national drug code;

(B) the national average drug acquisition cost, if available;

(C) the wholesale acquisition cost, if available; and

(D) the reimbursement amount; and

(4) specify the date on which a drug is added or removed from the list.

(d) In this section,

(1) "interchangeable biological product" has the meaning given in AS 08.80.480;

(2) "pharmaceutically equivalent" means a drug has identical amounts of the same active chemical ingredients in the same dosage form and meets the standards of strength, quality, and purity according to the United States Pharmacopeia published by the United States Pharmacopeial Convention or another similar nationally recognized publication;

(3) "pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler or distributor charges for a pharmaceutical product as listed on the pharmacy's invoice;

(4) "significant price update or modification" means

(A) an increase or decrease of 10 percent or more in the pharmacy acquisition cost from 60 percent or more of the pharmaceutical wholesalers doing business in the state;

(B) a change in the methodology in which the maximum allowable cost for a drug is determined; or

(C) a change in the value of a variable involved in the methodology used to determine the maximum allowable cost for a drug;

(5) "therapeutically equivalent" means a drug is from the same therapeutic class as another drug and, when administered in an appropriate amount, provides the same therapeutic effect as, and is identical in duration and intensity to, the other drug;

(6) "therapeutic class" means a group of similar drug products that have the same or similar mechanisms of action and are used to treat a specific condition.

*** Sec. 9.** AS 21.27.950 is repealed and reenacted to read:

Sec. 21.27.950. Reimbursement. (a) A pharmacy benefits manager shall

reimburse a pharmacy or pharmacist for a drug in an amount not less than the national average drug acquisition cost for the drug on the date that the drug is administered or dispensed. If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefits manager shall reimburse in an amount that is not less than the wholesale acquisition cost of the drug. If the wholesale acquisition cost of the drug is not available at the time a drug is administered or dispensed, a pharmacy benefits manager shall reimburse in an amount that is not less than the pharmacy acquisition cost of the drug.

(b) In addition to the reimbursement required under (a) of this section, a pharmacy benefits manager shall reimburse the pharmacy or pharmacist for a professional dispensing fee set by the director.

(c) The director shall periodically review dispensing fees paid under coverage provided to individuals entitled to medical benefits under AS 39.30.091 and available cost of dispensing surveys, including surveys conducted by the Department of Health for the medical assistance program under AS 47.07 and the national average drug acquisiton cost retail price survey conducted by the federal Centers for Medicare and Medicaid Services. The director shall set and adjust the professional dispensing fee accordingly. The director shall adjust the professional dispensing fee at least once every five years.

*** Sec. 10.** AS 21.27 is amended by adding new sections to read:

Sec. 21.27.951. Patient choice of pharmacy. (a) An insurer providing a covered person with a health care insurance plan and its pharmacy benefits manager may not

(1) prohibit or limit the person receiving pharmacy services under the insurer's health care insurance plan, including mail-order and specialty pharmacy services, from selecting a pharmacy of the person's choice to provide the pharmacy services if the pharmacy has notified the insurer, or the pharmacy benefits manager authorized to act on the insurer's behalf, of the pharmacy's agreement to accept as payment in full reimbursement for the pharmacy's services at rates applicable to pharmacies that are administered by the insurer or its pharmacy benefits manager, including any copayment required by the insurer's health care insurance plan; or

(2) restrict access to drugs by limiting distribution of a drug through an affiliate, except to the extent necessary to meet limited distribution requirements of the United States Food and Drug Administration or to ensure the appropriate dispensing of a drug that requires extraordinary special handling, provider coordination, or patient education when those requirements cannot be met by a network pharmacy; an insurer or its pharmacy benefits manager who restricts drug access, or limits drug distribution under the exceptions allowed by this paragraph shall, upon request, promptly provide a pharmacy or pharmacist with a complete written description of all extraordinary special handling, provider coordination, and patient education requirements necessary for the distribution or dispensing of a drug; in this paragraph, "affiliate" means a business, pharmacy, pharmacist, or provider who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a pharmacy benefits manager.

(b) An insurer providing a covered person with a health care insurance plan and its pharmacy benefits manager shall permit a pharmacy or pharmacist to enter into a direct service agreement or network pharmacy agreement with the insurer or its pharmacy benefits manager if the pharmacy or pharmacist

(1) meets the terms and conditions of participation in the direct service agreement or network pharmacy agreement;

(2) agrees to provide pharmacy services, including drugs, that meet the terms and conditions required under the insurer's health care insurance plan, including the terms of reimbursement; and

(3) not later than 30 days after being requested in writing to do so by the insurer or its pharmacy benefits manager, executes and delivers to the insurer or its pharmacy benefits manager the direct service agreement or network pharmacy agreement that the insurer or its pharmacy benefits manager requires of all its network pharmacies.

(c) An insurer or its pharmacy benefits manager shall act on a pharmacy's or pharmacist's request for a direct service agreement or a network pharmacy agreement not later than 30 days after the insurer or its pharmacy benefits manager receives the pharmacy's or pharmacist's request or, if the insurer or its pharmacy benefits manager

requests supplemental information, 30 days after the insurer or its pharmacy benefits manager receives the supplemental information.

(d) A network pharmacy or a pharmacy applying to become a network pharmacy under this section shall be presumed to meet the requirements of a specialty pharmacy upon its assertion that it meets the requirements of a specialty pharmacy.

(e) In this section,

(1) "specialty drug" means a drug that is subject to restricted distribution by the United States Food and Drug Administration;

(2) "specialty pharmacy" means a pharmacy capable of meeting the requirements of the United States Food and Drug Administration applicable to specialty drugs.

Sec. 21.27.952. Patient access to clinician-administered drugs. (a) An insurer or its pharmacy benefits manager may not

(1) refuse to authorize, approve, or pay a provider for providing covered clinician-administered drugs and related services to a covered person if the provider has agreed to participate in the insurer's health care insurance plan according to the terms offered by the insurer or its pharmacy benefits manager;

(2) if the criteria for medical necessity is met, condition, deny, restrict, refuse to authorize or approve, or reduce payment to a provider for a clinician-administered drug because the provider obtained the clinician-administered drug from a pharmacy that is not a network pharmacy in the insurer's or its pharmacy benefits manager's network;

(3) impose coverage or benefit limitations or require a covered person to pay an additional fee, a higher or additional copay or coinsurance, or a penalty when obtaining a clinician-administered drug from a network pharmacy authorized under the laws of this state to dispense or administer the drug;

(4) require a covered person to pay an additional fee, a higher or additional copay or coinsurance, or another form of a price increase for a clinician-administered drug when the drug is not dispensed by a pharmacy or acquired from an entity selected by the insurer or its pharmacy benefits manager;

(5) interfere with the right of a covered person to obtain a clinician-

administered drug from the provider or pharmacy of the person's choice, including by inducement, steering, or offering or promoting financial or other incentives;

(6) limit or exclude coverage for a clinician-administered drug when not dispensed by a pharmacy or acquired from an entity selected by the insurer or its pharmacy benefits manager when the drug would otherwise be covered;

(7) require a pharmacy to dispense a clinician-administered drug directly to a covered person or agent of the insured with the intention that the covered person or the agent of the insured will transport the medication to a provider for administration;

(8) require or encourage the dispensing of a clinician-administered drug to a covered person in a manner that is inconsistent with the supply chain security controls and chain of distribution set by 21 U.S.C. 360eee - 360eee-4 (Drug Supply Chain Security Act);

(9) require that a clinician-administered drug be dispensed or administered to a covered person in the residence of the covered person or require use of an infusion site external to the office, department, or clinic of the provider of the covered person; nothing in this paragraph prohibits the insurer or its pharmacy benefits manager, or an agent of the insurer or its pharmacy benefits manager, from offering the use of a home infusion pharmacy or external infusion site.

(b) In this section, "clinician-administered drug" means a drug, other than a vaccine, that requires administration by a provider and that the United States Food and Drug Administration or the drug's manufacturer has not approved for self-administration.

Sec. 21.27.953. Penalties. In addition to any other penalty provided by law, if a person violates AS 21.27.945 - 21.27.955, the director may, after notice and hearing, impose a penalty in accordance with AS 21.27.440.

*** Sec. 11.** AS 21.27.955(4) is amended to read:

(4) "list" means **a** [THE] list of [MULTI-SOURCE GENERIC] drugs for which a **pharmacy benefits manager has established** predetermined reimbursement **amounts, or methods for determining reimbursement amounts, to be paid to a network pharmacy or pharmacist for pharmacy services,** [AMOUNT

HAS BEEN ESTABLISHED] such as a maximum allowable cost or maximum allowable cost list or any other list of prices used by a pharmacy benefits manager;

*** Sec. 12.** AS 21.27.955(6) is repealed and reenacted to read:

(6) "network pharmacy" means a pharmacy or pharmacist who, under a contract or agreement with the insurer or its pharmacy benefits manager, has agreed to provide pharmacy services to a covered person with an expectation of receiving payment, other than in-network coinsurance, copayments, or deductibles, directly or indirectly from the insurer;

*** Sec. 13.** AS 21.27.955 is amended by adding new paragraphs to read:

(11) "covered person" means an individual receiving medication coverage or reimbursement provided by an insurer or its pharmacy benefits manager under a health care insurance plan;

(12) "drug" means a prescription drug;

(13) "health care insurance plan" has the meaning provided in AS 21.54.500;

(14) "insurer" has the meaning given in AS 21.97.900 and includes a company or group of companies under common management, ownership, or control;

(15) "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a drug;

(16) "national average drug acquisition cost" means the average acquisition cost for outpatient drugs covered by Medicaid, as determined by a monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services;

(17) "network" means an entity that, through contracts or agreements with providers, provides or arranges for access by groups of covered persons to health care services by providers who are not otherwise or individually contracted directly with an insurer or its pharmacy benefits manager;

(18) "plan sponsor" has the meaning given in AS 21.54.500;

(19) "provider" means a physician, pharmacist, hospital, clinic, hospital outpatient department, pharmacy under the common ownership or control of a provider, or other person licensed or otherwise authorized in this state to furnish health

care services;

(20) "wholesale acquisition cost" has the meaning given in 42 U.S.C. 1395w-3a(c)(6)(B).

*** Sec. 14.** AS 21.36 is amended by adding a new section to article 5 to read:

Sec. 21.36.520. Unfair trade practices. (a) An insurer providing a health care insurance plan or its pharmacy benefits manager may not

(1) violate AS 21.27.950;

(2) interfere with a covered person's right to choose a pharmacy or provider as provided in AS 21.27.951;

(3) interfere with a covered person's right of access to a clinician-administered drug as provided in AS 21.27.952;

(4) interfere with the right of a pharmacy or pharmacist to participate as a network pharmacy as provided in AS 21.27.951;

(5) reimburse a pharmacy or pharmacist an amount less than the amount the pharmacy benefits manager reimburses an affiliate for providing the same pharmacy services, calculated on a per-unit basis using the same generic product identifier or generic code number;

(6) impose a copayment, fee, or condition that is not equally imposed on all individuals in the same benefit category, class, or copayment level, whether or not the benefits are furnished by a pharmacy or pharmacist who is not a network pharmacy;

(7) steer, invite, or direct a patient to use an affiliate's services through verbal or written communication, including

(A) online messaging regarding the affiliate; or

(B) patient or prospective patient-specific advertising, marketing, or promotion of the affiliate;

(8) impose any monetary advantage, inducement, or penalty that could affect or influence a person's choice among pharmacies that have agreed to participate in the plan according to the terms offered by the insurer or its pharmacy benefits manager, including a higher or additional copayment or fee or promotion of one participating pharmacy over another;

(9) impose a reduction in reimbursement for pharmacy services because of the person's choice among pharmacies that have agreed to participate in the plan according to the terms offered by the insurer or its pharmacy benefits manager;

(10) use a covered person's pharmacy services data collected under the provision of claims processing services for the purpose of soliciting, marketing, or referring the person to an affiliate of the pharmacy benefits manager;

(11) require a covered person, as a condition of payment or reimbursement, to purchase pharmacist services or products, including drugs, through a mail-order pharmacy or pharmacy benefits manager affiliate;

(12) prohibit or limit a network pharmacy from mailing, shipping, or delivering drugs to a patient as an ancillary service; however, the insurer or its pharmacy benefits manager

(A) is not required to reimburse a delivery fee charged by a pharmacy unless the fee is specified in the contract between the pharmacy benefits manager and the pharmacy;

(B) may not require a patient signature as proof of delivery of a mailed or shipped drug if the network pharmacy

(i) maintains a mailing or shipping log signed by a representative of the pharmacy or keeps a record of each notification of delivery provided by the United States mail or a package delivery service; and

(ii) is responsible for the cost of mailing, shipping, or delivering a replacement for a drug that was mailed or shipped but not received by the covered person;

(13) impose on a pharmacist or pharmacy seeking to remain or become a network provider credentialing standards that are more strict than the licensing standards set by the Board of Pharmacy or charge a pharmacy a fee in connection with network enrollment;

(14) prohibit or limit a network pharmacy from informing an insured person of the difference between the out-of-pocket cost to the covered person to purchase a drug, medical device, or supply using the covered person's pharmacy

benefits and the pharmacy's usual and customary charge for the drug, medical device, or supply;

(15) conduct or participate in spread pricing in the state;

(16) assess, charge, or collect a form of remuneration that passes from a pharmacy or a pharmacist in a pharmacy network to the pharmacy benefits manager including claim processing fees, performance-based fees, network participation fees, or accreditation fees;

(17) reverse and resubmit the claim of a pharmacy more than 30 days after the date the claim was first adjudicated, and may not reverse and resubmit the claim of a pharmacy unless the insurer or pharmacy benefits manager

(A) provides prior written notification to the pharmacy;

(B) has just cause;

(C) first attempts to reconcile the claim with the pharmacy; and

(D) provides to the pharmacy, at the time of the reversal and resubmittal, a written description that includes details of and justification for the reversal and resubmittal.

(b) A provision of a contract between a pharmacy benefits manager and a pharmacy or pharmacist that is contrary to a requirement of this section is null, void, and unenforceable in this state.

(c) A violation of this section or a regulation adopted under this section is an unfair trade practice and subject to penalty under this chapter.

(d) For purposes of this section, a violation has occurred each time a prohibited act is committed.

(e) Nothing in this section may interfere with or violate a patient's right under AS 08.80.297 to know where the patient may have access to the lowest cost drugs or the requirement that a patient must receive notice of a change to a pharmacy network, including the addition of a new pharmacy or removal of an existing pharmacy from a pharmacy network.

(f) The director may adopt regulations to provide a grievance procedure for complaints alleging a violation of this section.

(g) In this section,

(1) "affiliate" has the meaning given in AS 21.27.951(a)(2);

(2) "clinician-administered drug" has the meaning given in AS 21.27.952(b);

(3) "covered person" has the meaning given in AS 21.27.955;

(4) "drug" has the meaning given in AS 21.27.955;

(5) "health care insurance plan" has the meaning given in AS 21.54.500;

(6) "insurer" has the meaning given in AS 21.27.955;

(7) "mail-order pharmacy" means a pharmacy whose primary business is to receive drugs by mail or through electronic submission and to dispense medication to a covered person through the use of the United States mail or other common or contract carrier services and who may provide consultation with a covered person electronically rather than face-to-face;

(8) "network pharmacy" has the meaning given in AS 21.27.955;

(9) "out-of-pocket cost" means a deductible, coinsurance, copayment, or similar expense owed by a covered person under the terms of the covered person's health care insurance plan;

(10) "provider" has the meaning given in AS 21.27.955;

(11) "spread pricing" means the method of pricing a drug in which the contracted price for a drug that a pharmacy benefits manager charges a health care insurance plan differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

*** Sec. 15.** AS 29.10.200 is amended by adding a new paragraph to read:

(68) AS 29.20.420 (health care insurance plans).

*** Sec. 16.** AS 29.20 is amended by adding a new section to article 5 to read:

Sec. 29.20.420. Health care insurance plans. (a) If a municipality offers a group health care insurance plan covering municipal employees, including by means of self-insurance, the municipal health care insurance plan, including the administration and management of pharmacy benefits under the plan, is subject to the requirements of AS 21.27.901 - 21.27.955 and AS 21.36.520.

(b) This section applies to home rule and general law municipalities.

(c) In this section, "health care insurance plan" has the meaning given in AS 21.54.500.

*** Sec. 17.** AS 39.30.090(a) is amended to read:

(a) The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.25.168, 14.25.480, AS 22.25.090, AS 39.35.535, 39.35.880, or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

(1) a group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance;

(2) each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration;

(3) a governmental unit may participate under a group policy if

(A) its governing body adopts a resolution authorizing participation and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing;

(4) in procuring a policy of group health or group life insurance as provided under this section or excess loss insurance as provided in AS 39.30.091, the Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from an insurer authorized to transact business in the state under AS 21.09, a hospital or medical service corporation authorized to transact business in this state under AS 21.87, or a health maintenance organization authorized to operate in this state under AS 21.86; an excess loss

insurance policy may be obtained from a life or health insurer authorized to transact business in this state under AS 21.09 or from a hospital or medical service corporation authorized to transact business in this state under AS 21.87;

(5) the Department of Administration shall make available bid specifications for desired insurance benefits or for administration of benefit claims and payments to (A) all insurance carriers authorized to transact business in this state under AS 21.09 and all hospital or medical service corporations authorized to transact business under AS 21.87 who are qualified to provide the desired benefits; and (B) insurance carriers authorized to transact business in this state under AS 21.09, hospital or medical service corporations authorized to transact business under AS 21.87, and third-party administrators licensed to transact business in this state and qualified to provide administrative services; the specifications shall be made available at least once every five years; the lowest responsible bid submitted by an insurance carrier, hospital or medical service corporation, or third-party administrator with adequate servicing facilities shall govern selection of a carrier, hospital or medical service corporation, or third-party administrator under this section or the selection of an insurance carrier or a hospital or medical service corporation to provide excess loss insurance as provided in AS 39.30.091;

(6) if the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees;

(7) a person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit;

(8) a person electing to have insurance under (7) of this subsection shall pay the cost of this insurance;

(9) for each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half;

(10) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section; the level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age, survivors, and disability insurance program; a person electing to have insurance under this paragraph shall pay the cost of the insurance; the commissioner of administration shall adopt regulations implementing this paragraph;

(11) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care insurance for that person and eligible dependents under this section; a person who elects insurance under this paragraph shall pay the cost of the insurance premium; the commissioner of administration shall adopt regulations to implement this paragraph;

(12) each licensee holding a current operating agreement for a vending facility under AS 23.15.010 - 23.15.210 shall be covered by the group policy that applies to governmental units other than the state**;**

(13) a group health insurance policy covering employees of a participating governmental unit must meet the requirements of AS 21.27.901 - 21.27.955 and AS 21.36.520, including requirements relating to administration and management of pharmacy benefits under the policy.

*** Sec. 18.** AS 39.30.091 is amended to read:

Sec. 39.30.091. Authorization for self-insurance and excess loss insurance. Notwithstanding AS 21.86.310 or AS 39.30.090, the Department of Administration may provide, by means of self-insurance, one or more of the benefits listed in AS 39.30.090(a)(1) for state employees eligible for the benefits by law or under a collective bargaining agreement and for persons receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37, and their dependents. The department shall procure any necessary excess loss insurance under AS 39.30.090. **A self-insured group medical plan covering active state employees provided under this section is subject to the requirements of AS 21.27.901 - 21.27.955 and AS 21.36.520, including requirements relating to administration and management of pharmacy**

benefits under the plan.

*** Sec. 19.** AS 45.50.471(b) is amended by adding a new paragraph to read:

(58) violating AS 21.36.520(a) (insurers and pharmacy benefits managers), if the violation is committed or performed with a frequency that indicates a general business practice.

*** Sec. 20.** AS 21.27.955(5) and 21.27.955(8) are repealed.

*** Sec. 21.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to a contract between a pharmacy benefits manager and a pharmacy or pharmacist entered into, renewed, or amended on or after the effective date of secs. 1 - 21 of this Act.

*** Sec. 22.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Commerce, Community, and Economic Development and the Department of Administration may adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law implemented by the regulation.

*** Sec. 23.** Section 22 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 24.** Except as provided in sec. 23 of this Act, this Act takes effect July 1, 2025.