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95th General Assembly
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A Bill

SENATE BILL 104

By: Senators C. Penzo, *M. Johnson*
By: Representative Lundstrum

For An Act To Be Entitled

AN ACT TO AMEND THE ARKANSAS PHARMACY BENEFITS MANAGER LICENSURE ACT; TO PROTECT PATIENTS' RIGHTS AND ACCESS TO MEDICATIONS; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE ARKANSAS PHARMACY BENEFITS MANAGER LICENSURE ACT; TO PROTECT PATIENTS' RIGHTS AND ACCESS TO MEDICATIONS; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative intent.

It is the intent of the General Assembly that this act shall regulate the business practices of healthcare payors and pharmacy benefits managers:

(1) To ensure adequate access to pharmacy services as intended and designed by underlying health benefit plans;

(2) To protect patients from unfair and deceptive trade practices within the state; and

(3) To ensure pharmacy benefits management companies do not interfere with a patient's rights under the patient's underlying health benefit plan and always consider each patient's unique conditions and limitations when enforcing any access prerequisites or conditions.

SECTION 2. Arkansas Code § 23-92-503, concerning the definitions used

in the Arkansas Pharmacy Benefits Manager Licensure Act, is amended to add additional subdivisions to read as follows:

(16)(A) "Affiliate" means an entity that controls, is controlled by, or is under common control with another entity, including an entity in which control is established through one (1) or more intermediary entities, such that the common controlling interest may be two (2) or more levels *removed from the specified entity.*

(B) Whether an entity is an "affiliate" does not depend on the percentage or form of ownership interest or any allocation of membership or ownership between entities, but it is the existence of control or common control that is the sole determinative factor;

(17)(A) "Carve-out network" means a subset of a pharmacy benefits manager's network that:

(i) Is created by the pharmacy benefits manager; and

(ii) Limits access to a certain pharmacy or pharmacist for a specific drug or category of drugs.

(B) "Carve-out network" includes any network that restricts enrollee access to in-person pharmacy services within this state by offering only limited methods of obtaining a prescription drug, including mail-order only options, while presenting the appearance of a full network of available pharmacies;

(18) "Enrollee" means an individual who is entitled to receive healthcare services under the terms of a health benefit plan;

(19)(A) "Ghost network" means a pharmacy benefits manager network that includes a pharmacy or pharmacist as a participating provider when that participating provider is:

(i) Not accepting new patients;

(ii) No longer in practice; or

(iii) Otherwise unavailable to or restricted from providing services to enrollees in this state.

(B) "Ghost network" includes a pharmacy network in which a significant number of listed participating providers are not accessible to enrollees within a reasonable time frame or geographic distance;

(20) "Healthcare payor affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control

with a healthcare payor; and

(21)(A) "Self-administered prescription drug" means a pharmaceutical that when prescribed does not require assistance by a third party to administer and can be dispensed by a pharmacy or pharmacist to an enrollee for self-administration under federal and state laws and regulations.

(B) "Self-administered prescription drug" does not include over-the-counter medications that do not require a prescription.

SECTION 3. Arkansas Code § 23-92-506(b), concerning prohibited practices under the Arkansas Pharmacy Benefits Manager Licensure Act, is amended to add an additional subdivision to read as follows:

(9) Unless reviewed and approved by the commissioner in coordination with the board, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the board.

SECTION 4. Arkansas Code Title 23, Chapter 92, Subchapter 5, is amended to add additional sections to read as follows:

23-92-512. Unfair and deceptive trade practices.

(a)(1) A healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate shall not engage in unfair or deceptive trade practices in the administration of pharmacy benefits.

(2) Unfair or deceptive trade practices under subdivision (a)(1) of this section include without limitation:

(A) Requiring an enrollee to utilize a particular pharmacy benefits manager affiliate;

(B) Requiring a pharmacy or pharmacist to forward or retransmit a prescription to a specific healthcare payor affiliate or pharmacy benefits manager affiliate unless the receiving healthcare payor affiliate or pharmacy benefits manager affiliate can provide verifiable documentation of the enrollee's consent to use that specific pharmacy;

(C) Implementing a policy or protocol that unreasonably restricts an enrollee's choice of pharmacy *within a* pharmacy benefits manager network, if:

(i)(a) The pharmacy meets the pharmacy benefits manager network's relevant and reasonable terms of participation requirements.

(b) A disagreement or concern regarding whether relevant and reasonable terms of participation requirements are relevant and reasonable shall be determined by the Insurance Commissioner; and

(ii) The pharmacy has existing approval to dispense *one (1) or more self-administered prescription drugs in one (1) or more pharmacy benefits manager networks for the underlying health benefit* plan;

(D)(i) Providing an incentive or imposing a penalty that effectively coerces or pressures an enrollee to use a particular healthcare payor affiliate or pharmacy benefits manager affiliate.

(ii) Adjustments to an enrollee's cost-sharing responsibilities, including copayments, coinsurance, or deductibles, that are part of the health benefit plan's design are not considered incentives or penalties under subdivision (a)(2)(D)(i) of this section;

(E) Failing to disclose to an enrollee the options available for obtaining prescription drugs within the pharmacy benefits manager network;

(F) Disclosing, sharing, or otherwise making available enrollee information or enrollee-identifiable prescription information submitted by a pharmacist or pharmacy to a healthcare payor affiliate or pharmacy benefits manager affiliate without the written consent of the enrollee;

(G) Using or disclosing enrollee information or enrollee-identifiable prescription information for marketing or solicitation purposes without the written consent of the enrollee; and

(H)(i) Engaging in any conduct that unlawfully restricts, limits, or interferes with an enrollee's right to choose a pharmacy or pharmacist, including without limitation actions that violate federal law or state law or improperly steer enrollees to a specific pharmacy or pharmacist.

(ii) The prohibition under subdivision (a)(2)(H)(i) of this section does not apply to a change in patient cost-sharing obligations, including copayments, coinsurance, or deductibles, that are permitted under applicable law.

(b)(1) A healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate shall not impose restrictive terms or conditions that limit an enrollee's or an enrollee's assigned representative's rights to seek an exception to or to appeal a coverage decision or restriction with his or her health benefit plan.

(2) A healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate shall ensure that:

(A) The processes for seeking an exception and filing an appeal are clearly communicated to patients in a publicly accessible manner on its website;

(B) The information necessary to utilize the processes under subdivision (b)(2)(A) of this section is presented in a manner that is understandable and not hidden or obscured; and

(C) An enrollee is not hindered or obstructed from exercising the rights granted to the enrollee under the enrollee's health benefit plan.

(c)(1) A healthcare payor shall not prohibit, restrict, or impede an enrollee's or an enrollee's authorized representative's ability to:

(A) Discuss the enrollee's health benefit plan, including prescription drug benefits, with the healthcare payor or its authorized representatives;

(B) Obtain necessary exceptions, approvals, authorizations, or related information to access the enrollee's benefits; or

(C) Appeal decisions regarding the enrollee's benefits coverage decisions as provided under the terms of the enrollee's health benefit plan.

(2) The healthcare payor shall ensure that an enrollee has reasonable access to the discussions, approvals, and appeals processes regardless of the pharmacy benefits manager, affiliate, or third-party administrator selected to administer prescription benefits.

(3) It is an unfair and deceptive trade practice for a healthcare payor to delegate responsibilities in a manner that obstructs, hinders, or prevents an enrollee from exercising the enrollee's rights under his or her health benefit plan.

(d)(1) A pharmacy benefits manager and pharmacy benefits manager affiliate shall adhere to all applicable federal and state privacy laws when

communicating with an enrollee.

(2) A pharmacy benefits manager and pharmacy benefits manager affiliate shall not use enrollee information for marketing purposes without the written consent of the enrollee.

(e) A pharmacy benefits manager and pharmacy benefits manager affiliate shall comply with the timely processing of complaints and appeals as established by rule of the commissioner.

(f)(1) The commissioner may promulgate rules necessary to implement, administer, and enforce this section.

(2) Rules that the commissioner may adopt under this section include without limitation rules relating to implementing a penalty structure for a healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate that fails to comply with this section that is based on the number of Arkansas residents serviced by the healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate.

(g)(1) A violation of this subchapter is an unfair and deceptive act or practice as defined by the Deceptive Trade Practices Act, § 4-88-101 et seq.

(2) All remedies, penalties, and authority granted to the Attorney General under the Deceptive Trade Practices Act, § 4-88-101 et seq., shall be available to the Attorney General for the enforcement of this subchapter.

23-92-513. Prohibition of ghost networks.

(a)(1) A pharmacy benefits manager shall not create, utilize, or maintain *a ghost network within this state.*

(2) For purposes of this section, a network shall not be considered a ghost network if the network includes at least one (1) mail-order pharmacy option and one (1) in-person pharmacy option that is physically located in this state if both the mail-order pharmacy option and the in-person pharmacy option are:

(A) Accepting new patients; and

(B) Otherwise available to an enrollee in this state.

(b)(1) A healthcare payor or pharmacy benefits manager shall not create, utilize, or maintain a carve-out network within this state by:

(A) Limiting enrollee access to specific pharmacies or pharmacists for self-administered prescription drugs when an enrollee is directed to use a healthcare payor affiliate, pharmacy benefits manager affiliate, or other limited option while the pharmacy benefits manager network appears to offer a full range of pharmacist services;

(B) Failing to provide adequate access to pharmacy services for all covered self-administered prescription drugs, including through a licensed pharmacy physically located within this state; or

(C) Representing that a broad network of pharmacies or pharmacists is available if, in practice, access to certain self-administered prescription drugs is restricted to a carve-out network that lacks sufficient *in-state providers accessible to an enrollee.*

(2) For purposes of this section, a network shall not be considered a carve-out network if the network includes at least one (1) mail-order pharmacy option and one (1) in-person pharmacy option that is physically located in this state if both the mail-order pharmacy option and the in-person pharmacy option are:

(A) Accepting new patients; and

(B) Otherwise available to an enrollee in this state.

(c) A healthcare payor or pharmacy benefits manager shall ensure that its pharmacy benefits manager network of participating pharmacists and pharmacies:

(1) Accurately reflects the availability of pharmacists and pharmacies actively accepting new patients;

(2) Provides an enrollee with reasonable access to pharmacist services within this state, including options for in-person consultations and medication pickup from a licensed pharmacist or pharmacy in this state;

(3) Is not solely serviced by a mail-order pharmacy; and

(4) Is not solely serviced by a pharmacy benefits manager affiliate or healthcare payor affiliate.

(d) A healthcare payor or pharmacy benefits manager shall:

(1) Regularly verify and update its pharmacy benefits manager network directory to reflect the current availability of participating pharmacists and pharmacies;

(2) Remove a pharmacist or pharmacy from its pharmacy benefits manager network directory if that pharmacist or pharmacy is:

(A) Not accepting new patients;

(B) No longer in practice; or

(C) Otherwise unavailable to provide services; and

(3) Provide accurate and accessible information to an enrollee regarding participating pharmacists and pharmacies within the pharmacy benefits manager network in a publicly accessible manner on its website.

(e)(1) The Insurance Commissioner may promulgate rules necessary to implement, administer, and enforce this section.

(2) Rules that the commissioner may adopt under this section include without limitation rules relating to:

(A) Requiring a healthcare payor and pharmacy benefits manager to submit periodic reports on pharmacy benefits manager network adequacy and accessibility;

(B) Investigating a complaint regarding a ghost network and taking appropriate enforcement action; and

(C) Implementing a penalty structure for a healthcare payor or pharmacy benefits manager that fails to comply with this section that:

(i) Is based on the number of Arkansas residents serviced by the healthcare payor or pharmacy benefits manager; and

(ii) Does not exceed one hundred thousand dollars ($100,000) per violation.

23-92-514. Patient accommodation and nonrestriction clause.

(a) A healthcare payor or pharmacy benefits manager shall not enforce the use of a particular healthcare payor affiliate or pharmacy benefits *manager affiliate without considering the enrollee's individual limitations, including* without limitation:

(1) Medical limitations, including chronic illnesses, temporary or permanent disabilities, or conditions requiring specialized care or that impair cognitive or motor functions;

(2) Complex therapies, when the self-administered prescription drug is one (1) of multiple pharmaceuticals provided to an enrollee receiving treatment and mailing the individual pharmaceutical has the potential to interfere with the appropriate and timely administration requirements;

(3) Physical limitations, including mobility impairments or

inability to retrieve mail or other deliveries without assistance or risk for physical harm to self while retrieving mail or other deliveries;

(4) Socioeconomic limitations, including financial hardships, lack of reliable transportation, lack of a caregiver, or other socioeconomic barriers that may prohibit an enrollee from being present during delivery or prohibit an enrollee from accessing the delivery location;

(5) Housing limitations, including homelessness, medical confinement, incarceration, unstable housing situations, residences without secure mail delivery options, or residences with shared mail facilities;

(6) Chain of custody, when a dispensing pharmacy cannot guarantee that the recipient of the self-administered prescription drug will be present according to federal and state laws and regulations;

(7) Prescribing provider order contradictions, when the dispensing pharmacy is unable to guarantee that the prescribing provider's orders will be followed if the self-administered prescription drug is delivered, including situations in which the prescribing provider requires administration under direct supervision of a medical professional for a customarily self-administered prescription drug;

(8) Medication storage and efficacy concerns, when the dispensing pharmacy is unable to guarantee that the enrollee will receive the self-administered prescription drug in a timely fashion that does not interfere with the environmental storage and transportation requirements denoted by the manufacturer of the pharmaceutical; and

(9) Other relevant limitations, including mental health conditions, cognitive or behavioral impairments, or any other factors that impede or put at risk an enrollee's ability to receive, access, or administer his or her self-administered prescription drugs.

(b)(1) An enrollee may obtain medications from a pharmacy of his or her choice when healthcare payor affiliate services or pharmacy benefits manager affiliate services are not suitable due to the limitations specified under subsection (a) of this section.

(2) A healthcare payor or pharmacy benefits manager shall facilitate access to in-person pharmacy services without imposing additional costs or penalties on the enrollee.

(c) A healthcare payor or pharmacy benefits manager shall not mandate the use of a healthcare payor affiliate or pharmacy benefits manager

affiliate in cases in which use of a pharmacy benefits manager affiliate or healthcare payor affiliate would adversely affect the enrollee's ability to receive or administer his or her self-administered prescription drug safely and effectively, considering the patient's individual circumstances under subsection (a) of this section as determined by the enrollee's healthcare provider.

(d) A healthcare payor and pharmacy benefits manager shall maintain compliance in all dispensing practices with:

(1) The prescribing healthcare provider's orders; and

(2) All applicable federal and state laws regarding medication dispensing and chain of custody.

(e) A healthcare payor or pharmacy benefits manager shall not retaliate against an enrollee or healthcare provider for exercising his or her rights under this section by:

(1) Increasing costs;

(2) Denying services; or

(3) Reporting to external agencies.

(f) A dispute arising from the enforcement of this section shall be subject to a fair and prompt resolution process as defined by rule by the Insurance Commissioner.

(g)(1) The commissioner may promulgate rules necessary to implement, administer, and enforce this section.

(2) Rules that the commissioner may adopt under this section include without limitation rules relating to:

(A) Resolving disputes that arise from enforcement of this section through a fair and prompt resolution process; and

(B) Implementing a penalty structure for a healthcare payor or pharmacy benefits manager that fails to comply with this section that:

(i) Is based on the number of Arkansas residents serviced by the healthcare payor or pharmacy benefits manager; and

(ii) Does not exceed one hundred thousand dollars ($100,000) per violation.

23-92-515. Self-administered prescription drug — Definition controlling.

(a) The definition of "self-administered prescription drug" under this subchapter is controlling, and that defined term shall not be altered, modified, reclassified, relabeled, or reinterpreted by a health benefit plan, healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate.

(b) A classification, labeling, or interpretation by a health benefit plan, healthcare payor, healthcare payor affiliate, pharmacy benefits manager, or pharmacy benefits manager affiliate does not override or supersede the definition of "self-administered prescription drug" under this subchapter.

23-92-516. Violation of Deceptive Trade Practices Act —*Enforcement — Exclusions.*

(a) A prohibition of an activity under this subchapter is applicable to a person or entity that:

(1) Performs the prohibited activity;

(2) Causes another person or entity to perform the prohibited activity;

(3) Solicits, advises, encourages, or coerces another person or entity to perform the prohibited activity;

(4) Aids or attempts to aid another person or entity in performing a prohibited activity; or

(5) Indirectly performs the prohibited activity.

(b)(1) This subchapter does not require a self-funded health benefit plan to:

(A) Alter existing covered benefits of the self-funded health benefit plan; or

(B) Modify underlying plan terms of the self-funded health benefit plan.

(2) However, to the extent not preempted by federal law, this section applies to the administration and business practices of pharmacy benefits within the state, including without limitation the conduct of pharmacy benefits managers and pharmacy benefits manager affiliates.

(c)(1) If a pharmacy benefits manager imposes or represents any requirement or limitation as health-benefit-plan-imposed, the actual terms of the underlying health benefit plan document shall control.

(2) The plan sponsor shall retain the authority to interpret and apply the health benefit plan sponsor's own health benefit plan's terms to the extent permitted by applicable federal and state law.

(d) If it is determined by the Insurance Commissioner that a pharmacy benefits manager or pharmacy benefits manager affiliate is operating outside the terms of the underlying health benefit plan, all dispute, enforcement, and penalties under this subchapter shall apply and may be enforced by the commissioner.

SECTION 5. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that an enrollee's access to prescription medications is of immediate concern; that undue restrictions on pharmacies and pharmacists hinder patient care; and that this act is immediately necessary to protect an enrollee's rights and ensure timely access to medications. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/C. Penzo

APPROVED: 4/10/25