

**SENATE SUBSTITUTE FOR  
HOUSE BILL NO. 4348**

A bill to license and regulate pharmacy benefit managers; to require reporting of certain data; to provide for the powers and duties of certain state governmental officers and entities; to provide remedies; to require the promulgation of rules; and to require and to provide sanctions for violation of this act.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

1           Sec. 1. This act may be cited as the "pharmacy benefit manager  
2 licensure and regulation act".

3           Sec. 5. As used in this act:

4           (a) "Affiliated pharmacy" means, except as otherwise provided  
5 in this subdivision, a network pharmacy that directly, or  
6 indirectly through 1 or more intermediaries, controls, is  
7 controlled by, or is under common control with, a pharmacy benefit

1 manager. As used in section 19, affiliated pharmacy does not  
2 include a pharmacy that controls, is controlled by, or is under  
3 common control with, a hospital as that term is defined in section  
4 20106 of the public health code, 1978 PA 368, MCL 333.20106.

5 (b) "Aggregate retained rebate percentage" means the  
6 percentage of all rebates received by a pharmacy benefit manager  
7 from all manufacturers, that is not passed on to the pharmacy  
8 benefit manager's Michigan health plan or insurer clients.  
9 Aggregate retained rebate percentage must be expressed without  
10 disclosing any identifying information regarding any health plan,  
11 drug, or therapeutic class, and must be calculated as follows:

12 (i) Calculate the aggregate dollar amount of all rebates that  
13 the pharmacy benefit manager received during the prior calendar  
14 year from all manufacturers and did not pass through to the  
15 pharmacy benefit manager's Michigan health plan or insurer clients.

16 (ii) Divide the result of the calculation under subparagraph (i)  
17 by the aggregate dollar amount of all rebates that the pharmacy  
18 benefit manager received during the prior calendar year from all  
19 manufacturers.

20 (c) "Carrier" means that term as defined in section 3701 of  
21 the insurance code of 1956, 1956 PA 218, MCL 500.3701.

22 (d) "Claim" means a request for payment for administering,  
23 filling, or refilling a drug or for providing a pharmacy service or  
24 a medical supply or device to an enrollee.

25 (e) "Claims processing services" means the administrative  
26 services performed in connection with the processing and  
27 adjudicating of claims relating to pharmacist services that include  
28 any of the following:

29 (i) Receiving payments for pharmacist services.

1           (ii) Making payments to pharmacists or pharmacies for  
2 pharmacist services.

3           (iii) Receiving and making the payments described in  
4 subparagraphs (i) and (ii).

5           (f) "Covered person" means a person that is insured in a  
6 health plan.

7           (g) "Department" means the department of insurance and  
8 financial services.

9           (h) "Director" means the director of the department.

10          (i) "Enrollee" means that term as defined in section 116 of  
11 the insurance code of 1956, 1956 PA 218, MCL 500.116.

12          (j) "Financially viable" means that 1 of the following  
13 conditions is met:

14           (i) The pharmacy benefit manager has received an unqualified  
15 opinion from an independent public accountant showing it is solvent  
16 based on generally accepted accounting principles.

17           (ii) If no independent public accountant opinion is obtained,  
18 the pharmacy benefit manager remains solvent after adjusting for  
19 goodwill and intangible assets.

20          (k) "Health plan" means a qualified health plan as that term  
21 is defined in section 1261 of the insurance code of 1956, 1956 PA  
22 218, MCL 500.1261.

23          (l) "Individual responsible for the conduct of affairs of the  
24 pharmacy benefit manager" means any of the following:

25           (i) A member of the board of directors, board of trustees,  
26 executive committee, or other governing board or committee.

27           (ii) A principal officer for a corporation or a partner or  
28 member for a partnership, association, or limited liability  
29 company.

1           (iii) A shareholder or member holding directly or indirectly 10%  
2 or more of the voting stock, voting securities, or voting interest  
3 of the pharmacy benefit manager.

4           (iv) Any person who exercises control over the affairs of the  
5 pharmacy benefit manager.

6           (m) "Insurer" means an insurer that delivers, issues for  
7 delivery, or renews in this state a health plan that provides drug  
8 coverage under the insurance code of 1956, 1956 PA 218, MCL 500.100  
9 to 500.8302.

10           Sec. 7. As used in this act:

11           (a) "Mail-order pharmacy" means a pharmacy whose primary  
12 business is to receive prescriptions by mail, fax, or through  
13 electronic submissions, dispense drugs to enrollees through the use  
14 of the United States Postal Service or other common carrier  
15 services, and provide consultation with patients electronically  
16 rather than face-to-face.

17           (b) "Manufacturer" means that term as defined in section 17706  
18 of the public health code, 1978 PA 368, MCL 333.17706.

19           (c) "Maximum allowable cost" means the maximum amount that a  
20 pharmacy benefit manager will reimburse a network pharmacy for the  
21 ingredient cost for a generic drug.

22           (d) "Maximum allowable cost list" means a listing of drugs  
23 used by a pharmacy benefit manager, directly or indirectly, to set  
24 the maximum allowable cost.

25           (e) "Multiple source drug" means a therapeutically equivalent  
26 drug that is available from 1 or more of the following:

27           (i) At least 1 brand-named manufacturer and at least 1 generic  
28 manufacturer.

29           (ii) Two or more generic manufacturers.

1 (f) "Network pharmacy" means a retail pharmacy or other  
2 pharmacy that contracts directly or through a pharmacy services  
3 administration organization with a pharmacy benefit manager.

4 (g) "Nonaffiliated pharmacy" means a network pharmacy that  
5 directly, or indirectly through 1 or more intermediaries, does not  
6 control, is not controlled by, and is not under common control  
7 with, a pharmacy benefit manager.

8 (h) "Person" means an individual, partnership, corporation,  
9 association, governmental entity, or any other legal entity.

10 (i) "Pharmacist" means that term as defined in section 17707  
11 of the public health code, 1978 PA 368, MCL 333.17707.

12 (j) "Pharmacist services" means products, goods, and services,  
13 or any combination of products, goods, and services, provided as a  
14 part of the practice of pharmacy.

15 (k) "Pharmacy" means that term as defined in section 17707 of  
16 the public health code, 1978 PA 368, MCL 333.17707.

17 (l) Except as otherwise provided in subdivision (m), "pharmacy  
18 benefit manager" means an entity that contracts with a pharmacy or  
19 a pharmacy services administration organization on behalf of a  
20 health plan or carrier to provide pharmacy health services to  
21 individuals covered by the health plan or carrier or administration  
22 that includes, but is not limited to, any of the following:

23 (i) Contracting directly or indirectly with pharmacies to  
24 provide drugs to enrollees or other covered persons.

25 (ii) Administering a drug benefit.

26 (iii) Processing or paying pharmacy claims.

27 (iv) Creating or updating drug formularies.

28 (v) Making or assisting in making prior authorization  
29 determinations on drugs.

1 (vi) Administering rebates on drugs.

2 (vii) Establishing a pharmacy network.

3 (m) "Pharmacy benefit manager" does not include the department  
4 of health and human services, a carrier, or an insurer.

5 (n) "Pharmacy benefit manager network" means a network of  
6 pharmacists or pharmacies that are offered by an agreement or  
7 contract to provide pharmacist services.

8 (o) "Pharmacy services administration organization" means an  
9 entity that provides contracting and other administrative services  
10 relating to prescription drug benefits to pharmacies.

11 (p) "Plan sponsor" means that term as defined in section 7705  
12 of the insurance code of 1956, 1956 PA 218, MCL 500.7705.

13 (q) "Practice of pharmacy" means that term as defined in  
14 section 17707 of the public health code, 1978 PA 368, MCL  
15 333.17707.

16 (r) "Preferred pharmacy" means a network pharmacy that offers  
17 covered drugs to health plan members at lower out-of-pocket costs  
18 than what the member would pay at a nonpreferred network pharmacy.

19 Sec. 9. As used in this act:

20 (a) "Rebate" means a formulary discount or remuneration  
21 attributable to the use of prescription drugs that is paid by a  
22 manufacturer or third party, directly or indirectly, to a pharmacy  
23 benefit manager after a claim has been adjudicated at a pharmacy.  
24 Rebate does not include a fee, including, but not limited to, a  
25 bona fide service fee or administrative fee, that is not a  
26 formulary discount or remuneration described in this subdivision.

27 (b) "Retail pharmacy" means a pharmacy that dispenses  
28 prescription drugs to the public at retail primarily to individuals  
29 that reside in close proximity to the pharmacy, typically by face-

1 to-face interaction with the individual or the individual's  
2 caregiver.

3 (c) "Rule" means a rule promulgated under the administrative  
4 procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

5 (d) "Specialty drug" means a drug that provides treatment for  
6 serious, chronic, or life-threatening diseases that is covered  
7 under a patient's health plan or by a patient's carrier to which  
8 any of the following apply:

9 (i) The cost of the drug exceeds the drug cost threshold  
10 established by the Centers for Medicare and Medicaid Services under  
11 the Medicare Part D program.

12 (ii) The drug requires special administration, including, but  
13 not limited to, injection, infusion, or inhalation.

14 (iii) The drug requires unique storage, handling, or  
15 distribution.

16 (iv) The drug requires special oversight, intensive monitoring,  
17 complex education and support, or care coordination with a person  
18 licensed under article 15 of the public health code, 1978 PA 368,  
19 MCL 333.16101 to 333.18838.

20 (e) "Specialty pharmacy" means a pharmacy that dispenses  
21 specialty drugs to patients and that is nationally accredited by an  
22 independent third party.

23 (f) "Spread pricing" means the model of prescription drug  
24 pricing in which a pharmacy benefit manager charges a health plan a  
25 contracted price for prescription drugs, and the contracted price  
26 for the prescription drugs differs from the amount the pharmacy  
27 benefit manager directly or indirectly pays the pharmacist or  
28 pharmacy for pharmacist services.

29 (g) Except as otherwise provided in subdivision (h), "third

1 party" means a person that is not an enrollee or insured in a  
2 health plan.

3 (h) "Third party" does not include a pharmacy benefit manager.

4 (i) "Wholesale distributor" means that term as defined in  
5 section 17709 of the public health code, 1978 PA 368, MCL  
6 333.17709.

7 Sec. 11. (1) A pharmacy benefit manager that provides services  
8 to residents of this state shall apply for, obtain, and maintain a  
9 license to operate as a pharmacy benefit manager from the director.  
10 A license under this act is renewable biennially and is  
11 nontransferable.

12 (2) Subject to this section, an applicant for a license to  
13 operate in this state as a pharmacy benefit manager shall submit to  
14 the director both of the following:

15 (a) An application in a form and manner prescribed by the  
16 director that is signed by an officer or individual responsible for  
17 the conduct or affairs of the pharmacy benefit manager verifying  
18 that the contents of the application form and any attachments are  
19 correct. The application form must include, but is not limited to,  
20 all of the following:

21 (i) A copy of all basic organizational documents of the  
22 pharmacy benefit manager, including, but not limited to, the  
23 articles of incorporation, bylaws, articles of association, trade  
24 name certificate, and other similar documents and all amendments to  
25 those documents.

26 (ii) A copy of a power of attorney duly executed by the  
27 pharmacy benefit manager if not domiciled in this state, appointing  
28 the director, the director's successors in office, and the  
29 director's authorized deputies as the attorney of the pharmacy



1 benefit manager in and for this state, on whom process in any legal  
2 action or proceeding against the pharmacy benefit manager on a  
3 cause of action arising in this state may be served.

4 (iii) The names, addresses, official positions, and professional  
5 qualifications of each individual who is responsible for the  
6 conduct of the affairs of the pharmacy benefit manager.

7 (iv) A copy of recent financial statements showing the pharmacy  
8 benefit manager's assets, liabilities, and sources of financial  
9 support that the director determines are sufficient to show that  
10 the pharmacy benefit manager is financially viable. If the pharmacy  
11 benefit manager's financial statements are prepared by an  
12 independent public accountant, a copy of the most recent regular  
13 financial statement satisfies the requirement to show financial  
14 viability unless the director determines that additional or more  
15 recent financial information is required for the proper  
16 administration of this act.

17 (v) A description of the pharmacy benefit manager, its  
18 services, facilities, and personnel.

19 (vi) A document in which the pharmacy benefit manager confirms  
20 that its business practices and each ongoing contract comply with  
21 this act.

22 (b) An application fee as provided by the director by rule.

23 (3) Within 30 days after any significant modification of  
24 information submitted with the application for a license under  
25 subsection (2), a pharmacy benefit manager shall file a notice of  
26 the modification with the director.

27 (4) The director may refuse to issue a license under this act  
28 if the director determines that the pharmacy benefit manager is not  
29 financially viable or that the pharmacy benefit manager or any

1 individual responsible for the conduct of the affairs of the  
2 pharmacy benefit manager has had a pharmacy benefit manager  
3 certificate of authority or license denied or revoked for cause in  
4 another state.

5 (5) The director may deny, suspend, or revoke the license of a  
6 pharmacy benefit manager, or may issue a cease and desist order if  
7 the pharmacy benefit manager is not licensed, if the director  
8 finds, after notice and opportunity for hearing, any of the  
9 following:

10 (a) That the pharmacy benefit manager has violated any lawful  
11 rule or order of the director or any law of this state applicable  
12 to the pharmacy benefit manager.

13 (b) That the pharmacy benefit manager has refused to be  
14 examined or to produce its accounts, records, and files for  
15 examination, or if any individual responsible for the conduct of  
16 affairs of the pharmacy benefit manager has refused to give  
17 information with respect to its affairs or has refused to perform  
18 any other legal obligation as to an examination when required by  
19 the director.

20 (c) That the pharmacy benefit manager has, without just cause,  
21 refused to pay proper claims or perform services arising under its  
22 contracts or has, without just cause, caused covered persons or  
23 enrollees to accept less than the amount due them or caused covered  
24 persons or enrollees to employ attorneys or bring suit against the  
25 pharmacy benefit manager or a payor that it represents to secure  
26 full payment or settlement of the claims.

27 (d) That the pharmacy benefit manager is required under this  
28 act to have a license and fails at any time to meet any  
29 qualification for which issuance of a license could have been

1 refused had the failure then existed and been known to the  
2 director, unless the director issued a license with knowledge of  
3 the ground for disqualification and had the authority to waive it.

4 (e) That any individual responsible for the conduct of affairs  
5 of the pharmacy benefit manager has been convicted of, or has  
6 entered a plea of guilty or nolo contendere to, a felony without  
7 regard to whether adjudication was withheld.

8 (f) That the pharmacy benefit manager's license has been  
9 suspended or revoked in another state.

10 (g) That a pharmacy benefit manager has failed to file a  
11 timely transparency report required under section 23.

12 (6) If a pharmacy benefit manager's license is suspended or  
13 restricted, the director may permit the operation of the pharmacy  
14 benefit manager for a limited time not to exceed 60 days. However,  
15 the director may permit a pharmacy benefit manager whose license  
16 has been suspended or restricted to operate for a period that  
17 exceeds 60 days if the director determines that the continued  
18 operation of the pharmacy benefit manager is in the beneficial  
19 interests of covered persons by ensuring minimal disruptions to the  
20 continuity of care. A pharmacy benefit manager whose license has  
21 been suspended or restricted is subject to a fine each month, as  
22 determined by the director, not to exceed \$20,000.00 per month,  
23 until the pharmacy benefit manager has remedied the violation  
24 leading to the suspension or restriction.

25 (7) The director may revoke the license of a pharmacy benefit  
26 manager if the pharmacy benefit manager has been operating under a  
27 suspended license for a period of more than 60 days.

28 (8) For purposes of this section, a pharmacy benefit manager  
29 has the same rights to notice and hearings that are provided to an

1 insurer under the insurance code of 1956, 1956 PA 218, MCL 500.100  
2 to 500.8302.

3 (9) The director may investigate officers, directors, and  
4 owners of a pharmacy benefit manager in the same manner as  
5 officers, directors, and owners of a business entity licensed under  
6 the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

7 (10) To renew a license as a pharmacy benefit manager, an  
8 applicant shall submit to the director all of the following:

9 (a) A renewal application in a form and manner prescribed by  
10 the director that is signed by an officer or authorized  
11 representative of the pharmacy benefit manager verifying that the  
12 contents of the renewal form are correct.

13 (b) A renewal schedule and fee as provided by the director by  
14 rule.

15 (c) A retail pharmacy benefit manager network adequacy report  
16 required under section 17.

17 (11) A pharmacy benefit manager license expires if a complete  
18 renewal filing and fee is not received by the due date as  
19 established in rule by the director.

20 Sec. 13. (1) The director shall promulgate rules that are  
21 necessary or required to implement this act.

22 (2) The rules promulgated by the director under subsection (1)  
23 must include fines, suspension of licensure, restriction of  
24 licensure, and revocation of licensure in accordance with this act.

25 Sec. 15. (1) A pharmacy benefit manager shall exercise good  
26 faith and fair dealing in the performance of its contractual duties  
27 to a health plan or network pharmacy. A provision in a contract  
28 that attempts to waive or limit the obligation under this  
29 subsection is void.

1 (2) A pharmacy benefit manager shall notify a health plan in  
2 writing of any activity, policy, or practice of the pharmacy  
3 benefit manager that directly or indirectly presents a conflict of  
4 interest with the duties imposed in this section.

5 (3) A pharmacy benefit manager shall not directly or  
6 indirectly, including indirectly through a pharmacy services  
7 administrative organization, charge or hold a pharmacist or  
8 pharmacy responsible for a fee related to a claim or reduce the  
9 amount of the claim at the time of the claim's adjudication or  
10 after the claim is adjudicated.

11 (4) This section does not apply to an audit under section 28  
12 of a pharmacy's records if either of the following applies:

13 (a) The review of claims data or statements indicates fraud,  
14 abuse, other intentional misconduct, or waste.

15 (b) An investigative method, other than a review described in  
16 subdivision (a), indicates that the pharmacy is or has committed  
17 fraud or other intentional misrepresentation.

18 (5) Except for the recoupment of money under an audit  
19 conducted under section 28, a pharmacy benefit manager shall not  
20 recoup money from a pharmacist or pharmacy in connection with a  
21 claim for which the pharmacist or pharmacy has been paid unless the  
22 recoupment is required by law.

23 Sec. 17. (1) A pharmacy benefit manager shall provide a  
24 reasonably adequate and accessible retail pharmacy benefit manager  
25 network for the provision of drugs for a health plan that must  
26 provide for convenient enrollee access to pharmacies within a  
27 reasonable distance from an enrollee's residence, as determined by  
28 the director. For purposes of this subsection, retail pharmacy  
29 benefit manager network does not include a mail-order pharmacy or

1 specialty pharmacy.

2 (2) A pharmacy benefit manager shall submit to the director a  
3 retail pharmacy benefit manager network adequacy report that  
4 describes the retail pharmacy benefit manager network and the  
5 retail pharmacy benefit manager network's accessibility in this  
6 state. The report must categorize the network by urban, suburban,  
7 and rural geography and must include the applicable zip codes.

8 (3) A pharmacy benefit manager may apply for a waiver from the  
9 director if the pharmacy benefit manager is unable to meet the  
10 network adequacy requirements under subsection (1).

11 (4) To apply for a waiver under subsection (3), a pharmacy  
12 benefit manager must submit to the director an application in a  
13 form and manner prescribed by the director that does both of the  
14 following:

15 (a) Demonstrates with specific data why the pharmacy benefit  
16 manager is not able to meet the network adequacy requirements under  
17 subsection (1).

18 (b) Includes information as to the steps that the pharmacy  
19 benefit manager has taken and will take to address network  
20 adequacy.

21 (5) If the director grants a waiver under subsection (3), the  
22 waiver expires after 2 years. If a pharmacy benefit manager seeks a  
23 renewal of the waiver, the director must consider the steps that  
24 the pharmacy benefit manager has taken over the 2-year period  
25 covered by the waiver to address network adequacy.

26 (6) A pharmacy benefit manager shall not conduct spread  
27 pricing in this state. However, if a contract between a plan  
28 sponsor and a health plan is in effect on the effective date of  
29 this act and the contract conflicts with this subsection, for that

1 contract, this subsection applies to the pharmacy benefit manager  
2 beginning on the date the contract is amended, extended, or  
3 renewed, or before January 1, 2028, whichever is earlier.

4 (7) A pharmacy benefit manager shall not charge a pharmacy or  
5 pharmacist a fee to process a claim electronically.

6 Sec. 19. (1) A pharmacy benefit manager shall not discriminate  
7 against a nonaffiliated pharmacy that is a retail pharmacy.

8 (2) A pharmacy benefit manager shall not impose limits,  
9 including quantity limits or refill frequency limits, on an  
10 enrollee's access to retail prescription drugs that differ based  
11 solely on whether the pharmacy benefit manager has an ownership  
12 interest in a pharmacy or the pharmacy has an ownership interest in  
13 the pharmacy benefit manager.

14 (3) A pharmacy benefit manager or carrier shall not prohibit a  
15 340B Program entity or a pharmacy that has a license in good  
16 standing in this state under contract with a 340B Program entity  
17 from participating in the pharmacy benefit manager's or carrier's  
18 provider network solely because it is a 340B Program entity or a  
19 pharmacy under contract with a 340B Program entity. A pharmacy  
20 benefit manager or carrier shall not reimburse a 340B Program  
21 entity or a pharmacy under contract with a 340B Program entity  
22 differently than other similarly situated pharmacies. As used in  
23 this subsection, "340B Program entity" means an entity authorized  
24 to participate in the federal 340B Program under section 340B of  
25 the public health service act, 42 USC 256b.

26 (4) Unless required by applicable law or as required under  
27 Medicaid by the department of health and human services, a carrier,  
28 health plan, or pharmacy benefit manager shall not require an  
29 enrollee or covered person to use only an affiliated pharmacy that

1 is a retail pharmacy.

2 (5) A carrier, health plan, pharmacy, or pharmacy benefit  
3 manager shall not financially induce an enrollee or covered person  
4 or prescriber to transfer an enrollee or covered person  
5 prescription to a retail affiliated pharmacy. As used in this  
6 subsection, "prescriber" means that term as defined in section  
7 17708 of the public health code, 1978 PA 368, MCL 333.17708.

8 (6) A carrier, health plan, or pharmacy benefit manager shall  
9 not require a retail nonaffiliated pharmacy to transfer an  
10 enrollee's or covered person's retail prescription to a retail  
11 affiliated pharmacy without the prior consent of the enrollee or  
12 patient.

13 (7) A pharmacy benefit manager shall not unreasonably restrict  
14 an enrollee or covered person from using a particular network  
15 retail pharmacy for the purposes of receiving pharmacist services  
16 covered by the enrollee's or covered person's health plan.

17 (8) Before a prescription is dispensed, an affiliated pharmacy  
18 shall disclose to an enrollee or covered person that the affiliated  
19 pharmacy is an affiliated pharmacy and that the enrollee or covered  
20 person is not obligated to use the affiliated pharmacy.

21 (9) This section does not prohibit a health plan or carrier  
22 from doing any of the following:

23 (a) Offering customized pharmacy network options to its  
24 clients.

25 (b) Offering mail order of specialty treatments.

26 (c) Establishing a tiered network.

27 Sec. 21. (1) A contract between a pharmacy benefit manager and  
28 a pharmacist or a pharmacy that provides drug coverage for health  
29 plans must not prohibit or restrict a pharmacy or pharmacist from,



1 or penalize a pharmacy or pharmacist for, disclosing to a covered  
2 person or enrollee health care information that the pharmacy or  
3 pharmacist considers appropriate regarding any of the following:

4 (a) The nature of the treatment or the risks or the  
5 alternatives to the treatment.

6 (b) The availability of alternate therapies, consultations, or  
7 tests.

8 (2) A pharmacy benefit manager shall not prohibit a pharmacy  
9 or pharmacist from discussing information regarding the total cost  
10 for pharmacist services for a drug or from selling a more  
11 affordable alternative to the covered person or enrollee if a more  
12 affordable alternative is available.

13 (3) A carrier, health plan, or pharmacy benefit manager shall  
14 not require a covered person or enrollee to make a payment for a  
15 prescription drug at the point of sale in an amount greater than  
16 the lesser of the following:

17 (a) The applicable copayment, coinsurance, and deductible.

18 (b) The final reimbursement amount to the network pharmacy.

19 Sec. 23. (1) Unless otherwise required more frequently by the  
20 director, by April 1, 2025 and each April 1 after that date, except  
21 as otherwise provided in subsection (5), a pharmacy benefit manager  
22 shall file a transparency report with the director that contains  
23 the information required under subsection (2) from the preceding  
24 calendar year. The transparency report must not disclose any of the  
25 following information:

26 (a) The identity of a specific health plan or enrollee.

27 (b) The price the pharmacy benefit manager charged a pharmacy  
28 for a specific drug or class of prescription drugs.

29 (c) The amount of any rebate or fee provided to the pharmacy

1 benefit manager for a prescription drug or class of prescription  
2 drugs.

3 (2) The transparency report required under subsection (1) must  
4 include all of the following information:

5 (a) The aggregate wholesale acquisition costs from a  
6 manufacturer or wholesale distributor for each therapeutic category  
7 of drugs for the pharmacy benefit manager's Michigan plan sponsors,  
8 net of rebates and other fees and payments, direct or indirect,  
9 from all sources.

10 (b) The aggregate amount of rebates that the pharmacy benefit  
11 manager received from all manufacturers for the pharmacy benefit  
12 manager's Michigan plan sponsors. The aggregate amount of rebates  
13 must include any utilization discounts the pharmacy benefit manager  
14 receives from a manufacturer or wholesale distributor.

15 (c) The aggregate amount of all fees that the pharmacy benefit  
16 manager received.

17 (d) The aggregate amount of rebates that the pharmacy benefit  
18 manager received from all manufacturers that were not passed  
19 through to Michigan health plans or insurers.

20 (e) The aggregate amount of fees that the pharmacy benefit  
21 manager received from all manufacturers that were not passed  
22 through to Michigan health plans, carriers, or insurers.

23 (f) The aggregate retained rebate percentage from business  
24 conducted in this state.

25 (g) All of the following information attributable to patient  
26 use of prescription drugs covered by Michigan health plans:

27 (i) The aggregate amount of rebates and fees that the pharmacy  
28 benefit manager received from manufacturers.

29 (ii) The aggregate amount of rebates and fees that the pharmacy

1 benefit manager received from manufacturers that were either of the  
2 following:

3 (A) Passed through to Michigan health plans or enrollees at  
4 the point of sale of a prescription drug.

5 (B) Retained by the pharmacy benefit manager.

6 (3) Except to the extent to prepare the report under  
7 subsection (4), all information submitted to the director in a  
8 transparency report under this section is exempt from disclosure  
9 under section 13 of the freedom of information act, 1976 PA 442,  
10 MCL 15.243.

11 (4) By August 1, 2025 and each August 1 after that date, the  
12 director shall prepare a report based on the information received  
13 by the director under this act and submit the report to the  
14 legislature. The report must contain aggregate data and must not  
15 contain any information that the director determines would cause  
16 financial, competitive, or proprietary harm to a pharmacy benefit  
17 manager or carrier that the pharmacy benefit manager services. The  
18 department shall post the report required under this subsection on  
19 the department's website.

20 (5) This section does not apply to a contract between a  
21 pharmacy benefit manager and the department of health and human  
22 services under Medicaid. As used in this subsection, "Medicaid"  
23 means benefits under the program of medical assistance established  
24 under title XIX of the social security act, 42 USC 1396 to 1396w-6,  
25 and administered by the department of health and human services  
26 under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

27 Sec. 27. (1) For each drug that a pharmacy benefit manager  
28 establishes a maximum allowable cost, the pharmacy benefit manager  
29 shall do all of the following:

1 (a) Provide each pharmacy subject to a maximum allowable cost  
2 list with access to the maximum allowable cost list and the source  
3 used to determine the maximum allowable cost for each drug.

4 (b) Update its maximum allowable cost list at least once every  
5 7 calendar days.

6 (c) Provide a process for each pharmacy subject to the maximum  
7 allowable cost list to receive prompt notification of an update to  
8 the maximum allowable cost list.

9 (d) Establish and maintain a reasonable administrative appeals  
10 process to allow a pharmacy subject to the maximum allowable cost  
11 list or an agent of a pharmacy subject to the maximum allowable  
12 cost list to challenge the adjudication of a pharmacy's claim.

13 (e) Investigate and resolve an appeal under this subsection  
14 within 14 calendar days after the pharmacy benefit manager receives  
15 the appeal. An appeal under this subsection must be submitted to  
16 the pharmacy benefit manager not later than 45 calendar days after  
17 the date the pharmacy's claim for reimbursement has been  
18 adjudicated.

19 (f) Respond in writing to any appealing pharmacy or an  
20 appealing pharmacy's agent not later than 30 calendar days after  
21 receipt of an appeal if the pharmacy filed the appeal more than 10  
22 calendar days after the date the pharmacy's claim for reimbursement  
23 is adjudicated.

24 (g) If an appeal is denied, provide the appealing pharmacy or  
25 the appealing pharmacy's agent the national drug code number  
26 available for purchase in this state at or below the appealed  
27 maximum allowable cost.

28 (h) If an appeal is granted, permit the pharmacy to reverse  
29 and rebill the claim and all claims for the drug.

1           (2) Before a pharmacy benefit manager places or continues a  
2 drug on a maximum allowable cost list, all of the following  
3 conditions must be met:

4           (a) The drug is available for purchase by pharmacies in this  
5 state from wholesale distributors operating in this state.

6           (b) The drug is not obsolete.

7           (c) The drug is a multiple source drug.

8           (3) All benefits payable by a carrier, health plan, or  
9 pharmacy benefit manager to a pharmacy must be paid within 14 days  
10 after adjudication of a claim if claims are submitted  
11 electronically.

12           Sec. 28. (1) Subject to this section, a carrier or a pharmacy  
13 benefit manager may conduct an audit of a pharmacy in this state. A  
14 carrier or a pharmacy benefit manager that conducts an audit of a  
15 pharmacy in this state shall do all of the following:

16           (a) In its pharmacy contract, identify and describe in detail  
17 the audit procedures, including the appeals process described in  
18 subdivision (m). A carrier or pharmacy benefit manager shall update  
19 its pharmacy contract and communicate any changes to the pharmacy  
20 as changes to the contract occur.

21           (b) Provide written notice to the pharmacy at least 2 weeks  
22 before initiating and scheduling the initial on-site audit for each  
23 audit cycle. If the pharmacy on average dispenses more than 600  
24 prescriptions per week, a carrier or pharmacy benefit manager shall  
25 not initiate or schedule an audit under this subsection during the  
26 first 5 business days of a month without the express consent of the  
27 pharmacy. A carrier or pharmacy benefit manager shall be flexible  
28 in initiating and scheduling an audit at a time that is reasonably  
29 convenient to the pharmacy. Within 3 business days after the

1 pharmacy receives notice of an on-site audit, the pharmacy may  
2 reschedule the audit to a date not more than 10 business days after  
3 the date proposed by the carrier or pharmacy benefit manager.

4 (c) Utilize every effort to minimize inconvenience and  
5 disruption to pharmacy operations during the audit process. A  
6 carrier or pharmacy benefit manager that conducts an audit of a  
7 pharmacy in this state shall not interfere with the delivery of  
8 pharmacy services to a patient.

9 (d) Conduct an audit that involves clinical or professional  
10 judgment by or in consultation with a pharmacist.

11 (e) Subject to the requirements of article 15 of the public  
12 health code, 1978 PA 368, MCL 333.16101 to 333.18838, for the  
13 purpose of validating a pharmacy record with respect to orders,  
14 refills, or changes in prescriptions, allow the use of either of  
15 the following:

16 (i) Hospital or physician records that are written or that are  
17 transmitted or stored electronically, including file annotations,  
18 document images, and other supporting documentation that is date-  
19 and time-stamped.

20 (ii) A prescription that complies with the requirements of the  
21 Michigan board of pharmacy created under section 17721 of the  
22 public health code, 1978 PA 368, MCL 333.17721, and federal law.

23 (f) Base any finding of an overpayment or underpayment on the  
24 actual overpayment or underpayment of claims.

25 (g) Subject to subsection (4), base any recoupment or payment  
26 adjustments of claims on a calculation that is reasonable and  
27 proportional in relation to the type of error detected.

28 (h) If there is a finding of an underpayment, reimburse the  
29 pharmacy as soon as possible after detection.

1 (i) Conduct its audit of the pharmacy under the same standards  
2 and parameters that the carrier or pharmacy benefit manager uses  
3 when auditing other similarly situated pharmacies.

4 (j) Audit only claims submitted or adjudicated within the 1-  
5 year period preceding the initiation of the audit unless a longer  
6 period is permitted under federal or state law.

7 (k) Not receive payment and not compensate the auditor based  
8 on the amount recovered.

9 (l) Not include the dispensing fee amount in a finding of an  
10 overpayment unless any of the following apply:

11 (i) The prescription was not dispensed. As used in this  
12 subparagraph, "dispense" means that term as defined in section  
13 17703 of the public health code, 1978 PA 368, MCL 333.17703.

14 (ii) The prescription was not delivered to the patient. As used  
15 in this subparagraph, "deliver" means that term as defined in  
16 section 17703 of the public health code, 1978 PA 368, MCL  
17 333.17703.

18 (iii) The prescriber denied prior authorization.

19 (iv) The prescription was a medication error by the pharmacy.

20 (v) The overpayment is solely based on an extra dispensing  
21 fee.

22 (m) Establish a written appeals process that includes a  
23 process to appeal preliminary audit reports and final audit reports  
24 prepared under this section. A pharmacy has 30 days after the  
25 pharmacy receives the final audit report to file an appeal under  
26 this section.

27 (n) Not limit the days' supply for unit-of-use items, such as  
28 topicals, drops, vials, and inhalants, beyond manufacturer  
29 recommendations.

1 (o) If the only commercially available package size exceeds  
2 the maximum days' supply, not use the dispensing of the package  
3 size as the basis for recoupment.

4 (p) If the only commercially available package size exceeds  
5 the maximum days' supply and the claim was affirmatively  
6 adjudicated, not recoup the claim as an early refill.

7 (q) In conducting an audit of wholesale invoices, all of the  
8 following:

9 (i) Not audit the claims of another carrier or pharmacy benefit  
10 manager.

11 (ii) Within 5 business days after a request by the audited  
12 pharmacy, provide supporting documentation provided to the carrier  
13 or pharmacy benefit manager by the audited pharmacy's suppliers.

14 (iii) Not utilize any of the following as a basis for  
15 recoupment:

16 (A) The national drug code for the dispensed drug is in a  
17 quantity that is a subunit or multiple of the purchased drug as  
18 reflected on a supporting wholesale invoice.

19 (B) The correct quantity dispensed is reflected on the audited  
20 pharmacy claim.

21 (C) The drug dispensed by the pharmacy on an audited pharmacy  
22 claim is identical to the labeler and product code section under  
23 the national drug code. A difference in the package code under the  
24 national drug code is not subject to recoupment.

25 (iv) Accept as evidence each of the following:

26 (A) Supplier invoices issued to the audited pharmacy before  
27 the date of dispensing the drug underlying the audited claim.

28 (B) Invoices issued to the audited pharmacy from any supplier  
29 permitted by law to transfer ownership of the drug acquired by the



1 audited pharmacy, subject to validation by the supplier.

2 (C) Copies of supplier invoices in the possession of the  
3 audited pharmacy.

4 (2) Upon completion of an audit of a pharmacy, the carrier or  
5 pharmacy benefit manager shall do all of the following:

6 (a) Deliver a preliminary written audit report to the pharmacy  
7 not later than 60 days after the completion of the audit. The  
8 preliminary written audit report must include contact information  
9 for the person performing the audit and a description of the  
10 appeals process established under subsection (1)(m).

11 (b) Allow the pharmacy at least 30 days after its receipt of  
12 the preliminary written audit report under subdivision (a) to  
13 produce documentation to address any discrepancy found during the  
14 audit.

15 (c) If an appeal is not filed, deliver a final written audit  
16 report to the pharmacy within 90 days after the time described in  
17 subdivision (b) has elapsed. If an appeal is filed, deliver a final  
18 written audit report to the pharmacy within 90 days after the  
19 conclusion of the appeal.

20 (d) Except as otherwise provided in this section, recoup  
21 disputed money or overpayments or restore underpayments only after  
22 the final written audit report is delivered to the pharmacy under  
23 subdivision (c).

24 (3) Except as required by federal law, a carrier or pharmacy  
25 benefit manager shall not conduct an extrapolation audit in  
26 calculating recoupments, restoration, or penalties for an audit  
27 under this section. For the purposes of this subsection,  
28 "extrapolation audit" means an audit of a sample of prescription  
29 drug benefit claims submitted by a pharmacy to the carrier that is

1 then used to estimate audit results for a larger batch or group of  
2 claims not reviewed during the audit.

3 (4) Any clerical or record-keeping error, including a  
4 typographical error, a scrivener's error, or a computer error,  
5 regarding a required document or record that is found during an  
6 audit under this section does not, on its face, constitute fraud.  
7 An error described in this subsection does not subject the  
8 individual involved to criminal penalties without proof of intent  
9 to commit fraud. To the extent that an audit results in the  
10 identification of a clerical or record-keeping error, including a  
11 typographical error, a scrivener's error, or a computer error, in a  
12 required document or record, the pharmacy is not subject to  
13 recoupment of money by the carrier or pharmacy benefit manager  
14 unless clerical error or record-keeping error surpasses the  
15 statistical threshold established by the Centers for Medicare and  
16 Medicaid Services or the carrier can provide proof of intent to  
17 commit fraud or the error results in actual financial harm to the  
18 carrier, pharmacy benefit manager, or a covered person or enrollee.

19 (5) This section does not apply to any of the following:

20 (a) An audit conducted to investigate fraud, willful  
21 misrepresentation, or abuse, including, but not limited to,  
22 investigative audits or audits conducted under any other statute  
23 that authorizes investigation relating to insurance fraud.

24 (b) An audit based on a criminal investigation.

25 (6) This section does not impair or supersede a provision  
26 regarding carrier pharmacy audits in the insurance code of 1956,  
27 1956 PA 218, MCL 500.100 to 500.8302. If any provision of this  
28 section conflicts with a provision of the insurance code of 1956,  
29 1956 PA 218, MCL 500.100 to 500.8302, with regard to carrier

1 pharmacy audits, the provision in the insurance code of 1956, 1956  
2 PA 218, MCL 500.100 to 500.8302, controls.

3 Sec. 29. (1) A contract between a retail pharmacy and a  
4 pharmacy benefit manager or plan sponsor must not prohibit the  
5 retail pharmacy from offering either of the following as an  
6 ancillary service of the retail pharmacy:

7 (a) The delivery of a prescription drug by mail or common  
8 carrier to a patient or personal representative on request of the  
9 patient or personal representative if the request is made before  
10 the drug is delivered.

11 (b) The delivery of a prescription to a patient or personal  
12 representative by an employee or contractor of the retail pharmacy.

13 (2) Except as otherwise provided in a contract described in  
14 subsection (1), the retail pharmacy shall not charge a plan sponsor  
15 or pharmacy benefit manager for the delivery service described in  
16 subsection (1).

17 (3) If a retail pharmacy provides a delivery service described  
18 in subsection (1) to a patient, the retail pharmacy must disclose  
19 both of the following to the patient or personal representative:

20 (a) Any fee charged to the patient for the delivery of a  
21 prescription drug.

22 (b) The plan sponsor or pharmacy benefit manager may not  
23 reimburse the patient for the fee described in subdivision (a).

24 (4) Except as otherwise provided in a contract between a mail-  
25 order pharmacy or specialty pharmacy and a carrier, health plan, or  
26 pharmacy benefit manager, the carrier, health plan, or pharmacy  
27 benefit manager shall not require pharmacist or pharmacy  
28 accreditation standards or recertification requirements  
29 inconsistent with, more stringent than, or in addition to federal

1 and state requirements to obtain reimbursement for a covered drug.

2 (5) A pharmacy benefit manager shall not cause or knowingly  
3 permit the use of any advertisement, promotion, solicitation,  
4 representation, proposal, or offer that is untrue, deceptive, or  
5 misleading.

6 (6) A pharmacy benefit manager shall not reverse and resubmit  
7 the claim of a network pharmacy:

8 (a) Without prior and proper notification to the network  
9 pharmacy.

10 (b) Without just cause or attempt to first reconcile the claim  
11 with the pharmacy.

12 (c) More than 90 days after the claim was first affirmatively  
13 adjudicated.

14 (7) The termination of a pharmacy from a pharmacy benefit  
15 manager network must not release the retail pharmacy benefit  
16 manager from the obligation to make any payment due to the pharmacy  
17 for an affirmatively adjudicated claim unless payments are withheld  
18 because of an investigation relating to insurance fraud.

19 (8) A carrier, health plan, or pharmacy benefit manager shall  
20 not retaliate against a pharmacist or pharmacy based on the  
21 pharmacist's or pharmacy's exercise of any right or remedy under  
22 this act. Retaliation prohibited by this subsection includes any of  
23 the following:

24 (a) Terminating or refusing to renew a contract with the  
25 pharmacist or pharmacy.

26 (b) Subjecting the pharmacist or pharmacy to increased audits.

27 (c) Failing to promptly pay the pharmacist or pharmacy any  
28 money owed by the pharmacy benefit manager to the pharmacist or  
29 pharmacy.

1           (9) This section does not prohibit the use of remote  
2 pharmacies, secure locker systems, or other types of pickup  
3 stations if such services are otherwise permitted by law.

4           (10) The provisions of this act may not be waived, voided, or  
5 nullified by contract.

6           (11) As used in this section, "personal representative" means  
7 an individual who has authority to act on behalf of another  
8 individual in making decisions related to health care as described  
9 in 45 CFR 164.502(g).

10          Sec. 30. (1) The director shall enforce this act.

11          (2) The director may examine or audit the relevant books and  
12 records of a pharmacy benefit manager providing claims processing  
13 services or other drug or device services for a health plan to  
14 determine if the pharmacy benefit manager is in compliance with  
15 this act.

16          (3) All of the following apply to information or data acquired  
17 during an examination under subsection (2), or otherwise acquired  
18 under this act:

19           (a) The information or data is considered proprietary and  
20 confidential.

21           (b) The information or data is not subject to the freedom of  
22 information act, 1976 PA 442, MCL 15.231 to 15.246.

23           (c) The information or data is only to be used for purposes of  
24 ensuring a pharmacy benefit manager's compliance with this act.

25          Sec. 31. A contract between a pharmacy benefit manager and an  
26 insurer that exists on the date of licensure of the pharmacy  
27 benefit manager must comply with the requirements of this act as a  
28 condition of licensure for the pharmacy benefit manager.

29          Sec. 33. (1) The director shall establish a retention schedule

1 for all records, books, papers, and other data on file with the  
2 department related to the enforcement of this act.

3 (2) The director shall not order the destruction or other  
4 disposal of a record, book, paper, or other data that is any of the  
5 following:

6 (a) Required by law to be filed or kept on file with the  
7 department until 10 years have passed.

8 (b) Filed during the director's administration or  
9 administrations.

10 Sec. 35. This act does not apply with respect to a claim that  
11 is entirely preempted by federal law, including Medicare Part D or  
12 the employee retirement income security act of 1974, Public Law 93-  
13 406.

14 Enacting section 1. This act takes effect January 1, 2024.