AN ACT

To amend and reenact Chapter 14 of Title 37 to add Part VI – Pharmacy Benefit
Prompt Pay Law, consisting of R.S. 37:1251, as well as Part VII – Pharmacy Audit
Integrity Law, consisting of R.S. 37:1252; and to amend and reenact R.S. 37:1164,
relative to definitions, 37:1182, relative to powers and duties of the board, 37:1184,
relative to fees, and 37:1241(A), relative to disciplinary action; and to repeal previous

Be it enacted by the Legislature of Louisiana:

Section 1. Chapter 14 of Title 37 is hereby amended and reenacted to read as follows:

Chapter 14 – Pharmacy Practice Act

CODING: Words in stricken type are proposed deletions from existing law; words underscored are proposed additions.
Part VI – Pharmacy Benefit Prompt Pay Law

§1251. Pharmacy Benefit Prompt Pay Law

This Section shall be known as the Pharmacy Benefit Prompt Pay Law.

§1251.1. Definitions

A. As used in this Part, the following terms shall have the meaning ascribed to them in this Section unless the context clearly indicates otherwise:

(1) “Board” means the Louisiana Board of Pharmacy.

(2) “Commissioner” means the Louisiana Commissioner of Insurance.

(3) “Day” means a calendar day, unless otherwise defined or limited.

(4) “Electronic claim” means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a pharmacy benefit manager and approved by the board.

(5) “Electronic adjudication” means the process of electronically receiving, reviewing, and accepting or rejecting an electronic claim.

(6) “Enrollee” means an individual who has enrolled in a pharmacy benefit management plan.

(7) “Health insurance plan” means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred

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provider organization agreement, or health maintenance organization contract offered by a health insurance issuer, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. However, ‘health insurance coverage’ shall not include benefits due under the workers compensation laws of this or any other state.

(8) “Pharmacy benefit manager” shall have the same definition as provided in R.S. 37:1252. However, through August 1, 2017, the term “pharmacy benefit manager” shall not include an insurance company that provides an integrated health benefit plan and that does not separately contract for pharmacy benefit management services. From and after August 1, 2017, the term “pharmacy benefit manager” shall not include an insurance company unless the insurance company is providing services as a pharmacy benefit manager as defined in R.S. 37:1252, in which case the insurance company shall be subject to R.S. 37:1251 only for those pharmacy benefit manager services. In addition, the term “pharmacy benefit manager” shall not include the pharmacy benefit manager of the Louisiana State Employee Retirement System (LASERS) or the Teachers’ Retirement System of Louisiana (TRSL) or Louisiana Medicaid Program or its contractors when performing pharmacy benefit manager services for the Medicaid Program.

(9) “Pharmacy benefit management plan” shall have the same definition as provided in R.S. 37:1252.
(10) “Pharmacist”, “pharmacist services”, “pharmacy”, and “pharmacies” shall have the same definitions as provided in R.S. 37:1164.

§1251.2. Reimbursement under current nationally recognized reference prices; time limit for payment; “clean claims”

A. Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefit manager, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the non-electronic claim.

B. Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.

C. If the board finds that any pharmacy benefit manager, agent or other party responsible for reimbursement for prescription drugs and other products and supplies has not utilized the most current nationally recognized reference in the pricing calculations, such finding shall substantiate a violation of R.S. 37:1241(A)(25).
D. (1) All benefits payable under a pharmacy benefit management plan shall be paid within fifteen (15) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within fifteen (15) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor’s health insurance plan. A “clean claim” means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment, or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefits manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this Subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

(2) A clean claim does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed, within thirty (30) days of the original
(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;

(c) Claims that require information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits or subrogation provisions under the plan sponsor’s health insurance plan; or

(d) Claims submitted by a pharmacist or pharmacy more than thirty (30) days after the date of service; if the pharmacist or pharmacy does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the pharmacist or pharmacy to the insured.

(3) Not later than fifteen (15) days after the date the pharmacy benefit manager actually received an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where
the claim is owed to the pharmacist or pharmacy) of the reasons why the
claim or portion thereof is not clean and will not be paid and what
substantiating documentation and information is required to adjudicate
the claim as clean. Any claim or portion thereof resubmitted with the
supporting documentation and information requested by the pharmacy
benefit manager shall be paid within twenty (20) days after receipt.

E. If the board finds that any pharmacy benefit manager, agent or other party
responsible for reimbursement for prescription drugs and other products and
supplies has not paid ninety-five percent (95%) of clean claims as defined in
Paragraph D of this Section received from all pharmacies in a calendar
quarter, such finding shall substantiate a violation of R.S. 37:1241(A)(26).

(1) Examinations to determine compliance with this Section may be
conducted by the board. The board may contract with qualified impartial
outside sources to assist in examination to determine compliance. The
expenses of any such examinations shall be paid by the pharmacy benefit
manager examined.

(2) Nothing in the provisions of this Section shall require a pharmacy benefit
manager to pay claims that are not covered under the terms of a contract or
policy of accident and sickness insurance or prepaid coverage.

(3) If the claim is not denied for valid and proper reasons by the end of the
applicable time period prescribed in this provision, the pharmacy benefit
manager must pay the pharmacy (when the claim is owed to the
pharmacy) or the patient (where the claim is owed to a patient) interest on
accrued benefits at the rate of one and one-half percent (1.5%) accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than one dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

(4) Any pharmacy benefit manager and a pharmacy may enter into an express written agreement concerning timely claim payment provisions which differ from, but are at least as stringent as the provisions set forth under Paragraph C of this Section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of Paragraph E(3) of this Section shall apply.

(5) The board may adopt rules and regulations necessary to ensure compliance with this Section.

F. (1) For purposes of this Paragraph F of this Section, “network pharmacy” means a licensed pharmacy in this state that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate. A network pharmacy or pharmacist may decline to provide a brand name drug, multisource generic drug, or service, if the network pharmacy or pharmacist is paid less than that network pharmacy’s
acquisition cost for the product. If the network pharmacy or pharmacist
delivers to provide such drug or service, the pharmacy or pharmacist shall
provide the customer with adequate information as to where the
prescription for the drug or service may be filled.

(2) The board shall adopt rules and regulations necessary to implement and
ensure compliance with this Section, including, but not limited to, rules
and regulations that address access to pharmacy services in rural or
underserved areas in cases where a network pharmacy or pharmacist
delivers to provide a drug or service under Subparagraph (1) of this
Paragraph.

§1251.3. Financial statements

A. Before beginning to do business as a pharmacy benefit manager, a pharmacy
benefit manager shall obtain a license from the board. To obtain a license, the
applicant shall submit an application to the board on a form to be prescribed
by the board.

B. Each pharmacy benefit manager providing pharmacy benefit management
plans in this state shall file a statement with the board annually by March 1 or
within sixty (60) days of the end of its fiscal year if not a calendar year. The
statement shall be verified by at least two (2) principal officers and shall cover
the preceding calendar year or the immediately preceding fiscal year of the
pharmacy benefit manager.

C. The statement shall be on forms prescribed by the board and shall include:
(1) A financial statement of the organization, including its balance sheet and
income statement for the preceding year; and
(2) Any other information relating to the operations of the pharmacy benefit
manager required by the board under this Section. However, no pharmacy
benefit manager shall be required to disclose proprietary information of
any kind to the board.

D. If the pharmacy benefit manager is audited annually by an independent
certified public accountant, a copy of the certified audit report shall be filed
annually with the board by June 30 or within thirty (30) days of the report
being final.

E. The board may extend the time prescribed for any pharmacy benefit manager
for filing annual statements or other reports or exhibits of any kind for good
cause shown. However, the board shall not extend the time for filing annual
statements beyond sixty (60) days after the time prescribed by Paragraph A of
this Section. The board may waive the requirements for filing financial
information for the pharmacy benefit manager if an affiliate of the pharmacy
benefit manager is already required to file such information under current law
with the Commissioner of Insurance and allow the pharmacy benefit manager
to file a copy of documents containing such information with the board in lieu
of the statement required by this Section.

§1251.4. Acceptance of report of financial examination of persons in other states

A. In lieu of or in addition to making its own financial examination of a
pharmacy benefit manager, the board may accept the report of a financial
examination of other persons responsible for the pharmacy benefit manager under the laws of another state certified by the applicable official of such other state.

B. The board shall coordinate financial examinations of a pharmacy benefit manager that provides pharmacy benefit management plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation. The pharmacy benefit manager being examined shall pay the cost of the examination. The cost of the examination shall be deposited in a special fund that shall provide all expenses for the licensing, supervision, and examination of all pharmacy benefit managers subject to regulation under R.S. 37:1251 and R.S. 37:1252.

C. The board may provide a copy of the financial examination to the person or entity who provides or operates the health insurance plan or to a pharmacist or pharmacy.

D. The board is authorized to hire independent financial consultants to conduct financial examinations of a pharmacy benefit manager and to expend funds collected under this Section to pay the costs of such examinations.

Part VII – Pharmacy Audit Integrity Law

§1252. Pharmacy Audit Integrity Law

This Section shall be known as the Pharmacy Audit Integrity Law.

§1252.1. Purpose
A. The purpose of this Section is to establish minimum and uniform standards
and criteria for the audit of pharmacy records by or on behalf of certain
entities.

§1252.2. Definitions

A. As used in this Part, the following terms shall have the meaning ascribed to
them in this Section unless the context clearly indicates otherwise:

(1) "Entity" means a pharmacy benefit manager, a managed care company, a
health plan sponsor, an insurance company, a third-party payor, or any
company, group, or agent that represents or is engaged by those entities.

(2) "Health insurance plan" means benefits consisting of prescription drugs,
other products and supplies, and pharmacist services provided directly,
through insurance or reimbursement, or otherwise and including items and
services paid for as prescription drugs, other products and supplies, and
pharmacist services under any hospital or medical service policy or
certificate, hospital or medical service plan contract, preferred provider
organization agreement, or health maintenance organization contract
offered by a health insurance issuer.

(3) "Individual prescription" means the original prescription for a drug
signed by the prescriber, and excludes refills referenced on the
prescription.

(4) "Pharmacy benefit manager" means a business that administers the
prescription drug/device portion of pharmacy benefit management plans or
health insurance plans on behalf of plan sponsors, insurance companies,
unions and health maintenance organizations. Pharmacy benefit managers may also provide some, all, but may not be limited to, the following services either directly or through outsourcing or contracts with other entities:

(a) Adjudicate drug claims or any portion of the transaction.
(b) Contract with retail and mail pharmacy networks.
(c) Establish payment levels for pharmacies.
(d) Develop formulary or drug list of covered therapies.
(e) Provide benefit design consultation.
(f) Manage cost and utilization trends.
(g) Contract for manufacturer rebates.
(h) Provide fee-based clinical services to improve member care.
(i) Third-party administration.

(5) “Pharmacy benefit management plan” means an arrangement for the delivery of pharmacist services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of the pharmacist services for an enrollee on a prepaid or insured basis that contains one or more incentive arrangements intended to influence the cost or level of pharmacist services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist services; and requires or creates benefit payment of differential incentives for enrollees to use under contract with the pharmacy benefit manager.
(6) “Pharmacist”, “pharmacist services”, and “pharmacy” or “pharmacies” shall have the meaning as provided in R.S. 37:1164.

§1252.3. Application

A. The provisions of this Section shall apply to any audit of the records of a pharmacy conducted by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department.

§1252.4. Audit procedures; reports

A. The entity conducting an audit shall follow these procedures:

(1) The pharmacy contract must identify and describe in detail the audit procedures;

(2) The entity conducting the on-site audit must give the pharmacy written notice at least two (2) weeks before conducting the initial on-site audit for each audit cycle, and the pharmacy shall have at least fourteen (14) days to respond to any desk audit requirements;

(3) The entity conducting the on-site audit shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

(4) Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;
(5) Any clerical or record-keeping error, such as a typographical error, scrivener’s error, or computer error, regarding a required document or record shall not constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud;

(6) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;

(7) Any finding of an overpayment or an underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except that recoupment shall be based on the actual overpayment or underpayment;

(8) A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed;

(9) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;

(10) The period covered by an audit may not exceed two (2) years from the date the claim was submitted to or adjudicated by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that
An audit may not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy:

Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions:

An exit interview that provides a pharmacy with an opportunity to respond to questions and comment on and clarify findings must be conducted at the end of the audit. The time of the interview must be agreed to by the pharmacy:

Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan, or insurer. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan:

The parameters of an audit must comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:
(a) The day supply for eyedrops must be calculated so that the consumer pays only one (1) thirty-day copayment if the bottle of eyedrops is intended by the manufacturer to be a thirty-day supply;

(b) The day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;

(c) The day supply for a topical product must be determined by the judgment of the pharmacist based upon the treated area;

(16) (a) Where an audit is for a specifically identified problem that has been disclosed to the pharmacy, the audit shall be limited to claims that are identified by prescription number;

(b) For an audit other than described in Subparagraph (16)(a), an audit shall be limited to one hundred (100) individual prescriptions that have been randomly selected;

(c) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on-site;

(d) Except for audits initiated under Subparagraph (16)(a), an entity shall not initiate an audit of a pharmacy more than one (1) time in a year;

(17) A recoupment shall not be based on:

(a) Documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the board; or

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(b) A requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the board;

(18) Except for Medicare claims, approval of drug, prescriber or patient eligibility upon adjudication of a claim shall not be reversed unless the pharmacy or pharmacist obtained the adjudication by fraud or misrepresentation of claim elements; and

(19) A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

B. The entity must provide the pharmacy with a written report of the audit and comply with the following requirements:

(1) The preliminary audit report must be delivered to the pharmacy within ninety (90) days after conclusion of the audit, with a reasonable extension to be granted upon request;

(2) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request;

(3) A final audit report shall be delivered to the pharmacy within one hundred twenty (120) days after receipt of the preliminary audit report or final appeal, as provided for in R.S. 37:1252.5, whichever is later;

(4) The audit report must be signed by the auditor;
(5) (a) No pharmacy shall be subject to recoupment of any portion of the reimbursement for the dispensed product of a prescription unless one or more of the following has occurred:

(i) The pharmacy has engaged in fraudulent activity or other intentional and willful misrepresentation, as evidenced by a review of claims data or statements, physical review, or any other investigative method.

(ii) The pharmacy has engaged in dispensing in excess of the benefit design, as established by the plan sponsor.

(iii) The pharmacy has not filled prescriptions in accordance with the prescriber’s order.

(iv) The pharmacy has received an actual overpayment.

(b) Recoupment of claims shall be based on the actual financial harm to the entity or on the actual overpayment or underpayment. A finding of an overpayment that is the result of dispensing in excess of the benefit design, as established by the plan sponsor, shall be calculated as the difference between what was dispensed in accordance with the prescriber’s orders and the dispensing requirements as set forth by the benefit design. Calculations of overpayments shall not include dispensing fees unless one or more of the following conditions has been satisfied:

(i) A prescription was not actually dispensed.

(ii) The prescriber denied authorization.
(iii) The prescription dispensed was a medication error by the pharmacy.

(iv) The identified overpayment is based solely on an extra dispensing fee.

(v) The pharmacy was noncompliant with program guidelines.

(vi) There was insufficient documentation.

(6) Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in R.S. 37:1252.5. If the identified discrepancy for an individual audit exceeds twenty-five thousand dollars ($25,000), future payments of that amount to the pharmacy may be withheld pending finalization of the audit;

(7) Interest shall not accrue during the audit period; and

(8) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor.

§1252.5. Appeal procedure; dismissal of report; mediation

A. Each entity conducting an audit shall establish a written appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

B. No interest shall be charged to or by the entity during the appeal period.
C. If, following the appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or that portion without the necessity of any further action.

D. If, following the appeal, any of the issues raised in the appeal are not resolved to the satisfaction of either party, that party may ask for mediation of those unresolved issues. The mediator chosen shall be by mutual consent.

§1252.6. Extrapolation audit; definition; prohibition

A. Notwithstanding any other provision in this Chapter, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits. An extrapolation audit mean an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

B. If the board finds that any entity has used extrapolation in calculating recoupments or penalties for audits, such finding shall substantiate a violation of R.S. 37:1241(A)(27).

§1252.7. Inapplicability of provisions to fraud, misrepresentation or abuse cases

A. The provisions of this Part shall not apply to:

1. Any quality assurance review, as defined by the time period prior to the reimbursement by the entity to the pharmacy.

2. An investigation that is initiated based on or that involves suspected or alleged fraud, willful misrepresentation, or abuse.

3. Any federally funded activity specifically preempted by law or rule.
(4) Any audit conducted pursuant to the participation of a pharmacy in the Louisiana Medicaid Program

§1252.8. Failure to comply with prescribed audit procedures

A. If the board finds that an entity conducting a pharmacy audit has failed to comply with the procedures itemized in R.S. 37:1252.4, such finding shall substantiate a violation of R.S. 37:1241(A)(28).

Section 2. R.S. 37:1164, 1182, 1184, and 1241(A) are hereby amended and reenacted to read as follows:

§1164. Definitions

* * *

(59) “Pharmacy benefit manager” means a business that administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. Pharmacy benefit managers may also provide some or all, but may not be limited to, the following services either directly or through outsourcing or contracts with other entities:

(a) Adjudicate drug claims or any portion of the transaction.

(b) Contract with retail and mail pharmacy networks.

(c) Establish payment levels for pharmacies.

(d) Develop formulary or drug list of covered therapies.

(e) Provide benefit design consultation.
(f) Manage cost and utilization trends.

(g) Contract for manufacturer rebates.

(h) Provide fee-based clinical services to improve member care.

(i) Third-party administration.

(60) “Pharmacy benefit management plan” means an arrangement for the delivery of pharmacist services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist services for an enrollee on a prepaid or insured basis that:

(a) Contains one or more incentive arrangements intended to influence the cost or level of pharmacist services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist services; and

(b) Requires or creates benefit payment differential incentives for enrollees to use under contract with the pharmacy benefit manager.

§1182. Powers and duties of the board

A. The board shall be responsible for the control and regulation of the practice of pharmacy and shall:

(25) Establish rules for the licensing and regulation of pharmacy benefit

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managers, monitor their activities for compliance with those rules, and
when noncompliance is discovered, shall initiate disciplinary
proceedings in accordance with its own rules for such activities

B. The board may:

(10) Assess and collect fees for the licensing and regulation of pharmacy
benefit managers, and when disciplinary proceedings are instituted
against such licensees, may levy and collect fines, and further, may
recover their administrative, investigative, and hearing costs.

§1184. Fees

A. Notwithstanding any other provision of this Chapter, the fees and costs
established by the board in accordance with R.S. 37:1182(A) shall not be less
than the following schedule:

(6) Pharmacy benefit managers

(a) Permit application fee $ 150.00
(b) Annual permit renewal fee $ 125.00

§1241. Refusal, restriction, suspension, or revocation of license

A. The board may, after due notice and hearing, assess a fine not to exceed the
sum of five thousand dollars for each offense, refuse to license, register,
certify, or permit any applicant, refuse to renew the license or permit of any person, or may revoke, summarily suspend, suspend, place on probation, reprimand, issue a warning against the person who was issued the license, registration, certificate, permit or any other designation deemed necessary to engage in the practice of pharmacy upon proof that the person:

*   *

(25) Has failed to reimburse a pharmacist or pharmacy for prescription drugs or other products or supplies using a current nationally recognized reference in the pricing calculation.

(26) Has failed to reimburse at least ninety-five percent (95%) of all clean claims within a calendar quarter in a timely manner.

(27) Has used extrapolation methods in calculating recoupment or penalty payments for a pharmacy audit.

(28) Has failed to comply with prescribed procedures during a pharmacy audit.

Section 3. R.S. 22:1856.1 is hereby repealed.