NATIONAL DIABETES VOLUNTEER LEADERSHIP COUNCIL

WE ARE DPAC DIABETES PATIENT ADVOCACY COALITION SAFETY QUALITY ACCESS

BILL SUMMARY

The **Access to Lifesaving Medicines Act (ALMA)** provides state legislators a framework to address the leading drivers of rising outpatient prescription costs and eliminate certain coverage-related barriers to appropriate, affordable medical care.

Its provisions address the roles and incentives of major stakeholders in the prescription medication delivery, coverage and reimbursement systems, and realign their practices and obligations in support of patients' rights to:

- Understand the terms of their prescription coverage;
- Compare treatment costs and make an informed decision in collaboration with their health care provider; and
- Pay the lowest available price for their prescriptions at the point of sale.

ALMA also contains diabetes-specific provisions to cap patient cost-sharing for lifesaving insulin and other diabetes medications, as well as devices, supplies and services.

MAJOR PROVISIONS

- **Eliminate consumer exposure to excess cost burden** – passing through rebates and other negotiated discounts, including co-pay cards, at the point of sale so patients pay the lowest available price for their prescriptions

- **Prohibit pharmacy gag clauses in prescription medication benefit contracts** – allowing pharmacists to discuss lower priced, therapeutically equivalent options with consumers and sell lower priced alternatives if one is available

- **Improve patient access to transparent prescription medication coverage and medically appropriate treatment** – eliminating patient cost sharing for lifesaving medicines; clarifying health carrier and pharmacy benefit manager (PBM) obligations to make certain coverage information available and understandable to consumers; and affirming that a prescriber's determination of medical necessity prevails

- **Require transparency reports from health carriers, PBMs and pharmaceutical manufacturers** – to discourage wholesale acquisition cost (a.k.a. WAC or "list price") inflation and ensure negotiated rebates, discounts and price concessions pass through to consumers

- **Require fee-only pharmacy benefit management state contracts** – eliminating spread pricing and PBM compensation based on a percent of list price or retained rebates in state employee health plans and Medicaid managed care contracts

AN ACT
Concerning Prescription Medication Costs

TITLE: This act shall be known as The Access to Lifesaving Medicines Act of 2019

PURPOSE The purpose of this bill is to improve the health of the people of [STATE / COMMONWEALTH] by reducing their prescription medication costs and improving access to affordable health care.

WHEREAS, rising costs make it difficult for [STATE / COMMONWEALTH] consumers to afford lifesaving medications, as well as the medical supplies, devices and services they need to manage chronic health conditions like diabetes; and

WHEREAS, numerous studies confirm that reducing or eliminating consumer cost sharing for chronic disease medications improves health outcomes and reduces overall health costs, yet diabetes care accounts for one of every four dollars the nation spends on health care, and all chronic conditions account for three of every four dollars in national health care spending; and

WHEREAS, consumers have the right to know all available options to reduce their prescription medication costs; and

WHEREAS, [STATE / COMMONWEALTH] consumers are subject to contractual agreements between health carriers, pharmacy benefit managers, health plan payers or sponsors, pharmacies and pharmacists, that are not transparent to the consumer and may impose excess cost burden, including cost sharing that does not reflect contractual rebates, discounts, price concessions or fees for prescription medications, and

WHEREAS, prescription medication formulary and utilization management methods employed by health carriers, pharmacy benefit managers, and health plan payers or sponsors may restrict consumer access to appropriate medical treatment, favoring financial incentives over a consumer's health or evidence-based clinical practice guidelines related to their health condition; and

WHEREAS, excess cost burden and restricted access to clinically appropriate treatment may harm consumer health and safety, and disproportionately impact consumers diagnosed with chronic or complex health conditions, or who may be uninsured, underinsured, or in a high deductible health plan

Be it enacted by the [SENATE / HOUSE OF REPRESENTATIVES / GENERAL ASSEMBLY] convened:

Section 1. DEFINITIONS For the purposes of this act:

(1) "Adjusted out-of-pocket amount" means the co-payment, co-insurance, or other cost sharing obligation the health care plan requires the insured to pay at the point of sale for a covered prescription medication otherwise payable, less the pro rata portion of any discounts, rebates and price concessions in connection with the prescription drug.

(2) “Aggregate retained rebate percentage” means the percentage calculated for each prescription medication for which a health carrier or pharmacy benefit manager receives rebates under a particular health care plan expressed without disclosing any identifying information regarding the health care plan, prescription medication, or therapeutic class. The percentage shall be calculated by dividing:

(a) Aggregate rebates that the health carrier or pharmacy benefit manager received during the prior calendar year from a pharmaceutical manufacturer related to utilization of the manufacturer’s prescription medication by insureds that did not pass through to the health plan payer or sponsor, by

(b) Aggregate rebates that the health carrier or pharmacy benefit manager received during the prior calendar year from a pharmaceutical manufacturer related to utilization of the manufacturer's prescription medication by insureds.

(3) “Claim” means any bill, claim, or proof of loss made by or on behalf of an insured or a provider to a health carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health care plan.

(4) “Commissioner” means the commissioner of the [STATE / COMMONWEALTH] [BUREAU/DEPARTMENT OF INSURANCE].

(5) “Co-pay card” means a discount coupon provided by a sponsor to an insured that allows the insured to pay only a certain amount of their total prescription medication cost; the remainder of the cost is paid by the card’s sponsor.

(6) “Cost share” or “cost sharing” means the co-payment, co-insurance, or other cost sharing obligation the health care plan requires the insured to pay at the point of sale for a covered prescription medication or device otherwise payable.

(7) “Excess cost burden” means any co-payments, co-insurance or other cost sharing an insured is required to pay at the point-of-sale to receive a prescription medication or device, that exceeds the health carrier or pharmacy benefit manager’s net cost after applying a pro rata portion of any discounts, rebates or concessions received from manufacturers, pharmacies or other third parties.

(8) “Health care plan” means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the [STATE / COMMONWEALTH]. Health care plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers’ compensation coverages..

(9) “Health care provider” or “provider” means a health care professional or facility.

(10) "Health carrier" means an entity subject to the insurance laws and regulations of the [STATE / COMMONWEALTH] and subject to the jurisdiction of the [BUREAU/DEPARTMENT OF INSURANCE] that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including but not limited to an insurer licensed to sell sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits or health care services..

(11) "Health plan payer or sponsor" means an employer, fraternal benefit society or other entity that provides or subsidizes a health care plan with outpatient prescription medication coverage for employees or members.

(12) "Insured" means a consumer covered under a health care plan with outpatient prescription medication coverage offered by a health carrier.

(13) "Maximum allowable claim" means the amount the health carrier or pharmacy benefits manager has agreed to pay the pharmacy for the prescription medication.

(14) "Maximum allowable cost" means the maximum dollar amount that a health carrier or its intermediary will reimburse a pharmacy provider for a group of drugs rated as "A", "AB", "NR" or "NA" in the most recent edition of the Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, published by the U.S. Food and Drug Administration, or similarly rated by a nationally recognized reference.

(15) "Pharmacist" means an individual licensed as a pharmacist by the [STATE / COMMONWEALTH] Board of Pharmacy.

(16) "Pharmacy benefit manager" means any person or entity that administers the prescription medication, prescription medical device, pharmacist services, or prescription medication claims processing or payment portion of a health care plan on behalf of a health carrier.

(17) "Point of sale" means the transaction in which goods or services, which may include but are not limited to prescription medications, medical devices, and supplies, are sold to the consumer.

(18) "Prescriber" means a health care provider currently licensed, registered or otherwise authorized in [STATE / COMMONWEALTH] to order and administer prescription medications or devices in the course of professional practice.

(19) "Rebate" includes but is not limited to the following:

(a) Negotiated price concessions, including but not limited to base rebates and reasonable estimates of any price protection rebates and performance-based rebates that may accrue directly or indirectly to the health carrier or pharmacy benefit manager as a result of point of sale prescription medication claims processing during the coverage year from a manufacturer, dispensing pharmacy or other party to the transaction.

(b) Reasonable estimates of any fees and other administrative costs that are passed through to the health carrier as a result of point of sale prescription medication claims processing and serve to reduce the health carrier's prescription medication liabilities for the coverage year.

(20) "Provider contract" means any contract between a provider and a health carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision

of health care services.

(21) "Spread pricing" shall mean any amount charged or claimed by a health carrier or pharmacy benefit manager that is in excess of the amount paid to the pharmacy that filled the prescription.

(22) "Wholesale acquisition cost" has the same meaning as provided in 42 U.S.C. 1395w-3a, as amended from time to time.

Section 2. Patient Prescription Medication Cost Reduction

I. Health carriers and pharmacy benefit managers that deliver, issue for delivery, renew, amend or continue a health care plan with outpatient prescription medication coverage in [STATE / COMMONWEALTH] are proscribed from imposing excess cost burden on insureds.

II. ALL discounts, rebates, price concessions and fees related to the prescription medication claim must be passed through to the insured at point of sale and may not be retained by the health carrier or pharmacy benefit manager. Health carriers and pharmacy benefit managers may retain transaction fees for each pharmacy claim processed. Transaction fees are to be established in provider contracts.

III. Outpatient prescription medication cost sharing for [STATE / COMMONWEALTH] insured shall be the lesser of:

(1) The applicable co-payment for the prescription medication that would be payable in the absence of this section;

(2) The maximum allowable cost;

(3) The maximum allowable claim;

(4) The adjusted out-of-pocket amount as determined pursuant to subsection II;

(5) The amount an insured would pay for the prescription medication if they purchased it without using their health care plan or any other source of prescription medication benefits or discounts; or

(6) The amount the pharmacy will be reimbursed for the prescription medication by the health carrier or pharmacy benefit manager.

Section 3. Payment Of Prescription Medication Cost Sharing By Certain Third Parties On Behalf Of An Insured

I. An insured may allow certain third parties to pay any cost sharing and the health carrier shall accept and count the payment toward the insured's out-of-pocket maximum, deductible, co-payment, co-insurance, or other cost sharing requirement, including payments from the following:

(1) A sponsor of a co-pay card.

(2) A State or Federal government program.

(3) Indian tribes, tribal organizations, or urban Indian organizations.

(4) A program conducted by an organization which is—

(a) exempt from taxation under section 501(a) of the Internal Revenue Code of 1986;

(b) described in clause (i) or (vi) of section 170(b)(1)(A) of such Code; and

(c) operated in compliance with applicable [STATE / COMMONWEALTH] laws.

Section 4. Access to Lifesaving Diabetes Care

I. Notwithstanding any provision of law to the contrary, health carriers and pharmacy benefit managers that deliver, issue for delivery, renew, amend or continue a health care plan

with outpatient prescription medication coverage in [STATE / COMMONWEALTH] shall cover all health care products and services used to manage an insured's diabetes or diabetes-related complications, including but not limited to prescription medications, medical devices, services, and supplies, authorized by a prescriber licensed by the [STATE / COMMONWEALTH].

II. No provider contract entered into in [STATE / COMMONWEALTH] shall contain a provision with a consumer cost sharing requirement at the point of sale that exceeds ten percent of the amount the dispensing pharmacy will be reimbursed by the health carrier or pharmacy benefit manager.

Section 5. Pharmacist Prescription Medication Cost Disclosures

I. No provider contract for outpatient pharmacy services entered into in [STATE / COMMONWEALTH] between a health carrier or pharmacy benefit manager and a pharmacy or pharmacist shall contain a provision prohibiting a pharmacy or pharmacist's disclosure to an individual purchasing prescription medication of information regarding:

(1) the cost of the prescription medication to the individual;

(2) the availability of any therapeutically equivalent alternative medications; or

(3) alternative methods of purchasing the prescription medication, including, but not limited to, paying a cash price, that are less expensive than the cost of the prescription medication to the individual.

II. Neither a pharmacy nor pharmacist shall be penalized, including through increased utilization review, reduced payments or other financial disincentives, by a health carrier or pharmacy benefit manager for disclosing such information to an insured or for selling to an insured a lower cost alternative if one is available.

Section 6. Consumer Access to Appropriate Treatment

I. Notwithstanding any provision of law to the contrary, health carriers and pharmacy benefit managers that deliver, issue for delivery, renew, amend or continue a health care plan with outpatient prescription medication coverage in [STATE / COMMONWEALTH] shall cover medically necessary prescription medications in the anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic, immunologic and atypical antipsychotic therapeutic classes, including non-formulary medications.

II. If the prescriber, after providing clinical documentation of an accepted use of such medications and consulting with the health carrier or pharmacy benefit manager, determines that such medications, in the prescriber's reasonable professional judgment, are medically necessary and warranted, the prescriber's determination shall be final.

III. Each health carrier and pharmacy benefit manager that delivers, issues for delivery, renews, amends or continues a health care plan providing outpatient prescription medication coverage shall:

(1) Make available to insureds, in an easily readable, accessible and understandable format, the following information for each such policy:

(a) any coverage exclusions;

(b) any restrictions on the use or quantity of a covered benefit, including on prescription medications or medications administered in a physician's office or a clinic;

(c) a specific description of how prescription medications are included or excluded from any applicable deductible, including a description of other out-of-pocket

expenses that apply to such medications; and

(d) the specific dollar amount of any co-payment and the percentage of any co-insurance imposed on each covered benefit, including each covered prescription medication; and

(e) information regarding any process available to insureds, and all documents necessary, to seek coverage of a noncovered outpatient prescription medication, including the process to appeal a coverage determination by the health carrier or pharmacy benefit manager;

(2) Make available to insureds a way to determine accurately

(a) whether a specific prescription medication is available under the health care plan prescription medication formulary;

(b) the co-insurance, co-payment, deductible or other out-of-pocket expense applicable to such prescription medication;

(c) whether such prescription medication is covered when dispensed by a physician or a clinic;

(d) whether such prescription medication requires prior authorization or the use of step therapy.

Section 7. Pharmacy Benefit Manager Transparency Requirement

I. Not later than [DATE], and annually thereafter, each pharmacy benefit manager licensed by the Commissioner shall file a transparency report with the Commissioner for the immediately preceding calendar year as a condition for maintaining licensure. The report shall contain the following information for health carriers that delivered, issued for delivery, renewed,

amended or continued health care plans that included outpatient prescription medication benefits managed by the pharmacy benefits manager during such calendar year:

(1) The transparency report shall contain the following information for each of the pharmacy benefit manager's contractual or other relationships with a health carrier or health plan payer or sponsor:

(a) The aggregate amount of all rebates that the pharmacy benefit manager received from pharmaceutical manufacturers.

(b) The aggregate administrative fees or other similar payments that the pharmacy benefit manager received.

(c) The aggregate rebates that the pharmacy benefit manager received from pharmaceutical manufacturers and did not pass through to the health carrier or health plan payer or sponsor.

(d) The highest, lowest, and mean aggregate retained rebate percentage.

(e) The aggregate rebates that the pharmacy benefit manager received from pharmaceutical manufacturers that the pharmacy benefit manager applied to insured claims at the point of sale.

II. The Commissioner shall establish a standardized form for reporting information pursuant this section after consultation with pharmacy benefit managers. The form shall be designed to minimize the administrative burden and cost of reporting on the department and pharmacy benefit managers.

III. The transparency report shall be made available in a form that does not disclose the identity of a specific health care plan, the prices charged for specific medications or classes of

medications, or the amount of any rebates provided for specific medications or classes of medications.

Section 8. Health Carrier Transparency Reporting Requirement

I. Each health carrier that delivers, issues for delivery, renews, amends or continues a health care plan with outpatient prescription medication benefits on or after [DATE], shall submit the following information and data to the Commissioner, for such health care plan for the immediately preceding calendar year, at the time that such health carrier submits a rate filing for such health care plan pursuant to [SECTION/CHAPTER __] of the general statutes, as amended by this act, as applicable:

(1) For covered outpatient prescription medications that were prescribed to insureds under such health care plan during such calendar year, the names of:

(a) The twenty-five most frequently prescribed outpatient prescription medications;

(b) The twenty-five outpatient prescription medications that the health care plan covered at the greatest cost, calculated by using the total annual plan spending by such health care plan for each outpatient prescription medication; and

(c) The twenty-five outpatient prescription medications that experienced the greatest year-over-year increase in cost, calculated by using the total annual plan spending by such health care plan for each outpatient prescription medication.

(2) The portion of the premium for such health care plan that is attributable to each of the following categories of covered outpatient prescription medications that were prescribed to insureds under such health care plan during such calendar year:

(a) Brand name medications;

(b) Generic medications; and

(c) Specialty medications.

(3) The year-over-year increase, calculated on a per member, per month basis and expressed as a percentage, in the total annual cost of each category of covered outpatient prescription medications set forth in this section.

(4) A comparison, calculated on a per member, per month basis, of the year-over-year increase in the cost of covered outpatient prescription medications to the year-over-year increase in the costs of other contributors to the premium cost of such health care plan.

(5) The names of the twenty-five most frequently prescribed outpatient prescription medications for which the health carrier received rebates from pharmaceutical manufacturers during such calendar year.

(6) The aggregate rebates which the health carrier received from pharmaceutical manufacturers during such calendar year

(7) The aggregate rebates which the health carrier received from pharmaceutical manufacturers that the health carrier applied to insured claims at the point of sale.

II. Beginning on [DATE], and annually thereafter, each health carrier shall submit to the Commissioner, in a form and manner prescribed by the Commissioner, a written certification for the immediately preceding calendar year, certifying that the health carrier accounted for all rebates in calculating the premium for health care plans that such health carrier delivered, issued for delivery, renewed, amended or continued during such calendar year.

III. Not later than [DATE], and annually thereafter, the Commissioner shall submit a report, in accordance with [SECTION/CHAPTER __] of the general statutes, to the

[LEGISLATIVE COMMITTEE WITH OVERSIGHT OF HEALTH INSURANCE MATTERS]. The report shall contain:

(1) an aggregation of the information and data submitted to the Commissioner pursuant to this act for the immediately preceding calendar year;

(2) a description of the impact of the cost of outpatient prescription medications on health insurance premiums in this [STATE / COMMONWEALTH]; and

(3) such other information as the Commissioner, in the Commissioner's discretion, deems relevant to the cost of outpatient prescription medications in this [STATE / COMMONWEALTH].

IV. Not later than [DATE], and annually thereafter, the Commissioner shall prepare a report, for the immediately preceding calendar year, describing the rebate practices of health carriers and pharmacy benefit managers. The report shall contain:

(1) an explanation of the manner in which health carriers accounted for rebates in calculating premiums for health care plans delivered, issued for delivery, renewed, amended or continued during such year;

(2) a statement disclosing whether, and describing the manner in which, health carriers and pharmacy benefit managers made rebates available to insureds at the point of sale during such year;

(3) any other manner in which health carriers and pharmacy benefit managers applied rebates during such year; and

(4) such other information as the Commissioner, in the Commissioner's discretion, deems relevant for the purposes of this section.

V. The Commissioner shall publish a copy of the report on the Department's website.

VI. No health care plan shall be delivered or issued for delivery in this state, nor shall any application, rider or endorsement be used in connection with such plan, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the Commissioner. Rate filings shall include the information and data required under [CHAPTER/SECTION __] of this act if the health care plan is subject to said section, and an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the plan. Each premium rate filed on or after [DATE], shall, if the health carrier intends to account for rebates, as defined in [SECTION __] of this act in the manner specified in [SECTION __] of this act, account for such rebates in such manner, if the policy is subject to [SECTION __] of this act.

Section 9. Pharmaceutical Manufacturer Transparency Reporting Requirement

I. A pharmaceutical manufacturer of a prescription medication with a wholesale acquisition cost not less than one hundred dollars for a thirty-day supply of or course of treatment with such medication, shall notify the Commissioner, in a form and manner prescribed by the Commissioner, within thirty days of any increase in wholesale acquisition cost exceeding:

(1) twenty per cent during the immediately preceding calendar year, or

(2) fifty per cent during the immediately preceding three calendar years.

II. On or before [DATE], and annually thereafter, the Commissioner in consultation with the [OTHER RELEVANT STATE/COMMONWEALTH BUREAUS, DIVISIONS, DEPARTMENTS OR EXECUTIVES], shall prepare a list of not more than twenty-five outpatient prescription medications that the Commissioner, in the Commissioner's discretion, determines are:

(1) provided at substantial cost to the state, considering the net cost of such medications; or

(2) critical to public health.

III. The list shall include outpatient prescription medications from different therapeutic classes of outpatient prescription medications and at least one generic outpatient prescription medication.

IV. The Commissioner shall not list any outpatient prescription medication under this section unless the wholesale acquisition cost of the medication, less all rebates paid to the state for such medication during the immediately preceding calendar year:

(1) increased by at least (a) twenty per cent during the immediately preceding calendar year, or (b) fifty per cent during the immediately preceding three calendar years, and

(2) was not less than one hundred dollars for (a) a thirty-day supply of such medication, or (b) a course of treatment of such medication lasting less than thirty days.

V. The pharmaceutical manufacturer of an outpatient prescription medication subject to reporting under this section shall provide to the Commissioner, in a form and manner specified by the Commissioner, a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription medication.

VI. The quality and types of information and data that a pharmaceutical manufacturer submits to the Commissioner shall be consistent with the quality and types of information and data that the pharmaceutical manufacturer includes in such pharmaceutical manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K, or any other public disclosure.

VII. The Commissioner shall establish a standardized form for reporting information and

data pursuant to this subsection after consulting with pharmaceutical manufacturers. The form shall be designed to minimize the administrative burden and cost of reporting on the office and pharmaceutical manufacturers.

Section 10. State Contracts or Subcontracts for Pharmacy Benefit Manager Services

I. Contracts for pharmacy benefit manager services, either directly with the [STATE / COMMONWEALTH department(s) contracting for Medicaid and state employee health benefits], or with a subcontractor or subsidiary of an entity that has a contract with the [STATE / COMMONWEALTH], shall be awarded based only on the following provisions:

(1) Any contract for pharmacy benefit manager services shall be limited to a transaction fee only, based on a set rate established by the [STATE / COMMONWEALTH department(s)] to be paid to the pharmacy benefit manager for each pharmacy claim processed.

(2) No pharmacy benefit manager may retain any portion of state supplemental rebates or credits submitted to the state by any pharmaceutical manufacturer.

(3) No pharmacy benefit manager may retain any portion of “spread pricing.”

II. The [STATE / COMMONWEALTH DEPARTMENT(S)] may terminate the contract with any pharmacy benefit manager or entity who is not willing to amend their contract to comply with the provisions of this section, and the provision of this service shall be opened for bid to other pharmacy benefit managers in accordance with the [SECTION/CHAPTER] of the general statutes.

III. After [DATE], any subsequent requests for proposal issued by the [STATE / COMMONWEALTH department(s)] that include the provision of pharmacy or pharmacy benefit manager services shall include the provisions of this section.

Section 11. Authority to Implement and Enforce Provisions

I. Any provision of a contract that violates the provisions of this section shall be considered void and unenforceable in [STATE / COMMONWEALTH]. Any general business practice that violates the provisions of this section shall constitute an unfair trade practice pursuant to [SECTION/CHAPTER __] of the general statutes. The invalidity or unenforceability of any contract provision under this section shall not affect any other provision of the contract.

II. The Commissioner may, pursuant to the provisions of [SECTION/CHAPTER __] of the general statutes, enforce the provisions of this section, and upon request, audit a contract for pharmacy services for compliance with the provisions of this section.

III. The Commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefit manager, health carrier or pharmaceutical manufacturer for each violation of this section by the pharmacy benefit manager, health carrier or pharmaceutical manufacturer.

IV. The Commissioner is directed and authorized to adopt regulations to implement and enforce these provisions for all health care plans subject to regulation by the [STATE / COMMONWEALTH] [DEPARTMENT/BUREAU OF INSURANCE].

Section 12. Date of Effect

I. The provisions in this bill will go into effect on the [DAY of the MONTH of the YEAR].