2023 South Dakota Legislature

House Bill 1135

AMENDMENT 1135A
FOR THE INTRODUCED BILL

An Act to provide for transparency in the pricing of prescription drugs.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That § 58-29E-1 be AMENDED:

58-29E-1. Terms used in this chapter mean:

(1) ~~"Covered entity," a nonprofit hospital or medical service corporation, health insurer, health benefit plan, or health maintenance organization; a health program administered by a department or the state in the capacity of provider of health coverage; or an employer, labor union, or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state. The term does not include a self-funded plan that is exempt from state regulation pursuant to ERISA, a plan issued for coverage for federal employees, or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long- term care, or other limited benefit health insurance policies and contracts;~~ "Brand name," the proprietary or registered trademark name given to a drug product by its manufacturer, labeler, or distributor and placed on the drug or on its container, label, or wrapping, at the time of packaging;

(2) "Covered individual," a member, participant, enrollee, contract holder, policy holder, or beneficiary of a ~~covered entity~~ third-party payor who is provided health coverage by the ~~covered entity~~ third-party payor. The term includes a dependent or other ~~person~~ individual provided health coverage through a policy, contract, or plan for a covered individual;

(3) ~~"Director," the director of the Division of Insurance;~~

~~(4)~~ "Generic drug," a chemically equivalent copy of a brand–name drug with an expired patent;

~~(5) "Labeler," an entity or person that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and that has a labeler code from the federal Food and Drug Administration under 21 C.F.R. § 270.20 (1999);~~

(4) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, provided the term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition, and further provided that the term does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, as of January 1, 2011, under which benefits for medical care are secondary or incidental to other insurance benefits;

(b) The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191, as of January 1, 2011;

(c) The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance; or

(d) The following, if offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance, as defined under 42

U.S.C. § 1395ss, as of January 1, 2011; coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, as of January 1, 2011; or similar supplemental coverage provided to coverage under a group health plan;

(5) "Health carrier," an entity that is subject to the insurance laws and rules of this state, or subject to the jurisdiction of the director of the Division of Insurance, and which contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(6) "Interchangeable biological product," a biological product that the U.S. Food and Drug Administration has:

(a) Licensed, and has determined meets the standards for interchangeability, pursuant to 42 U.S.C. § 262(k)(4), as of January 1, 2018; or

(b) Determined is therapeutically equivalent, as set forth in the latest edition of, or any supplement to, the Food and Drug Administration's publication entitled Approved Drug Products with Therapeutic Equivalence Evaluations, as adopted by the State Board of Pharmacy, in rules promulgated pursuant to chapter 1-26;

(7) "Maximum allowable cost," the maximum amount that a pharmacy may be reimbursed, as set by a pharmacy benefit manager or a third-party payor, for a brand name or a generic drug, an interchangeable biological product, or any other prescription drug and which may include:

(a) The average acquisition cost;

(b) The national average acquisition cost;

(c) The average manufacturer price;

(d) The average wholesale price;

(e) The brand effective rate;

(f) The generic effective rate;

(g) Discount indexing;

(h) Federal upper limits;

(i) The wholesale acquisition cost; and

(j) Any other term used by a pharmacy benefit manager or a health carrier to establish reimbursement rates for a pharmacy.

(8) "Maximum allowable cost list," a list of prescription drugs that:

(a) Includes the maximum allowable cost for each prescription drug; and

(b) Is used, directly or indirectly, by a pharmacy benefit manager;

(9) "Pharmaceutical manufacturer," any person engaged in the business of preparing, producing, converting, processing, packaging, labeling, or distributing a prescription drug, but not including a wholesale distributor or dispenser;

(10) "Pharmacist," an individual licensed by the State Board of Pharmacy, in accordance with chapter 36-11, to engage in the practice of pharmacy;

(11) "Pharmacy," a place that:

(a) Is licensed by the State Board of Pharmacy, in accordance with chapter 36-11;

(b) Is located within or outside of this state; and

(c) Provides for the dispensing of drugs and rendering of pharmaceutical care to residents of this state;

~~(6)~~(12) "Pharmacy ~~benefits~~ benefit management," the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals, the administration or management of prescription drug benefits provided by a ~~covered entity~~third-party payor for the benefit of covered individuals, or any of the following services provided with regard to the administration of ~~the following~~ pharmacy benefits:

(a) Mail service pharmacy;

(b) Claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to covered individuals;

(c) Clinical formulary development and management services;

(d) Rebate contracting and administration;

(e) Certain patient compliance, therapeutic intervention, and generic substitution programs; and

(f) Disease management programs involving prescription drug utilization;

~~(7)~~(13) "Pharmacy benefit management fee," a fee that covers the cost of providing pharmacy benefit management, but does not exceed the value of the service performed by the pharmacy benefit manager;

(14) "Pharmacy ~~benefits~~ benefit manager," ~~an entity~~a person that performs pharmacy ~~benefits~~ benefit management~~. The term~~, pursuant to a contract or other relationship with a third-party payor and includes ~~a~~:

(a) A person ~~or entity~~ acting ~~for a pharmacy benefits manager~~ in a contractual or employment relationship ~~in the performance of~~ for a pharmacy benefit

manager while providing pharmacy ~~benefits~~ benefit management for a covered entity; and~~includes mail~~

(b) A mail service pharmacy~~. The term does not include a health carrier licensed pursuant to Title 58 when the health carrier or its subsidiary is providing pharmacy benefits management to its own insureds; or a public self-funded pool or a private single employer self-funded plan that provides such benefits or services directly to its beneficiaries~~;

~~(8)~~(15) "Pharmacy benefit manager affiliate," a pharmacy that, or a pharmacist who, directly or indirectly, through one or more intermediaries, owns or controls, is owned and controlled by, or is under common ownership or control of, a pharmacy benefit manager;

(16) "Pharmacy benefit manager duty," a duty imposed upon a pharmacy benefit manager to provide to the Division of Insurance, during any action under section 18 of this Act:

(a) The amount charged or claimed by the pharmacy benefit manager in a format that allows the division to identify all instances of spread pricing; and

(b) Information regarding shared ownership interest, by any person defined in this section;

(17) "Pharmacy network," pharmacies that have contracted with a pharmacy benefit manager to dispense or sell prescription drugs to individuals covered under a health benefit plan for which the prescription drug benefit is managed by a pharmacy benefit manager;

(18) "Prescription drug," a drug classified by the United States Food and Drug Administration as requiring a prescription by a health care practitioner, prior to being administered or dispensed to a patient, and including interchangeable biological products, brand names, and generic drugs;

(19) "Prescription drug benefit," a health benefit plan providing third-party payment or prepayment for prescription drugs;

(20) "Prescription drug order," a practitioner's written or oral order, for a drug or a drug device, for a specific patient;

(21) "Proprietary information," information on pricing, costs, revenue, taxes, market share, negotiating strategies, customers, and personnel held by a private ~~entities~~entity and used for that private entity's business purposes;

~~(9)~~(22) "Rebate," a discount or other negotiated price concession that is paid directly or indirectly to a pharmacy benefit manager by a pharmaceutical manufacturer or by an entity in the prescription drug supply chain, other than a covered individual, and which is:

(a) Based on a pharmaceutical manufacturer's list price for a prescription drug;

(b) Based on utilization;

(c) Designed to maintain, for the pharmacy benefit manager, a net price for a prescription drug, during a specified period of time, in the event the pharmaceutical manufacturer's list price increases; or

(d) Based on estimates regarding the quantity of a prescribed drug that will be dispensed by a pharmacy to covered individuals;

(23) "Spread pricing," an amount charged or claimed by a pharmacy benefit manager that is in excess of the ingredient cost for a dispensed prescription drug, plus a dispensing fee paid directly or indirectly to a pharmacy, pharmacist, or other provider, on behalf of the third-party payor, less a pharmacy benefit management fee;

(24) "Third-party payor," any entity, other than a covered individual, a covered individual's representative, or a healthcare provider, which is responsible for any amount of reimbursement for a prescription drug benefit, provided the term includes a health carrier and a health benefit plan;

(25) "Trade secret," information, including a formula, pattern, compilation, program, device, method, technique, or process, that:

(a) Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and

(b) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy;

(26) "Unaffiliated pharmacy," a dispensing pharmacy that is not:

(a) Owned, in whole or in part, by a pharmacy benefit manager;

(b) A subsidiary of a pharmacy benefit manager; or

(c) An affiliate of a pharmacy benefit manager; and

(27) "Wholesale distributor," any person engaged in wholesale distribution, but not including:

(a) A manufacturer;

(b) A manufacturer's co-licensed partner;

(c) A repackager; or

(d) A third-party logistics provider.

Section 2. That § 58-29E-2 be AMENDED:

58-29E-2. ~~No~~ A person ~~or entity~~ may ~~perform or~~ not act as a pharmacy ~~benefits~~ benefit manager in this state without a ~~valid~~ license to operate as a third party administrator pursuant to chapter 58-29D. Sections 58-29D-26 and 58-29D-29 do not apply to pharmacy benefits managers.

Section 3. That § 58-29E-3 be AMENDED:

58-29E-3. Each pharmacy ~~benefits~~ benefit manager shall perform its duties ~~exercising~~ in good faith and with fair dealing toward the ~~covered entity~~third-party payor.

Section 4. That § 58-29E-4 be AMENDED:

58-29E-4. A ~~covered entity~~third-party payor may request that ~~any~~ a pharmacy ~~benefits~~ benefit manager, with which it has a pharmacy ~~benefits~~ benefit management services contract, disclose to the ~~covered entity,~~third-party payor the amount of all rebate revenues and the nature, type, and amounts of all other revenues that the pharmacy ~~benefits~~ benefit manager receives from each pharmaceutical manufacturer ~~or labeler~~ with ~~whom~~ which the pharmacy ~~benefits~~ benefit manager has a contract.~~The~~

Annually, at the time of contract renewal, the pharmacy ~~benefits~~ benefit manager shall disclose in writing:

(1) The aggregate amount, and for a list of drugs to be specified in the contract, the specific amount, of all rebates and other retrospective utilization discounts that are received by the pharmacy ~~benefits~~ benefit manager, directly or indirectly, from each pharmaceutical manufacturer ~~or labeler that~~, and which are earned in connection with the dispensing of prescription drugs to covered individuals of the health benefit plans issued by the ~~covered entity~~third-party payor or for which the ~~covered entity~~third-party payor is the designated administrator;

(2) The nature, type, and amount of all other revenue received by the pharmacy ~~benefits~~ benefit manager, directly or indirectly, from each pharmaceutical manufacturer ~~or labeler~~, for any other products or services, provided to the pharmaceutical manufacturer ~~or labeler~~ by the pharmacy ~~benefits~~ benefit manager,

with respect to programs that the ~~covered entity~~third-party payor offers or provides to its ~~enrollees~~covered individuals; and

(3) Any prescription drug utilization information requested by the ~~covered entity~~third-party payor and relating to covered individuals.

A pharmacy ~~benefits~~ benefit manager shall, within thirty days, provide ~~such~~ the information requested ~~by the covered entity for such disclosure within thirty days of receipt of the request~~in accordance with this section.

If requested, the information ~~shall~~ must be provided no less than once each year.

The contract entered into between the pharmacy ~~benefits~~ benefit manager and the ~~covered entity shall~~ third-party payor must set forth any fees to be charged for drug utilization reports requested by the ~~covered entity~~ third-party payor.

Section 5. That § 58-29E-5 be AMENDED:

58-29E-5. A pharmacy ~~benefits~~ benefit manager, unless authorized pursuant to the terms of its contract with a ~~covered entity~~third-party payor, may not contact any covered individual, without the express written permission of the ~~covered entity~~third-party payor.

Section 6. That § 58-29E-6 be AMENDED:

58-29E-6. Except for utilization information, a ~~covered entity~~third-party payor shall maintain ~~any~~ information disclosed in response to a request ~~pursuant to~~ under § 58-29E-4 as confidential and proprietary information, and may not use ~~such~~ that information for any other purpose or disclose ~~such~~ that information to any other person, except as provided in this chapter or in the pharmacy ~~benefits~~ benefit management services contract between the parties.

~~Any covered entity who~~A third-party payor that discloses information, in violation of this section, is subject to an action for injunctive relief and is liable for any damages ~~which~~ that are the direct and proximate result of ~~such~~ the disclosure.

Nothing in this section prohibits a ~~covered entity~~ third-party payor from disclosing confidential or proprietary information to the director of the Division of Insurance, upon request. ~~Any such information~~Information obtained by the director in accordance with this section is confidential and privileged, and is not open to public inspection or disclosure.

Section 7. That § 58-29E-7 be AMENDED:

58-29E-7. ~~The covered entity may have the pharmacy benefits manager's books and records related to the rebates or other information described in subdivisions 58-29E-4(1), (2), and (3), to the extent the information relates directly or indirectly to such covered entity's contract, audited in accordance with the terms of the pharmacy benefits management services contract between the parties. However, if the parties have not expressly provided for audit rights and the pharmacy benefits manager has advised the covered entity that other reasonable options are available and subject to negotiation, the covered entity may have such books and records audited as follows:~~

~~(1) Such audits may be conducted no more frequently than once in each twelve-month period upon not less than thirty business days' written notice to the pharmacy benefits manager;~~

~~(2) The covered entity may select an independent firm to conduct such audit, and such independent firm shall sign a confidentiality agreement with the covered entity and the pharmacy benefits manager ensuring that all information obtained during such audit will be treated as confidential. The firm may not use, disclose, or otherwise reveal any such information in any manner or form to any person or entity except as otherwise permitted under the confidentiality agreement. The covered entity shall treat all information obtained as a result of the audit as confidential, and may not use or disclose such information except as may be otherwise permitted under the terms of the contract between the covered entity and the pharmacy benefits manager or if ordered by a court of competent jurisdiction for good cause shown;~~

~~(3) Any such audit shall be conducted at the pharmacy benefits manager's office where such records are located, during normal business hours, without undue interference with the pharmacy benefits manager's business activities, and in accordance with reasonable audit procedures.~~

A third-party payor that has contracted with a licensed pharmacy benefit manager may audit the pharmacy benefit manager once each calendar year. The audit authorized by this section is in addition to any other statutory or contractual audit rights. As part of the audit, a third-party payor may request:

(1) All reimbursements paid to retail pharmacies, on a claim level, for all customers of the pharmacy benefit manager in this state, including ancillary charges, claw backs, dispensing fees, drug-specific reimbursements, other fees, rebates, and reimbursement adjustments;

(2) Differences in reimbursement amounts paid to affiliated and unaffiliated pharmacies, including differences in dispensing fees and reimbursed ingredient costs;

(3) Historical claims data, including:

(a) Acquisition costs;

(b) Administrative fees associated with claims;

(c) Amounts paid by a covered individual;

(d) Amounts paid by a third-party payor;

(e) Channels, whether mail or retail;

(f) Dispensing fees;

(g) Formulary tiers;

(h) Ingredient costs;

(i) Ingredient quantity;

(j) Sales tax;

(k) Supply availability by the number of days; and

(l) Usual and customary prices; and

(4) Aggregate rebate amounts, received by calendar quarter, directly or indirectly from manufacturers, including rebates from other entities affiliated with or related to the pharmacy benefit manager, if those entities negotiate or contract with manufacturers.

A pharmacy benefit manager shall, within thirty days, provide the information requested in accordance with this section, together with a certification, signed by the chief executive officer or the chief financial officer of the pharmacy benefit manager, attesting to the accuracy and completeness of the information.

Section 8. That chapter 58-29E be amended with a NEW SECTION:

A third-party payor that has contracted with a licensed pharmacy benefit manager may not publish, or directly or indirectly disclose:

(1) Any information that reveals the identity of a specific third-party payor or manufacturer;

(2) Prices charged for a specific drug or class of drugs;

(3) The amount of any rebates provided for a specific drug or class of drugs; or

(4) Any information that has the potential to compromise the financial, competitive, or proprietary nature of the pharmacy benefit manager's business.

The information referenced in ~~this section~~ § 58-29E-7 is protected from disclosure as confidential and proprietary. The information is privileged and not open to public inspection or disclosure.

A third-party payor that has contracted with a licensed pharmacy benefit manager shall impose the confidentiality protections set forth in ~~this section~~ § 58-29E-7 on any vendor or third party that may receive or have access to the information.

Section 9. That § 58-29E-8 be AMENDED:

58-29E-8. ~~With regard to the dispensation of a substitute prescription drug for a prescribed drug to a covered individual, when the pharmacy benefits manager requests a substitution, the following provisions apply:~~

~~(1) The~~A pharmacy ~~benefits~~ benefit manager may request ~~the substitution of~~ that a lower-priced generic and therapeutically equivalent prescription drug be dispensed to a covered individual, as a substitute for a higher-priced ~~prescribed~~ prescription drug~~;~~

~~(2) With regard to substitutions in which~~.

If the substitute prescription drug's net cost is ~~more~~ higher for the covered individual or the ~~covered entity~~third-party payor than the originally prescribed drug, the substitution ~~must~~ may be made only for medical reasons that benefit the covered individual.

If a substitution is being requested pursuant to this ~~subdivision~~section, the pharmacy ~~benefits~~ benefit manager ~~shall~~ must obtain the approval of the prescribing health professional.

Nothing in this section permits the substitution of an equivalent drug product contrary to § 36-11-46.2.

Section 10. That § 58-29E-8.1 be AMENDED:

58-29E-8.1. A pharmacy ~~benefits~~ benefit manager may neither prohibit a pharmacist or pharmacy from, nor penalize a pharmacist or pharmacy for ~~providing cost-sharing information on the amount a covered individual may pay for a particular~~, informing an individual about:

(1) The cost of a prescription drug;

(2) The amount of reimbursement that the pharmacy will receive for dispensing the prescription drug;

(3) The cost and clinical efficacy of a more affordable alternative prescription drug, if one is available; and

(4) Any differential between the amount an individual would pay under the individual's prescription drug benefit and a lower price the individual would pay for the prescription drug, if the individual obtained the prescription drug without making a claim for benefits on the individual's prescription drug benefit.

Section 11. That § 58-29E-10 be AMENDED:

58-29E-10. ~~Any covered entity~~A third-party payor may bring a civil action to enforce ~~the provisions of~~ this chapter or ~~to~~ seek civil damages for ~~the~~ a violation of ~~its provisions~~this chapter.

Section 12. That § 58-29E-12 be AMENDED:

58-29E-12. ~~No~~ A pharmacy benefit manager ~~shall~~ may not contractually require a pharmacy~~, who~~ that is a participating provider in a health benefit plan provided by a ~~covered entity, to charge~~ ~~or collect~~ third-party payor, from charging a covered individual or collecting from ~~an insured~~a covered individual a cost share for a prescription drug or pharmacy service that exceeds the amount retained by the pharmacist or pharmacy from all payment sources, for ~~the~~ filling ~~of~~ the prescription or providing the pharmacy service.

Section 13. That § 58-29E-13 be AMENDED:

58-29E-13. ~~No~~ A pharmacy benefit manager ~~contracting with a covered entity shall~~may not, directly or indirectly, retroactively adjust a claim for reimbursement submitted by a pharmacy for a prescription drug, unless ~~the adjustment is a result of either of the following~~:

(1) ~~A~~ The adjustment is necessitated by a pharmacy audit conducted in accordance with chapter 58-29F;~~or~~

(2) ~~A~~ The adjustment is necessitated by a technical billing error;

(3) The original claim was found to have been fraudulently submitted; or

(4) The claim submission was a duplicate for which the pharmacy had already received payment.

Section 14. That chapter 58-29E be amended with a NEW SECTION:

A pharmacy benefit manager may not assess, charge, or collect, from a pharmacy or pharmacist, any remuneration or fee, including:

(1) An accreditation fee;

(2) A brand effective rate fee;
(3) A claim processing fee;
(4) A credentialing fee;
(5) A dispensing fee;
(6) An effective rate fee;
(7) A generic effective rate fee;
(8) A pharmacy network participation fee; and
(9) A performance-based fee.

Section 15. That chapter 58-29E be amended with a NEW SECTION:

Prior to placing a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that the prescription drug is:
(1) Listed as therapeutically and pharmaceutically equivalent in the latest edition of, or any supplement to, the Food and Drug Administration's publication entitled Approved Drug Products with Therapeutic Equivalence Evaluations, as adopted by the State Board of Pharmacy, in rules promulgated pursuant to chapter 1-26;
(2) Not obsolete or temporarily unavailable; and
(3) Available for purchase, without limitation, by every pharmacy in this state, from a national or regional wholesale distributor licensed in this state.

Section 16. That chapter 58-29E be amended with a NEW SECTION:

A pharmacy benefit manager shall:
(1) Provide each pharmacy in a pharmacy network with reasonable access to each maximum allowable cost list to which the pharmacy is subject;
(2) Update a maximum allowable cost list, within seven calendar days from the date of any increase, at or above ten percent, in the price charged for a prescription drug on the list by one or more wholesale distributors doing business in this state;
(3) Update the maximum allowable cost list, within seven calendar days from the date of any change in the methodology, or any change in the value of a variable applied in the methodology, on which the maximum allowable cost list is based; and
(4) Provide a process under which each pharmacy in a pharmacy network may receive prompt notice of any change in a maximum allowable cost list to which the pharmacy is subject.

Section 17. That chapter 58-29E be amended with a NEW SECTION:

A pharmacy benefit manager may not reimburse any pharmacy located in this state an amount that is less than that which the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for dispensing the same prescription drug as that dispensed by the pharmacy.

The reimbursement amount must be calculated on a per unit basis, using the same generic product identifier or generic code number.

Section 18. That chapter 58-29E be amended with a NEW SECTION:

The director of the Division of Insurance may deny an application for licensure as a pharmacy benefit manager, may deny an application for the renewal of a pharmacy benefit manager license, and may suspend or revoke the license of a pharmacy benefit manager, if the director determines that the pharmacy benefit manager:

(1) Is in an unsound financial condition;

(2) Is using methods or practices that are potentially hazardous or injurious to covered individuals, third-party payors, or providers;

(3) Has failed to pay, within sixty days, any final judgment entered against it;

(4) Has violated any statute or rule, or an order of the director;

(5) Has refused:

(a) To be examined;

(b) To produce its accounts, records, and files for examination; or

(c) To provide information regarding its business or any duties set forth in this chapter;

(6) Has, without just cause:

(a) Refused to pay proper claims or perform services arising under its contracts;

(b) Required providers to accept less than the amount due them; or

(c) Required covered individuals to threaten or initiate legal action in order to secure their full payment or the settlement of their claims;

(7) Is affiliated with or under the same general management or interlocking directorate or ownership as another pharmacy benefit manager that transacts business in this state without a license;

(8) Fails to meet or continue meeting any qualification required for the issuance of an initial license;

(9) Has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony, without regard to whether adjudication was withheld;

(10) Has a license that is under suspension or revocation in another state; or

(11) Has provided false or misleading information to the director.

Section 19. That § 58-29E-11 be REPEALED:

~~The provisions of this chapter apply only to pharmacy benefits management services contracts entered into or renewed after June 30, 2004.~~