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Indicates New Matter

AMENDED

May 8, 2019

**S. 359**

Introduced by Senators Gambrell, Johnson, Senn, Grooms, Cromer and Scott

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Read the first time March 13, 2019.

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING ARTICLE 21 TO CHAPTER 71, TITLE 38 SO AS TO ESTABLISH A LICENSE REQUIREMENT FOR PHARMACY BENEFITS MANAGERS, TO PROHIBIT A PHARMACY BENEFITS MANAGER FROM RESTRICTING OR PENALIZING A PHARMACY FROM DISCLOSING CERTAIN INFORMATION, TO PROHIBIT A PHARMACY BENEFITS MANAGER FROM UNDERTAKING CERTAIN ACTIONS, TO SET CERTAIN REQUIREMENTS FOR A MAXIMUM ALLOWABLE COST LIST, AND TO AUTHORIZE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE TO ENFORCE THE PROVISIONS OF THIS ARTICLE; TO AMEND SECTION 38‑2‑10, AS AMENDED, RELATING TO ADMINISTRATIVE PENALTIES, SO AS TO APPLY CERTAIN ADMINISTRATIVE PENALTIES TO PHARMACY BENEFITS MANAGERS; TO AMEND SECTION 38‑71‑1810, RELATING TO PHARMACY AUDIT RIGHTS, SO AS TO ALLOW A PHARMACY TO SUBMIT RECORDS IN AN ELECTRONIC FORMAT OR BY CERTIFIED MAIL AND TO PROHIBIT CERTAIN ERRORS FROM SERVING AS THE SOLE BASIS OF THE REJECTION OF A CLAIM; AND TO REPEAL ARTICLE 20 OF CHAPTER 71, TITLE 38 RELATING TO PHARMACY BENEFIT MANAGERS.

Amend Title To Conform

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Article 21

Pharmacy Benefits Managers

Section 38‑71‑2200. As used in this article:

(1) ‘Claim’ means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering, filling, or refilling a prescription for a drug or for providing a medical supply or device.

(2) ‘Claims processing services’ means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(a) receiving payments for pharmacist services;

(b) making payments to pharmacists or pharmacies for pharmacist services; or

(c) both receiving and making payments.

(3) ‘Health benefit plan’ means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this State as defined in Section 38‑71‑670(6) and 38‑71‑840(14), including the state health plan as defined in Section 1‑11‑710. Notwithstanding this section, the state health plan is not subject to the provisions of this title unless specifically referenced.

(4) ‘Health care insurer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑670(7) and Section 38‑71‑840(16).

(5) ‘Maximum Allowable Cost List’ means a listing of generic drugs used by a pharmacy benefits manager to set the maximum allowable cost at which reimbursement to a pharmacy or pharmacist may be made.

(6) ‘Other prescription drug or device services’ means services other than claims processing services, provided directly or indirectly by a pharmacy benefits manager, whether in connection with or separate from claims processing services, including without limitation:

(a) negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;

(b) disbursing or distributing rebates;

(c) managing or participating in incentive programs or arrangements for pharmacist services;

(d) negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(e) developing formularies;

(f) designing prescription benefit programs; or

(g) advertising or promoting services.

(7) ‘Pharmacist’ has the same meaning as provided in Section 40‑43‑30(65).

(8) ‘Pharmacist services’ means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(9) ‘Pharmacy’ has the same meaning as provided in Section 40‑43‑30(67).

(10) ‘Pharmacy benefits manager’ means an entity that contracts with pharmacists or pharmacies on behalf of an insurer, third party administrator, or the South Carolina Public Employee Benefit Authority to:

(a) process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(b) pay pharmacies or pharmacists for prescription drugs or medical supplies; or

(c) negotiate rebates with manufacturers for drugs paid for or procured as described in this article.

(11) ‘Pharmacy benefits manager affiliate’ means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager.

Section 38‑71‑2210. “(A)(1) A person or organization may not establish or operate as a pharmacy benefits manager in this State for health benefit plans without obtaining a license from the Director of the Department of Insurance.

(2) Before granting a license, the director or his designee must be satisfied that the pharmacy benefits manager is competent, trustworthy, financially responsible, has a good personal and business reputation, has not had a professional or business license revoked, suspended, or denied in any jurisdiction within the preceding five years, and has not been convicted of a crime involving fraud, dishonesty, or moral turpitude in any jurisdiction. For purposes of this item, ‘convicted’ includes a plea of guilty or of nolo contendere.

(3) The director shall prescribe the application for a license to operate in this State as a pharmacy benefits manager and may charge an initial application fee of one thousand dollars and an annual renewal fee of five hundred dollars, provided the pharmacy benefits manager application form must collect the following information:

(a) the name, address, and telephone contact number of the pharmacy benefits manager;

(b) the name and address of the pharmacy benefits manager’s agent for service of process in the State;

(c) the name and address of each person with management or control over the pharmacy benefits manager;

(d) the name and address of each person with a beneficial ownership interest in the pharmacy benefits manager;

(e) a signed statement indicating that, to the best of their knowledge, no officer with management or control of the pharmacy benefit manager has been convicted of a felony or has violated any of the requirements of state law applicable to pharmacy benefits managers, or, if the applicant cannot provide such a statement, a signed statement describing the relevant conviction or violation; and

(f) a copy of the most recent fiscal year‑end audited financial statement of the pharmacy benefits manager; and

(g) in the case of a pharmacy benefits manager applicant that is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders:

(i) the applicant shall specify its legal structure and the total number of its partners, members, or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing ten percent or more of the voting securities of any other person;

(ii) the applicant shall agree that, upon request by the department, it shall furnish the department with information regarding the name, address, usual occupation, and professional qualifications of any other partners, members, or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing ten percent or more of the voting securities of any other person; and

(iii) the applicant or a pharmacy benefits manager that is licensed to conduct business in the State shall, unless otherwise provided for in this chapter, file a notice describing any material modification of this information.

(4) The director or his designee may revoke or suspend the license issued to a pharmacy benefits manager if he finds that:

(i) a condition exists which would have prohibited the issuance of the original license;

(ii) the pharmacy benefits manager has violated a provision of this chapter; or

(iii) the pharmacy benefits manager has deceived or dealt unjustly with the citizens of this State.

In lieu of revocation or suspension of a license, the director or his designee may impose an administrative monetary penalty not to exceed one thousand dollars for each offense.”

“Section 38‑71‑2220. (A) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any health care information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by the insurer or any other information the pharmacist deems appropriate within their scope of practice.

(B) A pharmacy or pharmacist must not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available, but a pharmacy benefits manager may proscribe a pharmacy or pharmacist from sharing proprietary or confidential information.

(C) A pharmacy benefits manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the director, law enforcement, or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager’s compliance with the requirements pursuant to this act. The information or data acquired during an examination or review pursuant to this section is considered proprietary and confidential and is not subject to the South Carolina Freedom of Information Act.”

Section 38‑71‑2230. (A) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:

(1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;

(2) charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for the receipt and processing of a pharmacy claim;

(3) engage, with the express intent or purpose of driving out competition or financially injuring competitors, in a pattern or practice of reimbursing independent pharmacies or pharmacists in this State consistently less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services;

(4) collect or require a pharmacy or pharmacist to collect from an insured a copayment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) the contracted copayment amount;

(b) the amount an individual would pay for a prescription drug if that individual was paying cash; or

(c) the contracted amount for the drug.

(5) require the use of mail order for filling prescriptions unless required to do so by the health benefit plan or the health benefit plan design;

(6) charge a fee related to the adjudication of a claim without providing the cause for each adjustment or fee;

(7) penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this chapter;

(8) prohibit a pharmacist or pharmacy from offering and providing direct and limited delivery services including incidental mailing services, to an insured as an ancillary service of the pharmacy; or

(9) any combination thereof.

(B) A claim for pharmacist services may not be retroactively denied or reduced after adjudication of the claim unless the:

(1) original claim was submitted fraudulently;

(2) original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services;

(3) pharmacist services were not properly rendered by the pharmacy or pharmacist; or

(4) adjustment was agreed upon by the pharmacy prior to the denial or reduction.

(C) This subsection may not be construed to limit overpayment recovery efforts as set forth in Section 38‑59‑250.

A pharmacy may not be subject to a charge‑back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy.

(D) Termination of a pharmacy or pharmacist from a pharmacy benefits manager network does not release the pharmacy benefits manager from the obligation to make any payment due to the pharmacy or pharmacist for pharmacist services properly rendered according to the contract.

(E) A pharmacy benefits manager may maintain more than one network for different pharmacy services. Each individual network may require different pharmacy accreditation standards or certification requirements for participating in the network provided that the pharmacy accreditation standards or certification requirements are applied without regard to a pharmacy’s or pharmacist’s status as an independent pharmacy or pharmacy benefits manager affiliate. Each individual pharmacy location as identified by its National Council for Prescription Drug Program identification number may have access to more than one network so long as the pharmacy location meets the pharmacy accreditation standards or certification requirements of each network.

(F) Nothing in this article abridges the right of a pharmacist to refuse to fill or refill a prescription as referenced in Section 40‑43‑86(E)(6) of the South Carolina Pharmacy Practice Act.

(G) Nothing in this article may be construed to require a pharmacy benefits manager to allow participation in a network that would not be required by Section 38‑71‑147.

(H)(1) A pharmacy benefits manager:

(A) owes a fiduciary duty to a health care insurer client and must discharge that duty in accordance with the provisions of applicable state and federal law;

(B) must perform its duties with care, skill, prudence, diligence, and professionalism; and

(C) must notify a health care insurer client in writing of any activity, policy, or practice of the pharmacy benefits manager that directly or indirectly presents a conflict of interest with the duties imposed pursuant to this section;

(2) A health care insurer or pharmacy benefits manager is prohibited from penalizing, requiring, or providing financial incentives including variations in premiums, deductibles, copayments, or coinsurance to covered persons as incentives to use a specific retail pharmacy, mail order pharmacy, or other network pharmacy provider in which a pharmacy benefits manager has an ownership interest or that has an interest in a pharmacy benefits manager.

Section 38‑71‑2240. (A) Before a pharmacy benefits manager places or continues to place a particular drug on a Maximum Allowable Cost List, the drug must:

(1) be listed as ‘A’ or ‘B’ rated in the most recent version of the Food and Drug Administration’s Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an ‘NR’ or ‘NA’ rating, or a similar rating, by a nationally recognized reference;

(2) be available for purchase in the state from national or regional wholesalers operating in this State; and

(3) not be obsolete.

(B) A pharmacy benefits manager shall:

(1) provide a process for network pharmacy providers to readily access the maximum allowable cost specific to that provider;

(2) update its Maximum Allowable Cost List at least once every seven calendar days;

(3) provide a process for each pharmacy subject to the Maximum Allowable Cost List to access any updates to the Maximum Allowable Cost List;

(4) ensure that dispensing fees are not included in the calculation of maximum allowable cost; and

(5) establish a reasonable administrative appeal procedure by which a contracted pharmacy can appeal the provider’s reimbursement for a drug subject to maximum allowable cost pricing if the reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. The reasonable administrative appeal procedure must include:

(a) a dedicated telephone number and email address or website for the purpose of submitting administrative appeals;

(b) the ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the pharmacy benefits manager that allows for the submission of such appeals.

(C) A pharmacy must be allowed no less than ten calendar days after the applicable fill date to file an administrative appeal.

(D) If an appeal is initiated, the pharmacy benefits manager shall within ten calendar days after receipt of notice of the appeal either:

(1) if the appeal is upheld:

(a) notify the pharmacy or pharmacist or his designee of the decision;

(b) make the change in the maximum allowable cost effective as of the date the appeal is resolved;

(c) permit the appealing pharmacy or pharmacist to reverse and rebill the claim in question; and

(d) make the change effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List effective as of the date the appeal is resolved; or

(2) if the appeal is denied, provide the appealing pharmacy or pharmacist the reason for the denial, the National Drug Code number, and the name of the national or regional pharmaceutical wholesalers operating in this State.

(E) The provisions of this section:

(1) do not apply to the Maximum Allowable Cost List maintained by the State Medicaid Program, the Medicaid managed care organizations under contract with the South Carolina Department of Health and Human Services or the South Carolina Public Employee Benefit Authority; and

(2) apply to the pharmacy benefits manager employed by the South Carolina Public Employee Benefit Authority if, at any time, the South Carolina Public Employee Benefit Authority engages the services of a pharmacy benefits manager to maintain the Maximum Allowable Cost List.

Section 38‑71‑2250. (A) The director shall enforce this article.

(B)(1) The director may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan that are relevant to determining if the pharmacy benefits manager is in compliance with this act. The pharmacy benefits manager shall pay the charges incurred in the examination, including the expenses of the director or his designee and the expenses and compensation of his examiners and assistants. The director or his designee promptly shall institute a civil action to recover the expenses of examination against a pharmacy benefits manager which refuses or fails to pay.

(2) The information or data acquired during an examination pursuant to this section is considered proprietary and confidential and is not subject to the South Carolina Freedom of Information Act.

(C) Violations of this article are subject to the penalties provided in Sections 38‑2‑10 through 38‑2‑30.

(D) The director may promulgate regulations regarding pharmacy benefits managers that are not inconsistent with this article.

“Section 38‑71‑2255. Every pharmacy benefits manager shall file and maintain with the department a surety bond in favor of the State. The surety bond must be issued by a corporate surety authorized to issue surety bonds in this State in the sum of one million dollars and must be subject to lawful levy of execution by a party to whom the licensee has been found to be legally liable. The surety bond must be maintained at all time by the pharmacy benefits manager while licensed with the department. The director may reduce the required amount of the surety bond if the amount is unreasonable relative to the size of the pharmacy benefits manager’s business operations in this State and would cause a significant financial hardship.

Section 38‑71‑2257. Every pharmacy benefits manager shall file by March first with the department, in the form and detail the director of his designee prescribes, a statement showing the business standing and financial condition of the pharmacy benefits manager as December thirty‑first of the preceding year.

Section 38‑71‑2260. (A) Nothing in this act is intended or may be construed to be in conflict with existing relevant federal law.

(B) This article does not apply to the South Carolina Department of Health and Human Services in the performance of its duties in administering Medicaid under Titles XIX and XXI of the Social Security Act or to the Medicaid managed care organizations under contract with the South Carolina Department of Health and Human Services.”

Section 38‑71‑2270. (A) Beginning June 1, 2020, and annually thereafter, a licensed pharmacy benefits manager must submit a transparency report containing data from the prior calendar year to the Department of Insurance. The transparency report must contain the:

(1) aggregate amount of all rebates received from all pharmaceutical manufacturers for all health care insurer clients and for each health care insurer client individually;

(2) aggregate administrative fees received from all manufacturers for all health care insurer clients and for each care insurer client individually;

(3) aggregate retained rebates received from all pharmaceutical manufacturers that did not pass through to health care insurers;

(4) aggregate retained rebate percentage; and

(5) highest, lowest, and mean aggregate retained rebate percentage for all health care insurer clients and each client individually.

(B) A pharmacy benefits manager submitting information to the department may designate the information as a trade secret. However, disclosure may be ordered by a court of appropriate jurisdiction for good cause shown or made in a court filing.

(C) Within sixty days of receipt of the report, the department must publish the transparency report of each pharmacy benefits manager on the agency’s website in a way that does not release any proprietary and trade secret information.

(D) The department may impose a civil penalty of not more than one thousand dollars per day per violation of this Section.

Section 38‑71‑2280. (A)(1) The Director of the Department of Insurance may review and approve the compensation program of a pharmacy benefits manager with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan under the standards adopted by the Department of Insurance.

(2) All information and data acquired is considered proprietary and confidential and not subject to the provisions of South Carolina Freedom of Information Act.

Section 38‑71‑2290. (A) The Director of the Department of Insurance may adopt rules regulating pharmacy benefits managers that are not inconsistent with this Act.

(B) Rules that the Director may adopt under this Act include without limitation rules relating to:

(1) Licensing;

(2) Application fees;

(3) Financial solvency requirements;

(4) Pharmacy benefits manager network adequacy;

(5) Prohibited market conduct practices;

(6) Data reporting requirements under State price‑gouging laws

(7) Compliance and enforcement requirements under State laws concerning Maximum Allowable Cost Lists;

(8) Rebates;

(9) Prohibitions and limitations on the corporate practice of medicine (CPOM);

(10) Compensation; and

(11) Lists of health benefit plans administered by a pharmacy benefits manager in this State.

(C) Rules adopted under this Act shall set penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure for violations of this Act and rules adopted under this Act.

Section 38-71-2285. Any rebate from a pharmaceutical manufacturer must be awarded or redeemable in such a manner so as to accrue to the benefit of the customer.

SECTION 2. Section 38‑2‑10 of the 1976 Code, as last amended by Act 219 of 2018, is further amended to read:

“Section 38‑2‑10. (A) Unless otherwise specifically provided by law, the following administrative penalties apply for each violation of the insurance laws of this State or federal insurance laws subject to enforcement by the Department of Insurance:

(1) If the violator is an insurer, pharmacy benefits manager, or a health maintenance organization licensed in this State, the director or his designee shall fine the violator in an amount not to exceed fifteen thousand dollars, suspend or revoke the violator’s authority to do business in this State, or both. If the violation is wilful, the director or his designee shall fine the violator in an amount not to exceed thirty thousand dollars, suspend or revoke the violator’s authority to do business in this State, or both.

(2) If the violator is a person, other than an insurer, pharmacy benefits manager, or a health maintenance organization, licensed by the director or his designee in this State, the director or his designee shall fine the person in an amount not to exceed two thousand five hundred dollars, suspend or revoke the license of the person, or both. If the violation is wilful, the director or his designee shall fine the person in an amount not to exceed five thousand dollars, suspend or revoke the license of the person, or both.

(B) The penalties in subsection (A) are in addition to any criminal penalties provided by law or any other remedies provided by law. The administrative proceedings in subsection (A) do not preclude civil or criminal proceedings from taking place before, during, or after the administrative proceeding.”

SECTION 3. A. Section 38‑71‑1810(B) of the 1976 is amended to read:

“(B) If a managed care organization, insurer, third‑party payor, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, then, with respect to this audit, the pharmacy has a right to:

(1) have at least fourteen days’ advance notice of the initial audit for each audit cycle with no audit to be initiated or scheduled during the first five days of any month without the express consent of the pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days;

(2) have an audit that involves clinical judgment be conducted with a pharmacist who is licensed and employed by or working under contract with the auditing entity;

(3) not have clerical or record‑keeping errors, including typographical errors, scrivener’s errors and computer errors, on a required document or record considered fraudulent in the absence of any other evidence or serve as the sole basis of rejection of a claim; however, the provisions of this item do not prohibit recoupment of fraudulent payments;

(4) have~~, if required under the terms of the contract with the auditing entity,~~ the auditing entity to provide the pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media;

(5) submit records related to the audit in electronic format or by certified mail;

(6) have the properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication approved by the auditing entity in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug pursuant to federal and state regulations;

~~(6)~~(7) have a projection of an overpayment or underpayment based on either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; however, the provisions of this item do not prohibit recoupments of actual overpayments unless the projection for overpayment or underpayment is part of a settlement by the pharmacy;

~~(7)~~(8) be free of recoupments based on either of the following subitems unless defined within the billing, submission, or audit requirements set forth in the pharmacy provider manual not inconsistent with current State Board of Pharmacy Regulations, except for cases of Food and Drug Administration regulation or drug manufacturer safety programs in accordance with federal or state regulations:

(a) documentation requirements in addition to, or exceeding requirements for, creating or maintaining documentation prescribed by the State Board of Pharmacy;

(b) a requirement that a pharmacy or pharmacist perform a professional duty in addition to, or exceeding, professional duties prescribed by the State Board of Pharmacy unless otherwise agreed to by contract with the auditing entity;

~~(8)~~(9) be subject, so long as a claim is made within the contractual claim submission time period, to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim unless a prescription error occurs. For purposes of this subsection, a prescription error includes, but is not limited to, wrong drug, wrong strength, wrong dose, or wrong patient;

~~(9)~~(10) be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements;

~~(10)~~(11) be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity;

~~(11)~~(12) have at least thirty days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit;

(13) have the option of providing documentation in electronic format or by certified mail;

~~(12)~~(14) have the period covered by an audit limited to twenty‑four months from the date a claim was submitted to, or adjudicated by, a managed care organization, an insurer, a third‑party payor, or an entity that represents responsible parties, unless a longer period is permitted by or under federal law;

~~(13)~~(15) have the preliminary audit report delivered to the pharmacy within one hundred twenty days after conclusion of the audit;

~~(14)~~(16) have a final audit report delivered to the pharmacy within ninety days after the end of the appeals period; and

~~(15)~~(17) not have the accounting practice of extrapolation used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans.”

B. The provisions of this section are effective upon approval by the Governor.

SECTION 4. Article 20 of Chapter 71, Title 38 is repealed.

SECTION 5. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this Act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 6. Except for Section 38-71-2220 in SECTION 1 and SECTION 3, this act takes effect on January 1, 2021. The provisions of Section 38-71-2220 in SECTION 1 and SECTION 3 take effect upon approval by the Governor.

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