**PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION ACT (EXCERPT)**
**Act 11 of 2022**

## 550.815 Definitions; A to I.

Sec. 5. As used in this act:

(a) "Affiliated pharmacy" means, except as otherwise provided in this subdivision, a network pharmacy that directly, or indirectly through 1 or more intermediaries, controls, is controlled by, or is under common control with, a pharmacy benefit manager. As used in section 19, affiliated pharmacy does not include a pharmacy that controls, is controlled by, or is under common control with, a hospital as that term is defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106.

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

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

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

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

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

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

(*i*) Receiving payments for pharmacist services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**History:** 2022, Act 11, Eff. Jan. 1, 2024.