

SECOND REGULAR SESSION

HOUSE BILL NO. 1677

101ST GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE WRIGHT.

4311H.01I

DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 338.015, 376.387, and 376.388, RSMo, and to enact in lieu thereof five new sections relating to payments for prescription drugs, with penalty provisions.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 338.015, 376.387, and 376.388, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 103.200, 338.015, 376.387, 376.388, and 376.414, to read as follows:

103.200. 1. For purposes of this section, the following terms mean:

(1) "Pharmacy", the same meaning given to the term in section 338.210;

(2) "Plan", the Missouri consolidated health care plan as described in section 103.005;

(3) "Rebate", any discount, negotiated concession, or other payment provided by a pharmaceutical manufacturer, pharmacy, or health benefit plan to an entity to sell, provide, pay, or reimburse a pharmacy or other entity in the state for the dispensation or administration of a prescription drug on behalf of itself or another entity.

2. Before March 1, 2024, and annually thereafter, the pharmacy benefits manager utilized by the Missouri consolidated health care plan shall file a report with the plan for the immediately preceding calendar year. The report shall contain the following information regarding the plan:

(1) The aggregate dollar amount of all rebates that the pharmacy benefits manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs that:

(a) Were covered by the plan during such calendar year; and

EXPLANATION — Matter enclosed in bold-faced brackets **[thus]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

17 (b) Were attributable to patient utilization of such drugs during such calendar
18 year; and

19 (2) The aggregate dollar amount of all rebates, excluding any portion of the
20 rebates received by the plan, concerning drug formularies that the pharmacy benefits
21 manager collected from pharmaceutical manufacturers that manufactured outpatient
22 prescription drugs that:

23 (a) Were covered by the plan during such calendar year; and

24 (b) Were attributable to patient utilization of such drugs by covered persons
25 under the plan during such calendar year.

26 3. In consultation with its pharmacy benefits manager, the plan shall establish a
27 form for reporting the information required under subsection 2 of this section. The
28 form shall be designed to minimize the administrative burden and cost of reporting on
29 the plan and its pharmacy benefits manager.

30 4. No documents, materials, or other information submitted to the plan under
31 subsection 2 of this section shall be subject to disclosure under chapter 610, except to the
32 extent they are included on an aggregated basis in the reports required under subsection
33 5 of this section. The plan shall not disclose information submitted under subsection 2
34 of this section in a manner that:

35 (1) Is likely to compromise the financial, competitive, or proprietary nature of
36 such information; or

37 (2) Would enable a third party to identify the value of a rebate provided for a
38 particular outpatient prescription drug or therapeutic class of outpatient prescription
39 drugs.

40 5. (1) Before July 1, 2024, and annually thereafter, the plan shall submit a report
41 to the standing committees of the general assembly having jurisdiction over health
42 insurance matters. The report shall contain an aggregation of the information
43 submitted to the plan under subdivision (1) of subsection 2 of this section for the
44 immediately preceding calendar year and such other information as the plan in its
45 discretion deems relevant for the purposes of this section. The plan shall provide its
46 pharmacy benefits manager and any third party affected by submission of a report
47 required by this subsection with a written notice describing the content of the report.

48 (2) Before July 1, 2024, and annually thereafter, the plan shall prepare a report
49 for the immediately preceding calendar year describing the rebate practices of the plan
50 and its pharmacy benefits manager. The plan shall provide the report to the standing
51 committees of the general assembly having jurisdiction over health insurance matters
52 and the director of the department of commerce and insurance. The report shall
53 contain:

54 (a) An explanation of the manner in which the plan accounted for rebates in
55 calculating premiums for such year;

56 (b) A statement disclosing whether, and describing the manner in which, the
57 plan made rebates available to enrollees at the point of purchase during such year;

58 (c) A statement describing any other manner in which the plan applied rebates
59 during such year; and

60 (d) Such other information as the plan in its discretion deems relevant for the
61 purposes of this section.

62 6. The plan may impose a penalty of no more than seven thousand five hundred
63 dollars on its pharmacy benefits manager for each violation of this section.

338.015. 1. The provisions of sections 338.010 to 338.015 shall not be construed to
2 inhibit the patient's freedom of choice to obtain prescription services from any licensed
3 pharmacist **or pharmacy**. ~~[However, nothing in sections 338.010 to 338.315 abrogates the~~
4 ~~patient's ability to waive freedom of choice under any contract with regard to payment or~~
5 ~~coverage of prescription expense.]~~

6 2. All pharmacists may provide pharmaceutical consultation and advice to persons
7 concerning the safe and therapeutic use of their prescription drugs.

8 3. All patients shall have the right to receive a written prescription from their
9 prescriber to take to the facility of their choice or to have an electronic prescription
10 transmitted to the facility of their choice.

11 4. No pharmacy benefits manager, as defined in section 376.388, shall prohibit or
12 redirect by contract, or otherwise penalize or restrict, a covered person, as defined in
13 section 376.387, from obtaining prescription services, consultation, or advice from a
14 contracted pharmacy, as defined in section 376.388.

376.387. 1. For purposes of this section, the following terms shall mean:

2 (1) "Covered person", ~~[the same meaning as such term is defined in section 376.1257]~~
3 **a policyholder, subscriber, enrollee, or other individual who receives prescription drug**
4 **coverage through a pharmacy benefits manager;**

5 (2) "Health benefit plan", the same meaning as such term is defined in section
6 376.1350;

7 (3) "Health carrier" or "carrier", the same meaning as such term is defined in section
8 376.1350;

9 (4) "Pharmacy", the same meaning as such term is defined in chapter 338;

10 (5) "Pharmacy benefits manager", the same meaning as such term is defined in
11 section 376.388.

12 2. No pharmacy benefits manager shall include a provision in a contract entered into
13 or modified on or after August 28, 2018, with a pharmacy or pharmacist that requires a

14 covered person to make a payment for a prescription drug at the point of sale in an amount
15 that exceeds the lesser of:

16 (1) The copayment amount as required under the health benefit plan; or

17 (2) The amount an individual would pay for a prescription if that individual paid with
18 cash.

19 3. A pharmacy or pharmacist shall have the right to provide to a covered person
20 information regarding the amount of the covered person's cost share for a prescription drug,
21 the covered person's cost of an alternative drug, and the covered person's cost of the drug
22 without adjudicating the claim through the pharmacy benefits manager. Neither a pharmacy
23 nor a pharmacist shall be proscribed by a pharmacy benefits manager from discussing any
24 such information or from selling a more affordable alternative to the covered person.

25 4. No pharmacy benefits manager shall, directly or indirectly, charge or hold a
26 pharmacist or pharmacy responsible for any fee amount related to a claim that is not known at
27 the time of the claim's adjudication, unless the amount is a result of improperly paid claims
28 ~~[or charges for administering a health benefit plan].~~

29 5. ~~[This section shall not apply with respect to claims under Medicare Part D, or any~~
30 ~~other plan administered or regulated solely under federal law, and to the extent this section~~
31 ~~may be preempted under the Employee Retirement Income Security Act of 1974 for self-~~
32 ~~funded employer-sponsored health benefit plans.~~

33 ~~6.]~~ A pharmacy benefits manager shall notify in writing any health carrier with which
34 it contracts if the pharmacy benefits manager has a conflict of interest, any commonality of
35 ownership, or any other relationship, financial or otherwise, between the pharmacy benefits
36 manager and any other health carrier with which the pharmacy benefits manager contracts.

37 ~~[7.]~~ **6. Any entity that enters into a contract to sell, provide, pay, or reimburse a**
38 **pharmacy in the state for prescription drugs on behalf of itself or another entity shall**
39 **define and apply the term "generic", with respect to prescription drugs, to mean any**
40 **"authorized generic drug", as defined in 21 CFR 314.3, approved under section 505(c)**
41 **of the Federal Food, Drug, and Cosmetic Act, as amended.**

42 7. Any entity that enters into a contract to sell, provide, pay, or reimburse a
43 pharmacy in the state for prescription drugs on behalf of itself or another entity shall
44 define and apply the term "rebate" as having the same meaning given to the term in
45 section 103.200.

46 8. A pharmacy benefits manager that has contracted with an entity to provide
47 pharmacy benefit management services for such an entity shall owe a fiduciary duty to
48 that entity, and shall discharge that duty in accordance with federal and state law.

49 9. The department of commerce and insurance shall enforce this section.

376.388. 1. As used in this section, unless the context requires otherwise, the following terms shall mean:

(1) "Contracted pharmacy" [~~or "pharmacy"~~], a pharmacy located in Missouri participating in the network of a pharmacy benefits manager through a direct or indirect contract;

(2) [~~"Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract 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, except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;~~

~~(3)~~ "Maximum allowable cost", the per-unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding a dispensing or professional fee;

[~~(4)~~] (3) "Maximum allowable cost list" or "MAC list", a listing of drug products that meet the standard described in this section;

[~~(5)~~] (4) "Pharmacy", as such term is defined in chapter 338;

[~~(6)~~] (5) "Pharmacy benefits manager", an entity that [~~contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state~~] administers or manages a pharmacy benefits plan or program;

(6) "Pharmacy benefits manager affiliate", 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;

(7) "Pharmacy benefits plan or program", a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in this state.

2. Upon each contract execution or renewal between a pharmacy benefits manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:

(1) Include in such contract or renewal the sources utilized to determine maximum allowable cost and update such pricing information at least every seven days; and

(2) Maintain a procedure to eliminate products from the maximum allowable cost list of drugs subject to such pricing or modify maximum allowable cost pricing at least every

38 seven days, if such drugs do not meet the standards and requirements of this section, in order
39 to remain consistent with pricing changes in the marketplace.

40 3. A pharmacy benefits manager shall reimburse pharmacies for drugs subject to
41 maximum allowable cost pricing that has been updated to reflect market pricing at least every
42 seven days as set forth under subdivision (1) of subsection 2 of this section.

43 4. A pharmacy benefits manager shall not place a drug on a maximum allowable cost
44 list unless there are at least two therapeutically equivalent multisource generic drugs, or at
45 least one generic drug available from at least one manufacturer, generally available for
46 purchase by network pharmacies from national or regional wholesalers.

47 5. (1) All contracts between a pharmacy benefits manager and a contracted pharmacy
48 or between a pharmacy benefits manager and a pharmacy's contracting representative or
49 agent, such as a pharmacy services administrative organization, shall include a process to
50 internally appeal, investigate, and resolve disputes regarding maximum allowable cost
51 pricing. The process shall include the following:

52 ~~[(1)]~~ (a) The right to appeal shall be limited to fourteen calendar days following the
53 reimbursement of the initial claim; and

54 ~~[(2)]~~ (b) A requirement that the pharmacy benefits manager shall respond to an
55 appeal described in this subsection no later than fourteen calendar days after the date the
56 appeal was received by such pharmacy benefits manager.

57 **(2) If a reimbursement to a contracted pharmacy is below the pharmacy's cost to**
58 **purchase the drug, the pharmacy benefits manager shall sustain an appeal and increase**
59 **reimbursement to the pharmacy and other contracted pharmacies to cover the cost of**
60 **purchasing the drug.**

61 **(3) A pharmacy benefits manager shall not reimburse a pharmacy or**
62 **pharmacist in the state an amount less than the amount that the pharmacy benefits**
63 **manager reimburses a pharmacy benefits manager affiliate for providing the same**
64 **pharmacist services.**

65 6. For appeals that are denied, the pharmacy benefits manager shall provide the
66 reason for the denial and identify the national drug code of a drug product that may be
67 purchased by contracted pharmacies at a price at or below the maximum allowable cost and,
68 when applicable, may be substituted lawfully.

69 7. If the appeal is successful, the pharmacy benefits manager shall:

70 (1) Adjust the maximum allowable cost price that is the subject of the appeal effective
71 on the day after the date the appeal is decided;

72 (2) Apply the adjusted maximum allowable cost price to all similarly situated
73 pharmacies as determined by the pharmacy benefits manager; and

74 (3) Allow the pharmacy that succeeded in the appeal to reverse and rebill the
75 pharmacy benefits claim giving rise to the appeal.

76 8. Appeals shall be upheld if:

77 (1) The pharmacy being reimbursed for the drug subject to the maximum allowable
78 cost pricing in question was not reimbursed as required under subsection 3 of this section; or

79 (2) The drug subject to the maximum allowable cost pricing in question does not meet
80 the requirements set forth under subsection 4 of this section.

376.414. 1. For purposes of this section, the following terms mean:

2 (1) "340B drug", a drug that is:

3 (a) A covered outpatient drug as defined in Section 340B of the Public Health
4 Service Act, 42 U.S.C. Section 256b, enacted by Section 602 of the Veterans Health Care
5 Act of 1992, Pub. L. 102-585; and

6 (b) Purchased under an agreement entered into under 42 U.S.C. Section 256b;

7 (2) "Covered entity", the same meaning given to the term in Section 340B(a)(4)
8 of the Public Health Service Act, 42 U.S.C. Section 256b(a)(4);

9 (3) "Health carrier", the same meaning given to the term in section 376.1350;

10 (4) "Pharmacy benefits manager", the same meaning given to the term in section
11 376.388;

12 (5) "Specified pharmacy", a pharmacy licensed under chapter 338 with which a
13 covered entity has contracted to dispense 340B drugs on behalf of the covered entity
14 regardless of whether the 340B drugs are distributed in person or through the mail.

15 2. A health carrier or pharmacy benefits manager shall not discriminate against
16 a covered entity or a specified pharmacy by doing any of the following:

17 (1) Reimbursing a covered entity or specified pharmacy for a quantity of a 340B
18 drug in an amount less than such health carrier or pharmacy benefits manager would
19 pay to any other similarly situated pharmacy that is not a covered entity or a specified
20 pharmacy for such quantity of such drug on the basis that the entity or pharmacy is a
21 covered entity or specified pharmacy or that the entity or pharmacy dispenses 340B
22 drugs;

23 (2) Imposing any terms or conditions on covered entities or specified pharmacies
24 that differ from such terms or conditions applied to other similarly situated pharmacies
25 that are not covered entities or specified pharmacies on the basis that the entity or
26 pharmacy is a covered entity or specified pharmacy or that the entity or pharmacy
27 dispenses 340B drugs including, but not limited to, terms or conditions with respect to
28 any of the following:

29 (a) Fees, chargebacks, clawbacks, adjustments, or other assessments;

30 (b) Professional dispensing fees;

31 (c) Restrictions or requirements regarding participation in standard or
32 preferred pharmacy networks;

33 (d) Requirements relating to the frequency or scope of audits or to inventory
34 management systems using generally accepted accounting principles; and

35 (e) Any other restrictions, conditions, practices, or policies that, as specified by
36 the director of the department of commerce and insurance, interfere with the ability of a
37 covered entity to maximize the value of discounts provided under 42 U.S.C. Section
38 256b;

39 (3) Interfering with an individual's choice to receive a 340B drug from a covered
40 entity or specified pharmacy, whether in person or via direct delivery, mail, or other
41 form of shipment;

42 (4) Requiring a covered entity or specified pharmacy to identify, either directly
43 or through a third party, 340B drugs; or

44 (5) Refusing to contract with a covered entity or specified pharmacy for reasons
45 other than those that apply equally to entities or pharmacies that are not covered
46 entities or specified pharmacies, or on the basis that:

47 (a) The entity or pharmacy is a covered entity or a specified pharmacy; or

48 (b) The entity or pharmacy is described in any of subparagraphs (A) to (O) of 42
49 U.S.C. Section 256b(a)(4).

50 3. The director of the department of commerce and insurance shall impose a
51 civil penalty on any pharmacy benefits manager that violates the requirements of this
52 section. Such penalty shall not exceed five thousand dollars per violation per day.

53 4. The director of the department of commerce and insurance shall promulgate
54 rules to implement the provisions of this section. Any rule or portion of a rule, as that
55 term is defined in section 536.010, that is created under the authority delegated in this
56 section shall become effective only if it complies with and is subject to all of the
57 provisions of chapter 536 and, if applicable, section 536.028. This section and chapter
58 536 are nonseverable, and if any of the powers vested with the general assembly
59 pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul
60 a rule are subsequently held unconstitutional, then the grant of rulemaking authority
61 and any rule proposed or adopted after August 28, 2022, shall be invalid and void.

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