

FIRST REGULAR SESSION

HOUSE BILL NO. 834

101ST GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE WRIGHT.

1731H.011

DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 338.015, 376.387, and 376.388, RSMo, and to enact in lieu thereof four 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Section A. Sections 338.015, 376.387, and 376.388, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 103.200, 338.015, 376.387, and 376.388, to read as follows: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, 2023, 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 rebates
20 received by the plan, concerning drug formularies that the pharmacy benefits manager
21 collected from pharmaceutical manufacturers that manufactured outpatient prescription
22 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 under
25 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 form
28 shall be designed to minimize the administrative burden and cost of reporting on the plan
29 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 of
34 this section in a manner that:

35 (1) Is likely to compromise the financial, competitive, or proprietary nature of such
36 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, 2023, 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 submitted
43 to the plan under subdivision (1) of subsection 2 of this section for the immediately
44 preceding calendar year and such other information as the plan in its discretion deems
45 relevant for the purposes of this section. The plan shall provide its pharmacy benefits
46 manager and any third party affected by submission of a report required by this subsection
47 with a written notice describing the content of the report.

48 (2) Before July 1, 2023, and annually thereafter, the plan shall prepare a report for
49 the immediately preceding calendar year describing the rebate practices of the plan and
50 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 and
52 the director of the department of commerce and insurance. The report shall contain:

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

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

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

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

61 6. The plan may impose a penalty of no more than seven thousand five hundred
62 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 prescriber
9 to take to the facility of their choice or to have an electronic prescription transmitted to the
10 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 376.1350;

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

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

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

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

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

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

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

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

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

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

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

36 ~~[7.]~~ **6. Any entity that enters into a contract to sell, provide, pay, or reimburse a**
37 **pharmacy in the state for prescription drugs on behalf of itself or another entity shall**
38 **define and apply the term "generic", with respect to prescription drugs, to mean any**
39 **"authorized generic drug", as defined in 21 CFR 314.3, approved under section 505(c) of**
40 **the Federal Food, Drug, and Cosmetic Act, as amended.**

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

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

48 **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)]~~ (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 seven days, if such drugs do not meet the standards and requirements of this section, in order to remain consistent with pricing changes in the marketplace.

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

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

43 5. **(1)** All contracts between a pharmacy benefits manager and a contracted pharmacy
44 or between a pharmacy benefits manager and a pharmacy's contracting representative or agent,
45 such as a pharmacy services administrative organization, shall include a process to internally
46 appeal, investigate, and resolve disputes regarding maximum allowable cost pricing. The
47 process shall include the following:

48 ~~[(4)]~~ **(a)** The right to appeal shall be limited to fourteen calendar days following the
49 reimbursement of the initial claim; and

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

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

57 **(3) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist**
58 **in the state an amount less than the amount that the pharmacy benefits manager**
59 **reimburses a pharmacy benefits manager affiliate for providing the same pharmacist**
60 **services.**

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

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

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

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

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

72 8. Appeals shall be upheld if

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

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

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