FIRST REGULAR SESSION

SENATE BILL NO. 45

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR FITZWATER.

0644S.02I KRISTINA MARTIN, Secretary

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.

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Section A. Sections 338.015, 376.387, and 376.388, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 338.015, 376.387, 376.388, and 376.448, to read as follows:

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

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

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

4. Notwithstanding any provision of law to the contrary, no pharmacy benefits manager, as defined in section 376.388, shall prohibit or redirect by contract, or

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

otherwise penalize or restrict, a covered person, as defined in section 376.387, from obtaining prescription services, consultation, or advice from a contracted pharmacy, as defined in section 376.388.

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

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

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

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

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

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

(6) "Pharmacy benefits manager rebate aggregator", any entity that negotiates with a pharmaceutical manufacturer on behalf of a pharmacy benefits manager for a rebate;

(7) "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. No pharmacy benefits manager shall include a provision in a contract entered into or modified on or after August 28, 2018, with a pharmacy or pharmacist that requires a covered person to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

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

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

3. A pharmacy or pharmacist shall have the right to:

(1) Provide to a covered person information regarding the amount of the covered person's cost share for a prescription drug, the covered person's cost of an alternative drug, and the covered person's cost of the drug without adjudicating the claim through the pharmacy benefits manager. Neither a pharmacy nor a pharmacist shall be proscribed by a pharmacy benefits manager from discussing any such information or from selling a more affordable alternative to the covered person; **and**

(2) Provide to a plan sponsor any information related to the sponsor's plan that does not disclose information about a specific covered person's prescription use.

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

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

6.**]** A pharmacy benefits manager shall notify in writing any health carrier with which it contracts if the pharmacy benefits manager has a conflict of interest, any

commonality of ownership, or any other relationship, financial or otherwise, between the pharmacy benefits manager and any other health carrier with which the pharmacy benefits manager contracts.

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

7. An entity shall define and apply the term "rebate" as having the same meaning given to the term in this section if the entity enters into a contract to sell, provide, pay, negotiate rebates for, or reimburse a pharmacy, pharmacy benefits manager, pharmacy benefits manager affiliate as defined in section 376.388, or pharmacy benefits manager rebate aggregator for prescription drugs on behalf of itself or another entity.

8. A pharmacy benefits manager that has contracted with an entity to provide pharmacy benefits management services for such an entity or any person who negotiates with a pharmacy benefits manager on behalf of a purchaser of health care benefits shall owe a fiduciary duty to that entity or purchaser of health care benefits, and shall discharge that duty in accordance with federal and state law.

9. Any entity that enters into a contract to sell, provide, pay, or reimburse a pharmacy in the state for prescription drugs on behalf of itself or another entity shall not prohibit a plan sponsor or a contracted pharmacy, as defined in section 376.388, from discussing any health benefit plan information or costs.

10. It shall be unlawful for any pharmacy benefits manager or any person acting on its behalf to charge a health benefit plan or payer a different amount for a prescription drug's ingredient cost or dispensing fee than the amount the pharmacy benefits manager reimburses a pharmacy for the prescription drug's ingredient cost or dispensing fee if the pharmacy benefits manager retains any amount of such difference.

[7.**]** **11.** 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 prescription drugs and 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.

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

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

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

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

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

(2) If a reimbursement to a contracted pharmacy is below the pharmacy's cost to purchase and dispense the drug, the pharmacy may decline to dispense the prescription.

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

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

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

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

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

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

8. Appeals shall be upheld if:

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

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

376.448. 1. As used in this section, the following terms mean:

(1) "Cost-sharing", any co-payment, coinsurance, deductible, amount paid by an enrollee for health care services in excess of a coverage limitation, or similar charge required by or on behalf of an enrollee in order to receive a specific health care service covered by a health benefit plan, whether covered under medical benefits or pharmacy benefits. The term "cost-sharing" shall include cost-sharing as defined in 42 U.S.C. Section 18022(c);

(2) "Enrollee", the same meaning given to the term in section 376.1350;

(3) "Generic drug", the same meaning given to the term in 42 CFR 423.4;

(4) "Health benefit plan", the same meaning given to the term in section 376.1350;

(5) "Health care service", the same meaning given to the term in section 376.1350;

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

(7) "Pharmacy benefits manager", the same meaning given to the term in section 376.388.

2. When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health benefit plan, a health carrier or pharmacy benefits manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee for any medication where a generic drug substitute for such medication is not available.

3. No health carrier or pharmacy benefits manager shall vary an enrollee's out-of-pocket maximum or any cost sharing requirement, or otherwise design benefits in a

manner that takes into account the availability of any cost-sharing assistance program, for any medication where a generic drug substitute for such medication is not available.

4. If, under federal law, application of the requirements under subsection 2 or 3 of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code of 1986, as amended, the requirement under that subsection shall apply to health savings account-qualified high deductible health plans with respect to any cost-sharing of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except with respect to items or services that are preventive care under Section 223(c)(2)(C) of the Internal Revenue Code of 1986, as amended, in which case the requirement of that subsection shall apply regardless of whether the minimum deductible under Section 223 has been satisfied.

5. Nothing in this section shall prohibit a health carrier or health benefit plan from utilizing step therapy pursuant to section 376.2034.

6. The provisions of this section shall not apply to health benefit plans covered under the federal Labor Management Relations Act of 1947, as amended.

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