MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative Hobgood-Wilkes To: Insurance

HOUSE BILL NO. 1298

1 AN ACT TO REQUIRE PHARMACY BENEFIT MANAGERS TO UTILIZE AND
2 ADHERE TO THE NATIONAL AVERAGE DRUG ACQUISITION COST THAT APPEARS
3 ON THE NATIONAL AVERAGE DRUG ACQUISITION COST LIST WHEN
4 DETERMINING THE INGREDIENT DRUG PRODUCT COMPONENT OF A PHARMACY'S
5 REIMBURSEMENT FOR DRUGS; TO PROHIBIT A PHARMACY BENEFIT MANAGER
6 FROM PAYING OR REIMBURSING A PHARMACY OR PHARMACIST FOR THE
7 INGREDIENT DRUG PRODUCT COMPONENT OF PHARMACIST SERVICES IN AN
8 AMOUNT THAT IS LESS THAN THE NATIONAL AVERAGE DRUG ACQUISITION
9 COST; TO BRING FORWARD SECTIONS 73-21-156, 73-21-153, 73-21-155,
10 73-21-157, 73-21-159, 73-21-161, 73-21-163, 83-9-6 AND 83-9-6.4,
11 MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE PHARMACY BENEFIT
12 PROMPT PAY ACT AND ACCIDENT AND HEALTH INSURANCE, FOR PURPOSES OF
13 POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

15 **SECTION 1.** A pharmacy benefits manager shall utilize and
16 adhere to the national average drug acquisition cost that appears
17 on the national average drug acquisition cost list when
18 determining the ingredient drug product component of a pharmacy's
19 reimbursement for drugs.

20 A pharmacy benefits manager shall not pay or reimburse a
21 pharmacy or pharmacist for the ingredient drug product component
22 of pharmacist services in an amount that is less than the national
23 average drug acquisition cost. If the national average drug

24 acquisition cost is unavailable at the time the drug is
25 administered or dispensed, the pharmacy benefit manager shall not
26 reimburse such pharmacy or pharmacist in an amount that is less
27 than the wholesale acquisition cost of the drug, as defined in
28 federal law.

29 **SECTION 2.** Section 73-21-156, Mississippi Code of 1972, is
30 brought forward as follows:

31 73-21-156. (1) As used in this section, the following terms
32 shall be defined as provided in this subsection:

33 (a) "Maximum allowable cost list" means a listing of
34 drugs or other methodology used by a pharmacy benefit manager,
35 directly or indirectly, setting the maximum allowable payment to a
36 pharmacy or pharmacist for a generic drug, brand-name drug,
37 biologic product or other prescription drug. The term "maximum
38 allowable cost list" includes without limitation:

39 (i) Average acquisition cost, including national
40 average drug acquisition cost;

41 (ii) Average manufacturer price;

42 (iii) Average wholesale price;

43 (iv) Brand effective rate or generic effective
44 rate;

45 (v) Discount indexing;

46 (vi) Federal upper limits;

47 (vii) Wholesale acquisition cost; and

48 (viii) Any other term that a pharmacy benefit
49 manager or a health care insurer may use to establish
50 reimbursement rates to a pharmacist or pharmacy for pharmacist
51 services.
52 (b) "Pharmacy acquisition cost" means the amount that a
53 pharmaceutical wholesaler charges for a pharmaceutical product as
54 listed on the pharmacy's billing invoice.
55 (2) Before a pharmacy benefit manager places or continues a
56 particular drug on a maximum allowable cost list, the drug:
57 (a) If the drug is a generic equivalent drug product as
58 defined in 73-21-73, shall be listed as therapeutically equivalent
59 and pharmaceutically equivalent "A" or "B" rated in the United
60 States Food and Drug Administration's most recent version of the
61 "Orange Book" or "Green Book" or have an NR or NA rating by
62 Medi-Span, Gold Standard, or a similar rating by a nationally
63 recognized reference approved by the board;
64 (b) Shall be available for purchase by each pharmacy in
65 the state from national or regional wholesalers operating in
66 Mississippi; and
67 (c) Shall not be obsolete.
68 (3) A pharmacy benefit manager shall:
69 (a) Provide access to its maximum allowable cost list
70 to each pharmacy subject to the maximum allowable cost list;
71 (b) Update its maximum allowable cost list on a timely
72 basis, but in no event longer than three (3) calendar days; and

73 (c) Provide a process for each pharmacy subject to the
74 maximum allowable cost list to receive prompt notification of an
75 update to the maximum allowable cost list.
76 (4) A pharmacy benefit manager shall:
77 (a) Provide a reasonable administrative appeal
78 procedure to allow pharmacies to challenge a maximum allowable
79 cost list and reimbursements made under a maximum allowable cost
80 list for a specific drug or drugs as:
81 (i) Not meeting the requirements of this section;
82 or
83 (ii) Being below the pharmacy acquisition cost.
84 (b) The reasonable administrative appeal procedure
85 shall include the following:
86 (i) A dedicated telephone number, email address
87 and website for the purpose of submitting administrative appeals;
88 (ii) The ability to submit an administrative
89 appeal directly to the pharmacy benefit manager regarding the
90 pharmacy benefit management plan or through a pharmacy service
91 administrative organization; and
92 (iii) A period of less than thirty (30) business
93 days to file an administrative appeal.
94 (c) The pharmacy benefit manager shall respond to the
95 challenge under paragraph (a) of this subsection (4) within thirty
96 (30) business days after receipt of the challenge.

97 (d) If a challenge is made under paragraph (a) of this
98 subsection (4), the pharmacy benefit manager shall within thirty
99 (30) business days after receipt of the challenge either:
100 (i) If the appeal is upheld:
101 1. Make the change in the maximum allowable
102 cost list payment to at least the pharmacy acquisition cost;
103 2. Permit the challenging pharmacy or
104 pharmacist to reverse and rebill the claim in question;
105 3. Provide the National Drug Code that the
106 increase or change is based on to the pharmacy or pharmacist; and
107 4. Make the change under item 1 of this
108 subparagraph (i) effective for each similarly situated pharmacy as
109 defined by the payor subject to the maximum allowable cost list;
110 or
111 (ii) If the appeal is denied, provide the
112 challenging pharmacy or pharmacist the National Drug Code and the
113 name of the national or regional pharmaceutical wholesalers
114 operating in Mississippi that have the drug currently in stock at
115 a price below the maximum allowable cost as listed on the maximum
116 allowable cost list; or
117 (iii) If the National Drug Code provided by the
118 pharmacy benefit manager is not available below the pharmacy
119 acquisition cost from the pharmaceutical wholesaler from whom the
120 pharmacy or pharmacist purchases the majority of prescription
121 drugs for resale, then the pharmacy benefit manager shall adjust

122 the maximum allowable cost as listed on the maximum allowable cost
123 list above the challenging pharmacy's pharmacy acquisition cost
124 and permit the pharmacy to reverse and rebill each claim affected
125 by the inability to procure the drug at a cost that is equal to or
126 less than the previously challenged maximum allowable cost.
127 (5) (a) A pharmacy benefit manager shall not reimburse a
128 pharmacy or pharmacist in the state an amount less than the amount
129 that the pharmacy benefit manager reimburses a pharmacy benefit
130 manager affiliate for providing the same pharmacist services.
131 (b) The amount shall be calculated on a per unit basis
132 based on the same brand and generic product identifier or brand
133 and generic code number.
134 **SECTION 3.** Section 73-21-153, Mississippi Code of 1972, is
135 brought forward as follows:
136 73-21-153. For purposes of Sections 73-21-151 through
137 73-21-163, the following words and phrases shall have the meanings
138 ascribed herein unless the context clearly indicates otherwise:
139 (a) "Board" means the State Board of Pharmacy.
140 (b) "Commissioner" means the Mississippi Commissioner
141 of Insurance.
142 (c) "Day" means a calendar day, unless otherwise
143 defined or limited.
144 (d) "Electronic claim" means the transmission of data
145 for purposes of payment of covered prescription drugs, other
146 products and supplies, and pharmacist services in an electronic

147 data format specified by a pharmacy benefit manager and approved
148 by the department.
149 (e) "Electronic adjudication" means the process of
150 electronically receiving, reviewing and accepting or rejecting an
151 electronic claim.
152 (f) "Enrollee" means an individual who has been
153 enrolled in a pharmacy benefit management plan.
154 (g) "Health insurance plan" means benefits consisting
155 of prescription drugs, other products and supplies, and pharmacist
156 services provided directly, through insurance or reimbursement, or
157 otherwise and including items and services paid for as
158 prescription drugs, other products and supplies, and pharmacist
159 services under any hospital or medical service policy or
160 certificate, hospital or medical service plan contract, preferred
161 provider organization agreement, or health maintenance
162 organization contract offered by a health insurance issuer.
163 (h) "Pharmacy benefit manager" shall have the same
164 definition as provided in Section 73-21-179. However, through
165 June 30, 2014, the term "pharmacy benefit manager" shall not
166 include an insurance company that provides an integrated health
167 benefit plan and that does not separately contract for pharmacy
168 benefit management services. From and after July 1, 2014, the
169 term "pharmacy benefit manager" shall not include an insurance
170 company unless the insurance company is providing services as a
171 pharmacy benefit manager as defined in Section 73-21-179, in which

172 case the insurance company shall be subject to Sections 73-21-151
173 through 73-21-159 only for those pharmacy benefit manager
174 services. In addition, the term "pharmacy benefit manager" shall
175 not include the pharmacy benefit manager of the Mississippi State
176 and School Employees Health Insurance Plan or the Mississippi
177 Division of Medicaid or its contractors when performing pharmacy
178 benefit manager services for the Division of Medicaid.
179 (i) "Pharmacy benefit manager affiliate" means a
180 pharmacy or pharmacist that directly or indirectly, through one or
181 more intermediaries, owns or controls, is owned or controlled by,
182 or is under common ownership or control with a pharmacy benefit
183 manager.
184 (j) "Pharmacy benefit management plan" shall have the
185 same definition as provided in Section 73-21-179.
186 (k) "Pharmacist," "pharmacist services" and "pharmacy"
187 or "pharmacies" shall have the same definitions as provided in
188 Section 73-21-73.
189 (l) "Uniform claim form" means a form prescribed by
190 rule by the State Board of Pharmacy; however, for purposes of
191 Sections 73-21-151 through 73-21-159, the board shall adopt the
192 same definition or rule where the State Department of Insurance
193 has adopted a rule covering the same type of claim. The board may
194 modify the terminology of the rule and form when necessary to
195 comply with the provisions of Sections 73-21-151 through
196 73-21-159.

197 (m) "Plan sponsors" means the employers, insurance
198 companies, unions and health maintenance organizations that
199 contract with a pharmacy benefit manager for delivery of
200 prescription services.

201 **SECTION 4.** Section 73-21-155, Mississippi Code of 1972, is
202 brought forward as follows:

203 73-21-155. (1) Reimbursement under a contract to a
204 pharmacist or pharmacy for prescription drugs and other products
205 and supplies that is calculated according to a formula that uses
206 Medi-Span, Gold Standard or a nationally recognized reference that
207 has been approved by the board in the pricing calculation shall
208 use the most current reference price or amount in the actual or
209 constructive possession of the pharmacy benefit manager, its
210 agent, or any other party responsible for reimbursement for
211 prescription drugs and other products and supplies on the date of
212 electronic adjudication or on the date of service shown on the
213 nonelectronic claim.

214 (2) Pharmacy benefit managers, their agents and other
215 parties responsible for reimbursement for prescription drugs and
216 other products and supplies shall be required to update the
217 nationally recognized reference prices or amounts used for
218 calculation of reimbursement for prescription drugs and other
219 products and supplies no less than every three (3) business days.

220 (3) (a) All benefits payable under a pharmacy benefit
221 management plan shall be paid within seven (7) days after receipt

222 of due written proof of a clean claim where claims are submitted
223 electronically, and shall be paid within thirty-five (35) days
224 after receipt of due written proof of a clean claim where claims
225 are submitted in paper format. Benefits due under the plan and
226 claims are overdue if not paid within seven (7) days or
227 thirty-five (35) days, whichever is applicable, after the pharmacy
228 benefit manager receives a clean claim containing necessary
229 information essential for the pharmacy benefit manager to
230 administer preexisting condition, coordination of benefits and
231 subrogation provisions under the plan sponsor's health insurance
232 plan. A "clean claim" means a claim received by any pharmacy
233 benefit manager for adjudication and which requires no further
234 information, adjustment or alteration by the pharmacist or
235 pharmacies or the insured in order to be processed and paid by the
236 pharmacy benefit manager. A claim is clean if it has no defect or
237 impropriety, including any lack of substantiating documentation,
238 or particular circumstance requiring special treatment that
239 prevents timely payment from being made on the claim under this
240 subsection. A clean claim includes resubmitted claims with
241 previously identified deficiencies corrected.
242 (b) A clean claim does not include any of the
243 following:
244 (i) A duplicate claim, which means an original
245 claim and its duplicate when the duplicate is filed within thirty
246 (30) days of the original claim;

247 (ii) Claims which are submitted fraudulently or
248 that are based upon material misrepresentations;
249 (iii) Claims that require information essential
250 for the pharmacy benefit manager to administer preexisting
251 condition, coordination of benefits or subrogation provisions
252 under the plan sponsor's health insurance plan; or
253 (iv) Claims submitted by a pharmacist or pharmacy
254 more than thirty (30) days after the date of service; if the
255 pharmacist or pharmacy does not submit the claim on behalf of the
256 insured, then a claim is not clean when submitted more than thirty
257 (30) days after the date of billing by the pharmacist or pharmacy
258 to the insured.
259 (c) Not later than seven (7) days after the date the
260 pharmacy benefit manager actually receives an electronic claim,
261 the pharmacy benefit manager shall pay the appropriate benefit in
262 full, or any portion of the claim that is clean, and notify the
263 pharmacist or pharmacy (where the claim is owed to the pharmacist
264 or pharmacy) of the reasons why the claim or portion thereof is
265 not clean and will not be paid and what substantiating
266 documentation and information is required to adjudicate the claim
267 as clean. Not later than thirty-five (35) days after the date the
268 pharmacy benefit manager actually receives a paper claim, the
269 pharmacy benefit manager shall pay the appropriate benefit in
270 full, or any portion of the claim that is clean, and notify the
271 pharmacist or pharmacy (where the claim is owed to the pharmacist

272 or pharmacy) of the reasons why the claim or portion thereof is
273 not clean and will not be paid and what substantiating
274 documentation and information is required to adjudicate the claim
275 as clean. Any claim or portion thereof resubmitted with the
276 supporting documentation and information requested by the pharmacy
277 benefit manager shall be paid within twenty (20) days after
278 receipt.

279 (4) If the board finds that any pharmacy benefit manager,
280 agent or other party responsible for reimbursement for
281 prescription drugs and other products and supplies has not paid
282 ninety-five percent (95%) of clean claims as defined in subsection
283 (3) of this section received from all pharmacies in a calendar
284 quarter, he shall be subject to administrative penalty of not more
285 than Twenty-five Thousand Dollars ($25,000.00) to be assessed by
286 the State Board of Pharmacy.

287 (a) Examinations to determine compliance with this
288 subsection may be conducted by the board. The board may contract
289 with qualified impartial outside sources to assist in examinations
290 to determine compliance. The expenses of any such examinations
291 shall be paid by the pharmacy benefit manager examined.

292 (b) Nothing in the provisions of this section shall
293 require a pharmacy benefit manager to pay claims that are not
294 covered under the terms of a contract or policy of accident and
295 sickness insurance or prepaid coverage.

296 (c) If the claim is not denied for valid and proper
297 reasons by the end of the applicable time period prescribed in
298 this provision, the pharmacy benefit manager must pay the pharmacy
299 (where the claim is owed to the pharmacy) or the patient (where
300 the claim is owed to a patient) interest on accrued benefits at
301 the rate of one and one-half percent (1-1/2%) per month accruing
302 from the day after payment was due on the amount of the benefits
303 that remain unpaid until the claim is finally settled or
304 adjudicated. Whenever interest due pursuant to this provision is
305 less than One Dollar ($1.00), such amount shall be credited to the
306 account of the person or entity to whom such amount is owed.
307 (d) Any pharmacy benefit manager and a pharmacy may
308 enter into an express written agreement containing timely claim
309 payment provisions which differ from, but are at least as
310 stringent as, the provisions set forth under subsection (3) of
311 this section, and in such case, the provisions of the written
312 agreement shall govern the timely payment of claims by the
313 pharmacy benefit manager to the pharmacy. If the express written
314 agreement is silent as to any interest penalty where claims are
315 not paid in accordance with the agreement, the interest penalty
316 provision of subsection (4)(c) of this section shall apply.
317 (e) The State Board of Pharmacy may adopt rules and
318 regulations necessary to ensure compliance with this subsection.
319 (5) (a) For purposes of this subsection (5), "network
320 pharmacy" means a licensed pharmacy in this state that has a

321 contract with a pharmacy benefit manager to provide covered drugs
322 at a negotiated reimbursement rate. A network pharmacy or
323 pharmacist may decline to provide a brand name drug, multisource
324 generic drug, or service, if the network pharmacy or pharmacist is
325 paid less than that network pharmacy's acquisition cost for the
326 product. If the network pharmacy or pharmacist declines to
327 provide such drug or service, the pharmacy or pharmacist shall
328 provide the customer with adequate information as to where the
329 prescription for the drug or service may be filled.
330 (b) The State Board of Pharmacy shall adopt rules and
331 regulations necessary to implement and ensure compliance with this
332 subsection, including, but not limited to, rules and regulations
333 that address access to pharmacy services in rural or underserved
334 areas in cases where a network pharmacy or pharmacist declines to
335 provide a drug or service under paragraph (a) of this subsection.
336 The board shall promulgate the rules and regulations required by
337 this paragraph (b) not later than October 1, 2016.
338 (6) A pharmacy benefit manager shall not directly or
339 indirectly retroactively deny or reduce a claim or aggregate of
340 claims after the claim or aggregate of claims has been
341 adjudicated.
342 **SECTION 5.** Section 73-21-157, Mississippi Code of 1972, is
343 brought forward as follows:
344 73-21-157. (1) Before beginning to do business as a
345 pharmacy benefit manager, a pharmacy benefit manager shall obtain

346 a license to do business from the board. To obtain a license, the
347 applicant shall submit an application to the board on a form to be
348 prescribed by the board.

349 (2) Each pharmacy benefit manager providing pharmacy
350 management benefit plans in this state shall file a statement with
351 the board annually by March 1 or within sixty (60) days of the end
352 of its fiscal year if not a calendar year. The statement shall be
353 verified by at least two (2) principal officers and shall cover
354 the preceding calendar year or the immediately preceding fiscal
355 year of the pharmacy benefit manager.

356 (3) The statement shall be on forms prescribed by the board
357 and shall include:

358 (a) A financial statement of the organization,
359 including its balance sheet and income statement for the preceding
360 year; and

361 (b) Any other information relating to the operations of
362 the pharmacy benefit manager required by the board under this
363 section.

364 (4) (a) Any information required to be submitted to the
365 board pursuant to licensure application that is considered
366 proprietary by a pharmacy benefit manager shall be marked as
367 confidential when submitted to the board. All such information
368 shall not be subject to the provisions of the federal Freedom of
369 Information Act or the Mississippi Public Records Act and shall
370 not be released by the board unless subject to an order from a

371 court of competent jurisdiction. The board shall destroy or
372 delete or cause to be destroyed or deleted all such information
373 thirty (30) days after the board determines that the information
374 is no longer necessary or useful.

375 (b) Any person who knowingly releases, causes to be
376 released or assists in the release of any such information shall
377 be subject to a monetary penalty imposed by the board in an amount
378 not exceeding Fifty Thousand Dollars ($50,000.00) per violation.
379 When the board is considering the imposition of any penalty under
380 this paragraph (b), it shall follow the same policies and
381 procedures provided for the imposition of other sanctions in the
382 Pharmacy Practice Act. Any penalty collected under this paragraph
383 (b) shall be deposited into the special fund of the board and used
384 to support the operations of the board relating to the regulation
385 of pharmacy benefit managers.

386 (c) All employees of the board who have access to the
387 information described in paragraph (a) of this subsection shall be
388 fingerprinted, and the board shall submit a set of fingerprints
389 for each employee to the Department of Public Safety for the
390 purpose of conducting a criminal history records check. If no
391 disqualifying record is identified at the state level, the
392 Department of Public Safety shall forward the fingerprints to the
393 Federal Bureau of Investigation for a national criminal history
394 records check.

395 (5) If the pharmacy benefit manager is audited annually by
396 an independent certified public accountant, a copy of the
397 certified audit report shall be filed annually with the board by
398 June 30 or within thirty (30) days of the report being final.
399 (6) The board may extend the time prescribed for any
400 pharmacy benefit manager for filing annual statements or other
401 reports or exhibits of any kind for good cause shown. However,
402 the board shall not extend the time for filing annual statements
403 beyond sixty (60) days after the time prescribed by subsection (1)
404 of this section. The board may waive the requirements for filing
405 financial information for the pharmacy benefit manager if an
406 affiliate of the pharmacy benefit manager is already required to
407 file such information under current law with the Commissioner of
408 Insurance and allow the pharmacy benefit manager to file a copy of
409 documents containing such information with the board in lieu of
410 the statement required by this section.
411 (7) The expense of administering this section shall be
412 assessed annually by the board against all pharmacy benefit
413 managers operating in this state.
414 (8) A pharmacy benefit manager or third-party payor may not
415 require pharmacy accreditation standards or recertification
416 requirements inconsistent with, more stringent than, or in
417 addition to federal and state requirements for licensure as a
418 pharmacy in this state.

419 **SECTION 6.** Section 73-21-159, Mississippi Code of 1972, is
420 brought forward as follows:
421 73-21-159. (1) In lieu of or in addition to making its own
422 financial examination of a pharmacy benefit manager, the board may
423 accept the report of a financial examination of other persons
424 responsible for the pharmacy benefit manager under the laws of
425 another state certified by the applicable official of such other
426 state.
427 (2) The board shall coordinate financial examinations of a
428 pharmacy benefit manager that provides pharmacy management benefit
429 plans in this state to ensure an appropriate level of regulatory
430 oversight and to avoid any undue duplication of effort or
431 regulation. The pharmacy benefit manager being examined shall pay
432 the cost of the examination. The cost of the examination shall be
433 deposited in a special fund that shall provide all expenses for
434 the licensing, supervision and examination of all pharmacy benefit
435 managers subject to regulation under Sections 73-21-71 through
436 73-21-129 and Sections 73-21-151 through 73-21-163.
437 (3) The board may provide a copy of the financial
438 examination to the person or entity who provides or operates the
439 health insurance plan or to a pharmacist or pharmacy.
440 (4) The board is authorized to hire independent financial
441 consultants to conduct financial examinations of a pharmacy
442 benefit manager and to expend funds collected under this section
443 to pay the costs of such examinations.

444 **SECTION 7.** Section 73-21-161, Mississippi Code of 1972, is
445 brought forward as follows:
446 73-21-161. (1) As used in this section, the term "referral"
447 means:
448 (a) Ordering of a patient to a pharmacy by a pharmacy
449 benefit manager affiliate either orally or in writing, including
450 online messaging;
451 (b) Offering or implementing plan designs that require
452 patients to use affiliated pharmacies; or
453 (c) Patient or prospective patient specific
454 advertising, marketing, or promotion of a pharmacy by an
455 affiliate.
456 The term "referral" does not include a pharmacy's inclusion
457 by a pharmacy benefit manager affiliate in communications to
458 patients, including patient and prospective patient specific
459 communications, regarding network pharmacies and prices, provided
460 that the affiliate includes information regarding eligible
461 nonaffiliate pharmacies in those communications and the
462 information provided is accurate.
463 (2) A pharmacy, pharmacy benefit manager, or pharmacy
464 benefit manager affiliate licensed or operating in Mississippi
465 shall be prohibited from:
466 (a) Making referrals;
467 (b) Transferring or sharing records relative to
468 prescription information containing patient identifiable and

469 prescriber identifiable data to or from a pharmacy benefit manager
470 affiliate for any commercial purpose; however, nothing in this
471 section shall be construed to prohibit the exchange of
472 prescription information between a pharmacy and its affiliate for
473 the limited purposes of pharmacy reimbursement; formulary
474 compliance; pharmacy care; public health activities otherwise
475 authorized by law; or utilization review by a health care
476 provider; or

477 (c) Presenting a claim for payment to any individual,
478 third-party payor, affiliate, or other entity for a service
479 furnished pursuant to a referral from an affiliate.

480 (3) This section shall not be construed to prohibit a
481 pharmacy from entering into an agreement with a pharmacy benefit
482 manager affiliate to provide pharmacy care to patients, provided
483 that the pharmacy does not receive referrals in violation of
484 subsection (2) of this section and the pharmacy provides the
485 disclosures required in subsection (1) of this section.

486 (4) If a pharmacy licensed or holding a nonresident pharmacy
487 permit in this state has an affiliate, it shall annually file with
488 the board a disclosure statement identifying all such affiliates.

489 (5) In addition to any other remedy provided by law, a
490 violation of this section by a pharmacy shall be grounds for
491 disciplinary action by the board under its authority granted in
492 this chapter.

493 (6) A pharmacist who fills a prescription that violates
494 subsection (2) of this section shall not be liable under this
495 section.

496 **SECTION 8.** Section 73-21-163, Mississippi Code of 1972, is
497 brought forward as follows:

498 73-21-163. Whenever the board has reason to believe that a
499 pharmacy benefit manager or pharmacy benefit manager affiliate is
500 using, has used, or is about to use any method, act or practice
501 prohibited in Sections 73-21-151 through 73-21-163 and that
502 proceedings would be in the public interest, it may bring an
503 action in the name of the board against the pharmacy benefit
504 manager or pharmacy benefit manager affiliate to restrain by
505 temporary or permanent injunction the use of such method, act or
506 practice. The action shall be brought in the Chancery Court of
507 the First Judicial District of Hinds County, Mississippi. The
508 court is authorized to issue temporary or permanent injunctions to
509 restrain and prevent violations of Sections 73-21-151 through
510 73-21-163 and such injunctions shall be issued without bond.

511 (2) The board may impose a monetary penalty on a pharmacy
512 benefit manager or a pharmacy benefit manager affiliate for
513 noncompliance with the provisions of the Sections 73-21-151
514 through 73-21-163, in amounts of not less than One Thousand
515 Dollars ($1,000.00) per violation and not more than Twenty-five
516 Thousand Dollars ($25,000.00) per violation. Each day a violation
517 continues for the same brand or generic product identifier or

518 brand or generic code number is a separate violation. The board
519 shall prepare a record entered upon its minutes that states the
520 basic facts upon which the monetary penalty was imposed. Any
521 penalty collected under this subsection (2) shall be deposited
522 into the special fund of the board.

523 (3) The board may assess a monetary penalty for those
524 reasonable costs that are expended by the board in the
525 investigation and conduct of a proceeding if the board imposes a
526 monetary penalty under subsection (2) of this section. A monetary
527 penalty assessed and levied under this section shall be paid to
528 the board by the licensee, registrant or permit holder upon the
529 expiration of the period allowed for appeal of those penalties
530 under Section 73-21-101, or may be paid sooner if the licensee,
531 registrant or permit holder elects. Any penalty collected by the
532 board under this subsection (3) shall be deposited into the
533 special fund of the board.

534 (4) When payment of a monetary penalty assessed and levied
535 by the board against a licensee, registrant or permit holder in
536 accordance with this section is not paid by the licensee,
537 registrant or permit holder when due under this section, the board
538 shall have the power to institute and maintain proceedings in its
539 name for enforcement of payment in the chancery court of the
540 county and judicial district of residence of the licensee,
541 registrant or permit holder, or if the licensee, registrant or
542 permit holder is a nonresident of the State of Mississippi, in the

543 Chancery Court of the First Judicial District of Hinds County,
544 Mississippi. When those proceedings are instituted, the board
545 shall certify the record of its proceedings, together with all
546 documents and evidence, to the chancery court and the matter shall
547 be heard in due course by the court, which shall review the record
548 and make its determination thereon in accordance with the
549 provisions of Section 73-21-101. The hearing on the matter may,
550 in the discretion of the chancellor, be tried in vacation.
551 (5) The board shall develop and implement a uniform penalty
552 policy that sets the minimum and maximum penalty for any given
553 violation of Sections 73-21-151 through 73-21-163. The board
554 shall adhere to its uniform penalty policy except in those cases
555 where the board specifically finds, by majority vote, that a
556 penalty in excess of, or less than, the uniform penalty is
557 appropriate. That vote shall be reflected in the minutes of the
558 board and shall not be imposed unless it appears as having been
559 adopted by the board.
560 **SECTION 9.** Section 83-9-6, Mississippi Code of 1972, is
561 brought forward as follows:
562 83-9-6. (1) This section shall apply to all health benefit
563 plans providing pharmaceutical services benefits, including
564 prescription drugs, to any resident of Mississippi. This section
565 shall also apply to insurance companies and health maintenance
566 organizations that provide or administer coverages and benefits
567 for prescription drugs. This section shall not apply to any

568 entity that has its own facility, employs or contracts with
569 physicians, pharmacists, nurses and other health care personnel,
570 and that dispenses prescription drugs from its own pharmacy to its
571 employees and dependents enrolled in its health benefit plan; but
572 this section shall apply to an entity otherwise excluded that
573 contracts with an outside pharmacy or group of pharmacies to
574 provide prescription drugs and services.

575 (2) As used in this section:

576 (a) "Copayment" means a type of cost sharing whereby
577 insured or covered persons pay a specified predetermined amount
578 per unit of service with their insurer paying the remainder of the
579 charge. The copayment is incurred at the time the service is
580 used. The copayment may be a fixed or variable amount.

581 (b) "Contract provider" means a pharmacy granted the
582 right to provide prescription drugs and pharmacy services
583 according to the terms of the insurer.

584 (c) "Health benefit plan" means any entity or program
585 that provides reimbursement for pharmaceutical services.

586 (d) "Insurer" means any entity that provides or offers
587 a health benefit plan.

588 (e) "Pharmacist" means a pharmacist licensed by the
589 Mississippi State Board of Pharmacy.

590 (f) "Pharmacy" means a place licensed by the
591 Mississippi State Board of Pharmacy.

592 (3) A health insurance plan, policy, employee benefit plan
593 or health maintenance organization may not:
594 (a) Prohibit or limit any person who is a participant
595 or beneficiary of the policy or plan from selecting a pharmacy or
596 pharmacist of his choice who has agreed to participate in the plan
597 according to the terms offered by the insurer;
598 (b) Deny a pharmacy or pharmacist the right to
599 participate as a contract provider under the policy or plan if the
600 pharmacy or pharmacist agrees to provide pharmacy services,
601 including but not limited to prescription drugs, that meet the
602 terms and requirements set forth by the insurer under the policy
603 or plan and agrees to the terms of reimbursement set forth by the
604 insurer;
605 (c) Impose upon a beneficiary of pharmacy services
606 under a health benefit plan any copayment, fee or condition that
607 is not equally imposed upon all beneficiaries in the same benefit
608 category, class or copayment level under the health benefit plan
609 when receiving services from a contract provider;
610 (d) Impose a monetary advantage or penalty under a
611 health benefit plan that would affect a beneficiary's choice among
612 those pharmacies or pharmacists who have agreed to participate in
613 the plan according to the terms offered by the insurer. Monetary
614 advantage or penalty includes higher copayment, a reduction in
615 reimbursement for services, or promotion of one participating
616 pharmacy over another by these methods;

617 (e) Reduce allowable reimbursement for pharmacy
618 services to a beneficiary under a health benefit plan because the
619 beneficiary selects a pharmacy of his or her choice, so long as
620 that pharmacy has enrolled with the health benefit plan under the
621 terms offered to all pharmacies in the plan coverage area;
622 (f) Require a beneficiary, as a condition of payment or
623 reimbursement, to purchase pharmacy services, including
624 prescription drugs, exclusively through a mail-order pharmacy; or
625 (g) Impose upon a beneficiary any copayment, amount of
626 reimbursement, number of days of a drug supply for which
627 reimbursement will be allowed, or any other payment or condition
628 relating to purchasing pharmacy services from any pharmacy,
629 including prescription drugs, that is more costly or more
630 restrictive than that which would be imposed upon the beneficiary
631 if such services were purchased from a mail-order pharmacy or any
632 other pharmacy that is willing to provide the same services or
633 products for the same cost and copayment as any mail order
634 service.
635 (4) A pharmacy, by or through a pharmacist acting on its
636 behalf as its employee, agent or owner, may not waive, discount,
637 rebate or distort a copayment of any insurer, policy or plan or a
638 beneficiary’s coinsurance portion of a prescription drug coverage
639 or reimbursement and if a pharmacy, by or through a pharmacist's
640 acting on its behalf as its employee, agent or owner, provides a
641 pharmacy service to an enrollee of a health benefit plan that

642 meets the terms and requirements of the insurer under a health
643 benefit plan, the pharmacy shall provide its pharmacy services to
644 all enrollees of that health benefit plan on the same terms and
645 requirements of the insurer. A violation of this subsection shall
646 be a violation of the Pharmacy Practice Act subjecting the
647 pharmacist as a licensee to disciplinary authority of the State
648 Board of Pharmacy.
649 (5) If a health benefit plan providing reimbursement to
650 Mississippi residents for prescription drugs restricts pharmacy
651 participation, the entity providing the health benefit plan shall
652 notify, in writing, all pharmacies within the geographical
653 coverage area of the health benefit plan, and offer to the
654 pharmacies the opportunity to participate in the health benefit
655 plan at least sixty (60) days before the effective date of the
656 plan or before July 1, 1995, whichever comes first. All
657 pharmacies in the geographical coverage area of the plan shall be
658 eligible to participate under identical reimbursement terms for
659 providing pharmacy services, including prescription drugs. The
660 entity providing the health benefit plan shall, through reasonable
661 means, on a timely basis and on regular intervals, inform the
662 beneficiaries of the plan of the names and locations of pharmacies
663 that are participating in the plan as providers of pharmacy
664 services and prescription drugs. Additionally, participating
665 pharmacies shall be entitled to announce their participation to
666 their customers through a means acceptable to the pharmacy and the

667 entity providing the health benefit plans. The pharmacy
668 notification provisions of this section shall not apply when an
669 individual or group is enrolled, but when the plan enters a
670 particular county of the state.

671 (6) A violation of this section creates a civil cause of
672 action for injunctive relief in favor of any person or pharmacy
673 aggrieved by the violation.

674 (7) The Commissioner of Insurance shall not approve any
675 health benefit plan providing pharmaceutical services which does
676 not conform to this section.

677 (8) Any provision in a health benefit plan which is
678 executed, delivered or renewed, or otherwise contracted for in
679 this state that is contrary to this section shall, to the extent
680 of the conflict, be void.

681 (9) It is a violation of this section for any insurer or any
682 person to provide any health benefit plan providing for
683 pharmaceutical services to residents of this state that does not
684 conform to this section.

685 **SECTION 10.** Section 83-9-6.4, Mississippi Code of 1972, is
686 brought forward as follows:

687 83-9-6.4. (1) An individual or group health insurance
688 policy providing prescription drug coverage in the state shall
689 permit and apply a prorated daily cost-sharing rate to
690 prescriptions that are dispensed by a network pharmacy for a
691 partial supply if the prescriber or pharmacist determines the fill

692 or refill to be in the best interest of the patient and the
693 patient requests or agrees to a partial supply for the purpose of
694 synchronizing the patient's medications.

695 (2) No individual or group health insurance policy providing
696 prescription drug coverage shall deny coverage for the dispensing
697 of a medication that is dispensed by a network pharmacy on the
698 basis that the dispensing is for a partial supply if the
699 prescriber or pharmacist determines the fill or refill to be in
700 the best interest of the patient and the patient requests or
701 agrees to a partial supply for the purpose of synchronizing the
702 patient's medications.

703 (3) No individual or group health insurance policy providing
704 prescription drug coverage shall use payment structures
705 incorporating prorated dispensing fees. Dispensing fees for
706 partially filled or refilled prescriptions shall be paid in full
707 for each prescription dispensed, regardless of any prorated daily
708 cost-sharing rate for the beneficiary or fee paid for alignment
709 services.

710 (4) The provisions of this section shall be fully applicable
711 to any managed health care delivery entities including the State
712 and School Employees Health Insurance Plan and the Mississippi
713 Medicaid Program.

714 **SECTION 11.** This act shall take effect and be in force from
715 and after July 1, 2023.