By: Representative Hobgood-Wilkes To: Insurance

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1612

1 AN ACT TO AMEND SECTION 73-21-153, MISSISSIPPI CODE OF 1972,
2 TO DEFINE NEW TERMS AND REVISE THE DEFINITIONS OF EXISTING TERMS
3 UNDER THE PHARMACY BENEFIT PROMPT PAY ACT; TO AMEND SECTION
4 73-21-155, MISSISSIPPI CODE OF 1972, TO PROHIBIT PHARMACY BENEFIT
5 MANAGERS FROM CHARGING A PLAN SPONSOR MORE FOR A PRESCRIPTION DRUG
6 THAN THE NET AMOUNT IT PAYS A PHARMACY FOR THE PRESCRIPTION DRUG;
7 TO AMEND SECTION 73-21-156, MISSISSIPPI CODE OF 1972, TO REQUIRE
8 PHARMACY BENEFIT MANAGERS TO PROVIDE A REASONABLE ADMINISTRATIVE
9 APPEAL PROCEDURE TO ALLOW PHARMACIES TO CHALLENGE A REIMBURSEMENT
10 FOR A SPECIFIC DRUG OR DRUGS AS BEING BELOW THE REIMBURSEMENT RATE
11 REQUIRED BY THE PRECEDING PROVISION; TO PROVIDE THAT IF THE APPEAL
12 IS UPHELD, THE PHARMACY BENEFIT MANAGER SHALL MAKE THE CHANGE IN
13 THE PAYMENT TO THE REQUIRED REIMBURSEMENT RATE; TO PROVIDE THAT A
14 PATIENT SHALL NOT PAY A COPAYMENT FOR A PRESCRIPTION THAT EXCEEDS
15 THE TOTAL REIMBURSEMENT PAID BY THE PHARMACY BENEFIT MANAGER TO
16 THE PHARMACY; TO AMEND SECTION 73-21-157, MISSISSIPPI CODE OF
17 1972, TO REQUIRE THAT A PHARMACY BENEFIT MANAGER LICENSE BE
18 RENEWED ANNUALLY; THAT A PHARMACY SERVICES ADMINISTRATIVE
19 ORGANIZATION TO PROVIDE TO A PHARMACY OR PHARMACIST A COPY OF ANY
20 CONTRACT ENTERED INTO ON BEHALF OF THE PHARMACY OR PHARMACIST BY
21 THE PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION; TO AMEND
22 SECTION 73-21-161, MISSISSIPPI CODE OF 1972, TO PROHIBIT
23 PHARMACIES, PHARMACY BENEFIT MANAGERS AND PHARMACY BENEFIT MANAGER
24 AFFILIATES FROM ORDERING A PATIENT TO USE AN AFFILIATE PHARMACY OF
25 ANOTHER PHARMACY BENEFIT MANAGER, OR OFFERING OR IMPLEMENTING PLAN
26 DESIGNS THAT PENALIZE A PATIENT WHEN A PATIENT CHOOSES NOT TO USE
27 AN AFFILIATE PHARMACY OR THE AFFILIATE PHARMACY OF ANOTHER
28 PHARMACY BENEFIT MANAGER, OR INTERFERING WITH THE PATIENT'S RIGHT
29 TO CHOOSE THE PATIENT'S PHARMACY OR PROVIDER OF CHOICE; TO CREATE
30 NEW SECTION 73-21-162, MISSISSIPPI CODE OF 1972, TO PROHIBIT
31 PHARMACY BENEFIT MANAGERS AND PHARMACY BENEFIT MANAGER AFFILIATES
32 FROM PENALIZING OR RETALIATING AGAINST A PHARMACIST, PHARMACY OR
33 PHARMACY EMPLOYEE FOR EXERCISING ANY RIGHTS UNDER THIS ACT,
34 INITIATING ANY JUDICIAL OR REGULATORY ACTIONS, OR APPEARING BEFORE

35 ANY GOVERNMENTAL AGENCY, LEGISLATIVE MEMBER OR BODY OR ANY
36 JUDICIAL AUTHORITY; TO AMEND SECTION 73-21-163, MISSISSIPPI CODE
37 OF 1972, TO AUTHORIZE THE DEPARTMENT OF INSURANCE, FOR THE
38 PURPOSES OF CONDUCTING INVESTIGATIONS, TO CONDUCT EXAMINATIONS OF
39 PHARMACY BENEFIT MANAGERS AND TO ISSUE SUBPOENAS TO OBTAIN
40 DOCUMENTS OR RECORDS THAT IT DEEMS RELEVANT TO THE INVESTIGATION;
41 TO PROVIDE THAT MONIES FROM PENALTIES SHALL BE DEPOSITED IN A
42 SPECIAL FUND FOR PURPOSES OF THE BOARD IN REGULATING PHARMACY
43 BENEFIT MANAGERS; AND FOR RELATED PURPOSES.

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

45 **SECTION 1.** Section 73-21-153, Mississippi Code of 1972, is
46 amended as follows:

47 73-21-153. For purposes of Sections 73-21-151 through
48 73-21-163, the following words and phrases shall have the meanings
49 ascribed herein unless the context clearly indicates otherwise:

50 (a) "Board" means the State Board of Pharmacy.

51 (b) "Clean claim" means a completed billing instrument,
52 paper or electronic, received by a pharmacy benefit manager from a
53 pharmacist or pharmacies or the insured, which is accepted and
54 payment remittance advice is provided by the pharmacy benefit
55 manager. A clean claim includes resubmitted claims with
56 previously identified deficiencies corrected.

57 (*** * ***c) "Commissioner" means the Mississippi
58 Commissioner of Insurance.

59 (*** * ***d) "Day" means a calendar day, unless otherwise
60 defined or limited.

61 (*** * ***e) "Electronic claim" means the transmission of
62 data for purposes of payment of covered prescription drugs, other
63 products and supplies, and pharmacist services in an electronic

64 data format specified by a pharmacy benefit manager and approved
65 by the department.
66 (* * *f) "Electronic adjudication" means the process
67 of electronically receiving * * * and reviewing an electronic
68 claim and either accepting and providing payment remittance advice
69 for the electronic claim or rejecting an electronic claim.
70 (* * *g) "Enrollee" means an individual who has been
71 enrolled in a pharmacy benefit management plan or a health
72 insurance plan or both.
73 (* * *h) "Health insurance plan" means benefits
74 consisting of prescription drugs, other products and supplies, and
75 pharmacist services provided directly, through insurance or
76 reimbursement, or otherwise and including items and services paid
77 for as prescription drugs, other products and supplies, and
78 pharmacist services under any hospital or medical service policy
79 or certificate, hospital or medical service plan contract,
80 preferred provider organization agreement, or health maintenance
81 organization contract offered by a health insurance issuer.
82 (i) "Payment remittance advice" means the claim detail
83 that the pharmacy receives when successfully processing an
84 electronic or paper claim. The claim detail shall contain, but is
85 not limited to:
86 (i) The amount that the pharmacy benefit manager
87 will reimburse for product ingredient; and

88 (ii) The amount that the pharmacy benefit manager
89 will reimburse for product dispensing fee; and
90 (iii) The amount that the pharmacy benefit manager
91 dictates the patient must pay.
92 (j) "Pharmacist," "pharmacist services" and "pharmacy"
93 or "pharmacies" shall have the same definitions as provided in
94 Section 73-21-73.
95 (* * *k) "Pharmacy benefit manager" * * * includes
96 those entities defined as a pharmacy benefit manager in Section
97 73-21-179 and also includes those entities sponsoring or providing
98 cash discount cards as defined in Section 83-9-6.1. * * * The
99 term "pharmacy benefit manager" shall not include:
100 (i) An insurance company unless the insurance
101 company is providing services as a pharmacy benefit manager as
102 defined in Section 73-21-179, in which case the insurance company
103 shall be subject to Sections 73-21-151 through * * * 73-21-163
104 only for those pharmacy benefit manager services * * *; and
105 (ii) The pharmacy benefit manager of the
106 Mississippi State and School Employees Health Insurance Plan or
107 its contractors when performing pharmacy benefit manager services
108 for the plan, or the Mississippi Division of Medicaid or its
109 contractors when performing pharmacy benefit manager services for
110 the Division of Medicaid.
111 (l) "Pharmacy benefit management plan" means an
112 arrangement for the delivery of pharmacist's services in which a

113 pharmacy benefit manager undertakes to administer the payment or
114 reimbursement of any of the costs of pharmacist's services for an
115 enrollee or participant on a prepaid or insured basis or otherwise
116 that:
117 (i) Contains one or more incentive arrangements
118 intended to influence the cost or level of pharmacist's services
119 between the plan sponsor and one or more pharmacies with respect
120 to the delivery of pharmacist's services; and
121 (ii) Requires or creates benefit payment
122 differential incentives for enrollees to use under contract with
123 the pharmacy benefit manager.
124 (* * *m) "Pharmacy benefit manager affiliate"
125 means * * * an entity that directly or indirectly, * * * owns or
126 controls, is owned or controlled by, or is under common ownership
127 or control with a pharmacy benefit manager.
128 * * *
129 (n) "Pharmacy services administrative organization"
130 means any entity that contracts with a pharmacy or pharmacist to
131 assist with third-party payer interactions and that may provide a
132 variety of other administrative services, including contracting
133 with pharmacy benefits managers on behalf of pharmacies and
134 managing pharmacies' claims payments for third-party payers.
135 (o) "Plan sponsors" means the employers, insurance
136 companies, unions and health maintenance organizations that

137 contract with a pharmacy benefit manager for delivery of
138 prescription services.
139 (* * *p) "Uniform claim form" means a form prescribed
140 by rule by the State Board of Pharmacy; however, for purposes of
141 Sections 73-21-151 through * * * 73-21-163, the board shall adopt
142 the same definition or rule where the State Department of
143 Insurance has adopted a rule covering the same type of claim. The
144 board may modify the terminology of the rule and form when
145 necessary to comply with the provisions of Sections 73-21-151
146 through * * * 73-21-163.
147 * * *
148 (q) "Wholesale acquisition cost" means the wholesale
149 acquisition cost of the drug as defined in 42 USC Section
150 1395w-3a(c)(6)(B).
151 **SECTION 2.** Section 73-21-155, Mississippi Code of 1972, is
152 amended as follows:
153 73-21-155. (1) Reimbursement under a contract to a
154 pharmacist or pharmacy for prescription drugs and other products
155 and supplies that is calculated according to a formula that uses
156 Medi-Span, Gold Standard or a nationally recognized reference that
157 has been approved by the board in the pricing calculation shall
158 use the most current reference price or amount in the actual or
159 constructive possession of the pharmacy benefit manager, its
160 agent, or any other party responsible for reimbursement for
161 prescription drugs and other products and supplies on the date of

162 electronic adjudication or on the date of service shown on the
163 nonelectronic claim.
164 (2) Any contract that provides for less than reimbursement
165 provided in subsection (1) of this section violates the public
166 policy of the state and is void.
167 (* * *3) Pharmacy benefit managers, their agents and other
168 parties responsible for reimbursement for prescription drugs and
169 other products and supplies shall be required to update the
170 nationally recognized reference prices or amounts used for
171 calculation of reimbursement for prescription drugs and other
172 products and supplies no less than every three (3) business days.
173 (* * *4) (a) All benefits payable under a pharmacy benefit
174 management plan shall be paid within seven (7) days after receipt
175 of * * * a clean electronic claim where * * * the claim was
176 electronically adjudicated, and shall be paid within thirty-five
177 (35) days after receipt of due written proof of a clean claim
178 where claims are submitted in paper format. Benefits due under
179 the plan and claims are overdue if not paid within seven (7) days
180 or thirty-five (35) days, whichever is applicable, after the
181 pharmacy benefit manager receives a clean claim containing
182 necessary information essential for the pharmacy benefit manager
183 to administer preexisting condition, coordination of benefits and
184 subrogation provisions under the plan sponsor's health insurance
185 plan. * * *
186 * * *

187 (* * *b) * * * If an electronic claim is denied, the
188 pharmacy benefit manager shall * * * notify the pharmacist or
189 pharmacy * * * of the reasons why the claim or portion thereof is
190 not clean and will not be paid and what substantiating
191 documentation and information is required to adjudicate the claim
192 as clean. If a written claim is denied, the pharmacy benefit
193 manager shall notify the pharmacy or pharmacies. * * * No later
194 than thirty-five (35) days * * * of receipt of such claim, the
195 pharmacy benefit manager shall * * * provide the pharmacist or
196 pharmacy * * * the reasons why the claim or portion thereof is not
197 clean and will not be paid and what substantiating documentation
198 and information is required to adjudicate the claim as clean. Any
199 claim or portion thereof resubmitted with the supporting
200 documentation and information requested by the pharmacy benefit
201 manager shall be paid within twenty (20) days after receipt.
202 (c) A claim for pharmacist services may not be
203 retroactively denied or reduced after adjudication of the claim
204 unless the:
205 (i) Original claim was submitted fraudulently;
206 (ii) Original claim payment was incorrect because
207 the pharmacy or pharmacist had already been paid for the
208 pharmacist services;
209 (iii) Pharmacist services were not rendered by the
210 pharmacy or pharmacist; or

211 (iv) Adjustment was agreed upon by the pharmacy
212 prior to the denial or reduction.
213 (* * *5) If the board finds that any pharmacy benefit
214 manager, agent or other party responsible for reimbursement for
215 prescription drugs and other products and supplies has not paid
216 ninety-five percent (95%) of clean claims * * * received from all
217 pharmacies in a calendar quarter, he shall be subject to
218 administrative penalty of not more than Twenty-five Thousand
219 Dollars ($25,000.00) to be assessed by the State Board of
220 Pharmacy.
221 (a) Examinations to determine compliance with
222 this * * * section may be conducted by the * * * Department of
223 Insurance. The * * * department may contract with qualified
224 impartial outside sources to assist in examinations to determine
225 compliance. If, after the conclusion of the examination, the
226 pharmacy benefit manager was found to be in compliance with all of
227 the requirements of this section, then the Department of Insurance
228 shall pay all of the costs of the examination. However, if the
229 pharmacy benefit manager was not in compliance with all or a part
230 of this section, then the expenses of any such examinations shall
231 be paid by the pharmacy benefit manager examined and deposited
232 into a special fund that is created in the State Treasury, which
233 shall be used by the board, upon appropriation by the Legislature,
234 to support the operations of the board relating to the regulation
235 of pharmacy benefit managers.

236 (b) Nothing in the provisions of this section shall
237 require a pharmacy benefit manager to pay claims that are not
238 covered under the terms of a contract or policy of accident and
239 sickness insurance or prepaid coverage.
240 (c) If the claim is not denied for valid and proper
241 reasons by the end of the applicable time period prescribed in
242 this provision, the pharmacy benefit manager must pay the pharmacy
243 (where the claim is owed to the pharmacy) or the patient (where
244 the claim is owed to a patient) interest on accrued benefits at
245 the rate of one and one-half percent (1-1/2%) per month accruing
246 from the day after payment was due on the amount of the benefits
247 that remain unpaid until the claim is finally settled or
248 adjudicated. Whenever interest due pursuant to this provision is
249 less than One Dollar ($1.00), such amount shall be credited to the
250 account of the person or entity to whom such amount is owed.
251 (d) Any pharmacy benefit manager and a pharmacy may
252 enter into an express written agreement containing timely claim
253 payment provisions which differ from, but are at least as
254 stringent as, the provisions set forth under subsection (*** * ***4)
255 of this section, and in such case, the provisions of the written
256 agreement shall govern the timely payment of claims by the
257 pharmacy benefit manager to the pharmacy. If the express written
258 agreement is silent as to any interest penalty where claims are
259 not paid in accordance with the agreement, the interest penalty
260 provision of *** * *** paragraph (c) of this subsection shall apply.

261 (e) The State Board of Pharmacy may adopt rules and
262 regulations necessary to ensure compliance with this subsection.
263 (* * *6) (a) For purposes of this subsection (* * *6),
264 "network pharmacy" means a licensed pharmacy in this state that
265 has a contract with a pharmacy benefit manager to provide covered
266 drugs at a negotiated reimbursement rate. A network pharmacy or
267 pharmacist may decline to provide a brand name drug, multisource
268 generic drug, or service, if the network pharmacy or pharmacist is
269 paid less than that network pharmacy's * * * cost for the * * *
270 prescription. If the network pharmacy or pharmacist declines to
271 provide such drug or service, the pharmacy or pharmacist shall
272 provide the customer with adequate information as to where the
273 prescription for the drug or service may be filled.
274 (b) The State Board of Pharmacy shall adopt rules and
275 regulations necessary to implement and ensure compliance with this
276 subsection, including, but not limited to, rules and regulations
277 that address access to pharmacy services in rural or underserved
278 areas in cases where a network pharmacy or pharmacist declines to
279 provide a drug or service under paragraph (a) of this
280 subsection. * * *
281 (* * *7) A pharmacy benefit manager shall not directly or
282 indirectly retroactively deny or reduce a claim or aggregate of
283 claims after the claim or aggregate of claims has been
284 adjudicated.

285 **SECTION 3.** Section 73-21-156, Mississippi Code of 1972, is
286 amended as follows:
287 73-21-156. (1) As used in this section, the following terms
288 shall be defined as provided in this subsection:
289 (a) "Maximum allowable cost list" means a listing of
290 drugs or other methodology used by a pharmacy benefit manager,
291 directly or indirectly, setting the maximum allowable payment to a
292 pharmacy or pharmacist for a generic drug, brand-name drug,
293 biologic product or other prescription drug. The term "maximum
294 allowable cost list" includes without limitation:
295 (i) Average acquisition cost, including national
296 average drug acquisition cost;
297 (ii) Average manufacturer price;
298 (iii) Average wholesale price;
299 (iv) Brand effective rate or generic effective
300 rate;
301 (v) Discount indexing;
302 (vi) Federal upper limits;
303 (vii) Wholesale acquisition cost; and
304 (viii) Any other term that a pharmacy benefit
305 manager or a health care insurer may use to establish
306 reimbursement rates to a pharmacist or pharmacy for pharmacist
307 services.

308 (b) "Pharmacy acquisition cost" means the amount that a
309 pharmaceutical wholesaler charges for a pharmaceutical product as
310 listed on the pharmacy's billing invoice.
311 (2) Before a pharmacy benefit manager places or continues a
312 particular drug on a maximum allowable cost list, the drug:
313 (a) If *** * *** a generic equivalent drug product as
314 defined in 73-21-73, shall be listed as therapeutically equivalent
315 and pharmaceutically equivalent "A" or "B" rated in the United
316 States Food and Drug Administration's most recent version of the
317 "Orange Book" or "Green Book" or have an NR or NA rating by
318 Medi-Span, Gold Standard, or a similar rating by a nationally
319 recognized reference approved by the board;
320 (b) Shall be available for purchase by each pharmacy in
321 the state from national or regional wholesalers operating in
322 Mississippi; and
323 (c) Shall not be obsolete.
324 (3) A pharmacy benefit manager shall:
325 (a) Provide access to its maximum allowable cost list
326 to each pharmacy subject to the maximum allowable cost list;
327 (b) Update its maximum allowable cost list on a timely
328 basis, but in no event longer than three (3) calendar days; and
329 (c) Provide a process for each pharmacy subject to the
330 maximum allowable cost list to receive prompt notification of an
331 update to the maximum allowable cost list.
332 (4) A pharmacy benefit manager shall:

333 (a) Provide a reasonable administrative appeal
334 procedure to allow pharmacies to challenge a maximum allowable
335 cost list and reimbursements made under a maximum allowable cost
336 list for a specific drug or drugs as:
337 (i) Not meeting the requirements of this section;
338 or
339 (ii) Being below the pharmacy acquisition cost.
340 (b) The reasonable administrative appeal procedure
341 shall include the following:
342 (i) A dedicated telephone number, email address
343 and website for the purpose of submitting administrative appeals;
344 (ii) The ability to submit an administrative
345 appeal directly to the pharmacy benefit manager regarding the
346 pharmacy benefit management plan or through a pharmacy service
347 administrative organization; and
348 (iii) A period of <u>no</u> less than *** * *** <u>forty-five</u>
349 <u>(45)</u> business days to file an administrative appeal.
350 (c) The pharmacy benefit manager shall respond to the
351 challenge under paragraph (a) of this subsection (4) within *** * ***
352 <u>forty-five (45)</u> business days after receipt of the challenge.
353 (d) If a challenge is made under paragraph (a) of this
354 subsection (4), the pharmacy benefit manager shall within *** * ***
355 <u>forty-five (45)</u> business days after receipt of the challenge
356 either:
357 (i) *** * *** <u>Uphold</u> the appeal *** * *** <u>and</u>:

358 1. Make the change in the maximum allowable
359 cost list payment to at least the pharmacy acquisition cost;
360 2. Permit the challenging pharmacy or
361 pharmacist to reverse and rebill the claim in question if
362 necessary;
363 3. Provide the National Drug Code that the
364 increase or change is based on to the pharmacy or pharmacist; and
365 4. Make the change under item 1 of this
366 subparagraph (i) effective for each similarly situated pharmacy as
367 defined by the payor subject to the maximum allowable cost list;
368 or
369 (ii) * * * Deny the appeal * * * and:
370 1. Provide the challenging pharmacy or
371 pharmacist the National Drug Code and the name of the national or
372 regional pharmaceutical wholesalers operating in Mississippi that
373 have the drug currently in stock at a price below the maximum
374 allowable cost as listed on the maximum allowable cost list; * * *
375 and
376 * * *2. If the National Drug Code provided
377 by the pharmacy benefit manager is not available below the
378 pharmacy acquisition cost from the pharmaceutical wholesaler from
379 whom the pharmacy or pharmacist purchases the majority of
380 prescription drugs for resale, then the pharmacy benefit manager
381 shall adjust the maximum allowable cost as listed on the maximum
382 allowable cost list above the challenging pharmacy's pharmacy

383 acquisition cost and permit the pharmacy to reverse and rebill
384 each claim affected by the inability to procure the drug at a cost
385 that is equal to or less than the previously challenged maximum
386 allowable cost.

387 (5) (a) The Department of Insurance may conduct an audit or
388 audits of appeals denied under the provisions of subsection (4) of
389 this section to ensure compliance with its requirements. In
390 conducting audits, the department is empowered to request
391 production of documents pertaining to compliance with the
392 provisions of this section, and documents so requested shall be
393 produced within seven (7) days of the request unless extended by
394 the department or its duly authorized staff.

395 (b) If, after the conclusion of the audit, the pharmacy
396 benefit manager was found to be in compliance with all of the
397 requirements of this section, then the Department of Insurance
398 shall pay all costs of the audit. However, if the pharmacy
399 benefit manager was not in compliance with all or a part of this
400 section, then the pharmacy benefit manager being audited shall pay
401 all costs of such audit. The cost of the audit examination shall
402 be deposited into the special fund created in Section 73-21-155,
403 and shall be used by the board to support the operations of the
404 board relating to the regulation of pharmacy benefit managers.

405 (c) The department is authorized to hire independent
406 consultants to conduct appeal audits of a pharmacy benefit manager

407 and expend funds collected under this section to pay the cost of
408 performing audit examination services.
409 (* * *6) (a) A pharmacy benefit manager shall not
410 reimburse a pharmacy or pharmacist in the state an amount less
411 than the amount that the pharmacy benefit manager reimburses a
412 pharmacy benefit manager affiliate for providing the same
413 pharmacist services.
414 (b) The amount shall be calculated on a per unit basis based
415 on the same brand and generic product identifier or brand and
416 generic code number.
417 (7) A pharmacy benefit manager or third-party payer may not
418 charge or cause a patient to pay a copayment that exceeds the
419 total reimbursement paid by the pharmacy benefit manager to the
420 pharmacy.
421 **SECTION 4.** Section 73-21-157, Mississippi Code of 1972, is
422 amended as follows:
423 73-21-157. (1) Before beginning to do business as a
424 pharmacy benefit manager, a pharmacy benefit manager shall obtain
425 a license to do business from the board. This license shall be
426 renewed annually on or before the anniversary date of the license.
427 To obtain a license or to renew a license, the applicant shall
428 submit an application to the board on a form to be prescribed by
429 the board.
430 (2) Each pharmacy benefit manager providing pharmacy
431 management benefit plans in this state shall file a statement with

432 the board annually by March 1 or within sixty (60) days of the end
433 of its fiscal year if not a calendar year. The statement shall be
434 verified by at least two (2) principal officers and shall cover
435 the preceding calendar year or the immediately preceding fiscal
436 year of the pharmacy benefit manager.
437 (3) The statement shall be on forms prescribed by the board
438 and shall include:
439 (a) A financial statement of the organization,
440 including its balance sheet and income statement for the preceding
441 year; and
442 (b) Any other information relating to the operations of
443 the pharmacy benefit manager required by the board under this
444 section.
445 (4) (a) Any information required to be submitted to the
446 board pursuant to licensure application that is considered
447 proprietary by a pharmacy benefit manager shall be marked as
448 confidential when submitted to the board. All such information
449 shall not be subject to the provisions of the federal Freedom of
450 Information Act or the Mississippi Public Records Act and shall
451 not be released by the board unless subject to an order from a
452 court of competent jurisdiction. The board shall destroy or
453 delete or cause to be destroyed or deleted all such information
454 thirty (30) days after the board determines that the information
455 is no longer necessary or useful.

456 (b) Any person who knowingly releases, causes to be
457 released or assists in the release of any such information shall
458 be subject to a monetary penalty imposed by the board in an amount
459 not exceeding Fifty Thousand Dollars ($50,000.00) per violation.
460 When the board is considering the imposition of any penalty under
461 this paragraph (b), it shall follow the same policies and
462 procedures provided for the imposition of other sanctions in the
463 Pharmacy Practice Act. Any penalty collected under this paragraph
464 (b) shall be deposited into the special fund, and shall be used by
465 the board, upon appropriation of the Legislature, to support the
466 operations of the board relating to the regulation of pharmacy
467 benefit managers.
468 (c) All employees of the board who have access to the
469 information described in paragraph (a) of this subsection shall be
470 fingerprinted, and the board shall submit a set of fingerprints
471 for each employee to the Department of Public Safety for the
472 purpose of conducting a criminal history records check. If no
473 disqualifying record is identified at the state level, the
474 Department of Public Safety shall forward the fingerprints to the
475 Federal Bureau of Investigation for a national criminal history
476 records check.
477 (5) If the pharmacy benefit manager is audited annually by
478 an independent certified public accountant, a copy of the
479 certified audit report shall be filed annually with the board by
480 June 30 or within thirty (30) days of the report being final.

481 (6) The board may extend the time prescribed for any
482 pharmacy benefit manager for filing annual statements or other
483 reports or exhibits of any kind for good cause shown. However,
484 the board shall not extend the time for filing annual statements
485 beyond sixty (60) days after the time prescribed by subsection (1)
486 of this section. The board may waive the requirements for filing
487 financial information for the pharmacy benefit manager if an
488 affiliate of the pharmacy benefit manager is already required to
489 file such information under current law with the Commissioner of
490 Insurance and allow the pharmacy benefit manager to file a copy of
491 documents containing such information with the board in lieu of
492 the statement required by this section.
493 (7) The expense of administering this section shall be
494 assessed annually by the board against all pharmacy benefit
495 managers operating in this state.
496 (8) A pharmacy benefit manager or third-party payor may not
497 require pharmacy accreditation standards or recertification
498 requirements inconsistent with, more stringent than, or in
499 addition to federal and state requirements for licensure as a
500 pharmacy in this state.
501 (9) A pharmacy or pharmacist that belongs to a pharmacy
502 services administrative organization shall be provided with a true
503 and correct copy of any contract that the pharmacy services
504 administrative organization enters into with a pharmacy benefit

505 manager or third-party payer on the pharmacy's or pharmacist's
506 behalf.
507 **SECTION 5.** Section 73-21-161, Mississippi Code of 1972, is
508 amended as follows:
509 73-21-161. (1) As used in this section, the term "referral"
510 means:
511 (a) Ordering of a patient to a pharmacy benefit manager
512 affiliate by a pharmacy benefit manager or a pharmacy benefit
513 manager affiliate either orally or in writing, including online
514 messaging, or any form of communication;
515 (b) Requiring a patient to use an affiliate pharmacy of
516 another pharmacy benefit manager;
517 (* * *c) Offering or implementing plan designs that
518 require patients to use affiliated pharmacies or affiliated
519 pharmacies of another pharmacy benefit manager or that penalize a
520 patient, including requiring a patient to pay the full cost for a
521 prescription or a higher cost-share, when a patient chooses not to
522 use an affiliate pharmacy or the affiliate pharmacy of another
523 pharmacy benefit manager; or
524 (* * *d) Patient or prospective patient specific
525 advertising, marketing, or promotion of a pharmacy by * * * a
526 pharmacy benefit manager or pharmacy benefit manager affiliate.
527 The term "referral" does not include a pharmacy's inclusion
528 by a pharmacy benefit manager or a pharmacy benefit manager
529 affiliate in communications to patients, including patient and

530 prospective patient specific communications, regarding network
531 pharmacies and prices, provided that the pharmacy benefit manager
532 or a pharmacy benefit manager affiliate includes information
533 regarding eligible nonaffiliate pharmacies in those communications
534 and the information provided is accurate.

535 (2) A pharmacy, pharmacy benefit manager, or pharmacy
536 benefit manager affiliate licensed or operating in Mississippi
537 shall be prohibited from:

538 (a) Making referrals;

539 (b) Transferring or sharing records relative to
540 prescription information containing patient identifiable and
541 prescriber identifiable data to or from a pharmacy benefit manager
542 affiliate for any commercial purpose; however, nothing in this
543 section shall be construed to prohibit the exchange of
544 prescription information between a pharmacy and its affiliate for
545 the limited purposes of pharmacy reimbursement; formulary
546 compliance; pharmacy care; public health activities otherwise
547 authorized by law; or utilization review by a health care
548 provider; *** * ***

549 (c) Presenting a claim for payment to any individual,
550 third-party payor, affiliate, or other entity for a service
551 furnished pursuant to a referral from *** * *** a pharmacy benefit
552 manager or pharmacy benefit manager affiliate *** * ***; or

553 (d) Interfering with the patient's right to choose the
554 patient's pharmacy or provider of choice, including inducement,

555 required referrals or offering financial or other incentives or
556 measures that would constitute a violation of Section 83-9-6.
557 (3) This section shall not be construed to prohibit a
558 pharmacy from entering into an agreement with a pharmacy benefit
559 manager affiliate to provide pharmacy care to patients, provided
560 that the pharmacy does not receive referrals in violation of
561 subsection (2) of this section and the pharmacy provides the
562 disclosures required in subsection (1) of this section.
563 (4) If a pharmacy licensed or holding a nonresident pharmacy
564 permit in this state has an affiliate, it shall annually file with
565 the board a disclosure statement identifying all such affiliates.
566 (5) In addition to any other remedy provided by law, a
567 violation of this section by a pharmacy shall be grounds for
568 disciplinary action by the board under its authority granted in
569 this chapter.
570 (6) A pharmacist who fills a prescription that violates
571 subsection (2) of this section shall not be liable under this
572 section.
573 **SECTION 6.** The following shall be codified as Section
574 73-21-162, Mississippi Code of 1972:
575 73-21-162. (1) Retaliation is prohibited.
576 (a) A pharmacy benefit manager may not retaliate
577 against a pharmacist or pharmacy based on the pharmacist's or
578 pharmacy's exercise of any right or remedy under this chapter.

579 Retaliation prohibited by this section includes, but is not
580 limited to:
581 (i) Terminating or refusing to renew a contract
582 with the pharmacist or pharmacy;
583 (ii) Subjecting the pharmacist or pharmacy to an
584 increased frequency of audits, number of claims audited, or amount
585 of monies for claims audited; or
586 (iii) Failing to promptly pay the pharmacist or
587 pharmacy any money owed by the pharmacy benefit manager to the
588 pharmacist or pharmacy.
589 (b) For the purposes of this section, a pharmacy
590 benefit manager is not considered to have retaliated against a
591 pharmacy if the pharmacy benefit manager:
592 (i) Takes an action in response to a credible
593 allegation of fraud against the pharmacist or pharmacy; and
594 (ii) Provides reasonable notice to the pharmacist
595 or pharmacy of the allegation of fraud and the basis of the
596 allegation before initiating an action.
597 (2) A pharmacy benefit manager or pharmacy benefit manager
598 affiliate shall not penalize or retaliate against a pharmacist,
599 pharmacy or pharmacy employee for exercising any rights under this
600 chapter, initiating any judicial or regulatory actions or
601 discussing or disclosing information pertaining to an agreement
602 with a pharmacy benefit manager or a pharmacy benefit manager
603 affiliate when testifying or otherwise appearing before any

604 governmental agency, legislative member or body or any judicial
605 authority.

606 **SECTION 7.** Section 73-21-163, Mississippi Code of 1972, is
607 amended as follows:

608 73-21-163. (1) Whenever the board or Department of
609 Insurance has reason to believe that a pharmacy benefit manager or
610 pharmacy benefit manager affiliate is using, has used, or is about
611 to use any method, act or practice prohibited in Sections
612 73-21-151 through 73-21-163 and that proceedings would be in the
613 public interest, *** * *** either the board or department may bring an
614 action in the name of the board or department against the pharmacy
615 benefit manager or pharmacy benefit manager affiliate to restrain
616 by temporary or permanent injunction the use of such method, act
617 or practice. The action shall be brought in the Chancery Court of
618 the First Judicial District of Hinds County, Mississippi. The
619 court is authorized to issue temporary or permanent injunctions to
620 restrain and prevent violations of Sections 73-21-151 through
621 73-21-163 and such injunctions shall be issued without bond.

622 (2) The board or department may impose a monetary penalty on
623 a pharmacy benefit manager or a pharmacy benefit manager affiliate
624 for noncompliance with the provisions of the Sections 73-21-151
625 through 73-21-163, in amounts of not less than One Thousand
626 Dollars ($1,000.00) per violation and not more than Twenty-five
627 Thousand Dollars ($25,000.00) per violation. Each day that a
628 violation continues *** * *** is a separate violation. The board or

629 department shall prepare a record entered upon its minutes that
630 states the basic facts upon which the monetary penalty was
631 imposed. Any penalty collected under this subsection (2) shall be
632 deposited into the special fund of the board created in Section
633 73-21-155, and shall be used by the board to support the
634 operations of the board relating to the regulation of pharmacy
635 benefit managers.
636 (3) For the purposes of conducting investigations, the
637 board, through its executive director, or the Department of
638 Insurance, through its commissioner, may conduct examinations of a
639 pharmacy benefit manager and may also issue subpoenas to any
640 individual, pharmacy, pharmacy benefit manager, or any other
641 entity having documents or records that it deems relevant to the
642 investigation. The board or department may contract with
643 qualified impartial outside sources to assist in examinations to
644 determine noncompliance with the provisions of Sections 73-21-151
645 through 73-21-163. Money collected by the board or department
646 under subsection (2) of this section may be used to pay the cost
647 of conducting or contracting for such examinations.
648 (* * *4) The board or department may assess a monetary
649 penalty for those reasonable costs that are expended by the board
650 or department in the investigation and conduct of a proceeding if
651 the board or department imposes a monetary penalty under
652 subsection (2) of this section. A monetary penalty assessed and
653 levied under this section shall be paid to the board by the

654 licensee, registrant or permit holder upon the expiration of the
655 period allowed for appeal of those penalties under Section
656 73-21-101, or may be paid sooner if the licensee, registrant or
657 permit holder elects. Any penalty collected by the board or
658 department under this subsection (* * *4) shall be deposited into
659 the special fund of the board created in Section 73-21-155, and
660 shall be used by the board to support the operations of the board
661 relating to the regulation of pharmacy benefit managers.
662 (* * *5) When payment of a monetary penalty assessed and
663 levied by the board or department against a licensee, registrant
664 or permit holder in accordance with this section is not paid by
665 the licensee, registrant or permit holder when due under this
666 section, the board or department shall have the power to institute
667 and maintain proceedings in its name for enforcement of payment in
668 the chancery court of the county and judicial district of
669 residence of the licensee, registrant or permit holder, or if the
670 licensee, registrant or permit holder is a nonresident of the
671 State of Mississippi, in the Chancery Court of the First Judicial
672 District of Hinds County, Mississippi. When those proceedings are
673 instituted, the board or department shall certify the record of
674 its proceedings, together with all documents and evidence, to the
675 chancery court and the matter shall be heard in due course by the
676 court, which shall review the record and make its determination
677 thereon in accordance with the provisions of Section 73-21-101.

678 The hearing on the matter may, in the discretion of the
679 chancellor, be tried in vacation.
680 (*** * ***6) The board shall develop and implement a uniform
681 penalty policy that sets the minimum and maximum penalty for any
682 given violation of Sections 73-21-151 through 73-21-163. The
683 board shall adhere to its uniform penalty policy except in those
684 cases where the board specifically finds, by majority vote, that a
685 penalty in excess of, or less than, the uniform penalty is
686 appropriate. That vote shall be reflected in the minutes of the
687 board and shall not be imposed unless it appears as having been
688 adopted by the board.
689 **SECTION 8.** This act shall take effect and be in force from
690 and after July 1, 2024.