MISSISSIPPI LEGISLATURE REGULAR SESSION 2025

By: Representative Turner

To: Insurance; State Affairs

HOUSE BILL NO. 1413

AN ACT TO CREATE THE PHARMACY BENEFIT MANAGER TRANSPARENCY ACT; TO PROVIDE DEFINITIONS; TO PROVIDE FOR THE LICENSING OF A PHARMACY BENEFIT MANAGER; TO PROVIDE WHEN THE LICENSE OF A PHARMACY BENEFIT MANAGER MAY BE REVOKED; TO PROVIDE THAT A PHARMACY BENEFIT MANAGER SHALL HAVE A FIDUCIARY DUTY TO A HEALTH CARRIER CLIENT; TO PROVIDE CERTAIN BUSINESS PRACTICES THAT A PHARMACY BENEFIT MANAGER SHALL FOLLOW; TO REQUIRE EACH LICENSED PHARMACY BENEFIT MANAGER TO SUBMIT A TRANSPARENCY REPORT CONTAINING DATA FROM THE PREVIOUS YEAR TO THE BOARD OF PHARMACY; TO PROVIDE WHAT MUST BE INCLUDED IN THE TRANSPARENCY REPORT; TO PROHIBIT RETALIATION; TO BRING FORWARD SECTIONS 73-21-73, 73-21-83 AND 73-21-91, MISSISSIPPI CODE OF 1972, WHICH PROVIDE THE LICENSING REQUIREMENTS FOR A PHARMACY BENEFIT MANAGER, FOR THE PURPOSE OF POSSIBLE AMENDMENT; TO BRING FORWARD SECTIONS 73-21-151, 73-21-153, 73-21-155, 73-21-156, 73-21-157, 73-21-159, 73-21-161 AND 73-21-163, MISSISSIPPI CODE OF 1972, WHICH ESTABLISH THE PHARMACY BENEFIT PROMPT PAY ACT, FOR THE PURPOSE OF POSSIBLE AMENDMENT; TO BRING FORWARD SECTIONS 73-21-175, 73-21-177, 73-21-179, 73-21-181, 73-21-183, 73-21-185, 73-21-187, 73-21-189 AND 73-21-191, MISSISSIPPI CODE OF 1972, WHICH ESTABLISH THE PHARMACY AUDIT INTEGRITY ACT, FOR THE PURPOSE OF POSSIBLE AMENDMENT; TO BRING FORWARD SECTIONS 73-21-201, 73-21-203 AND 73-21-205, MISSISSIPPI CODE OF 1972, WHICH ESTABLISH THE PRESCRIPTION DRUGS CONSUMER AFFORDABLE ALTERNATIVE PAYMENT OPTIONS ACT, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Sections 1 through 6 shall be known and may be cited as the "Pharmacy Benefit Manager Transparency Act".

SECTION 2. The following words and phrases shall have the meanings as defined in this section unless the context clearly indicates otherwise:

(a) "Pharmacy benefit manager" means a person, business, or other entity that, pursuant to a contract or under an employment relationship with a health carrier, a self-insurance plan, or other third-party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the health carrier, self-insurance plan, or other third-party payer including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs. In addition, the term "pharmacy benefit manager" shall not include the pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan or the Mississippi Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner of Insurance, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the cost of

health care services, including a health insurance company, a health maintenance organization, a hospital and health services corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

(c) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services.

(d) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(e) "Pharmacy" means an established location, either physical or electronic that is licensed by the state and that has entered into a network contract with a pharmacy benefit manager and/or health carrier.

(f) "Network pharmacy" means a retail or other licensed pharmacy provider that contracts with a pharmacy benefit manager.

(g) "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, an independent pharmacy, or a network of independent pharmacies that is licensed as a pharmacy by this state and that dispenses medications to the public.

(h) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, telefax or

through electronic submissions and to dispense medication to covered persons through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.

(i) "Aggregate retained rebate percentage" means the percentage of all rebates received from a manufacturer or other entity to a pharmacy benefit manager for prescription drug utilization which is not passed on to pharmacy benefit manger's health carrier clients. The percentage shall be calculated for each health carrier for rebates in the prior calendar years as follows:

(i) The sum total dollar amount of rebates received from all pharmaceutical manufacturers for all utilization of covered persons of a health carrier that was not passed through to the health carrier; and

(ii) Divided by the sum total dollar amount of all rebates received from all pharmaceutical manufacturers for covered persons of a health carrier.

(j) "Rebates" mean all price concessions paid by a manufacturer to a pharmacy benefit manager or health carrier, including rebates, discounts, and other price concessions that are based on actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness a drug has in a value-based or performance-based contract.

(k) "Trade secret" shall have the same definition as provided in Section 75-26-3.

(l) "Cost share/cost sharing" means the amount paid by a covered person as required under the covered person's health benefit plan.

(m) "Board" means the Mississippi Board of Pharmacy.

SECTION 3. (1) A pharmacy benefit manager shall be licensed by the Mississippi Board of Pharmacy before conducting business in the state.

(2) Licensure pursuant to this section is not transferable.

(3) The license may be granted only when the board is satisfied that the entity possesses the necessary organization, background expertise, and financial integrity to supply the services sought to be offered.

(4) The board may issue a license subject to restrictions or limitations upon the authorization, including the type of services that may be supplied or the activities in which the entity may be engaged.

(5) All licenses are valid for a period of three (3) years.

(6) The board shall develop an application for licensure that includes at least the following information:

(a) The name of the pharmacy benefit manager;

(b) The address and contact telephone number for the pharmacy benefit manager;

(c) The name and address of the pharmacy benefit manager agent for service of process in the state;

(d) The name and address of each person beneficially interested in the pharmacy benefit manager; and

(e) The name and address of each person with management or control over the pharmacy benefit manager.

(7) The board may suspend, revoke or place on probation a pharmacy benefit manager license under any of the following circumstances:

(a) The pharmacy benefit manager has engaged in fraudulent activity that constitutes a violation of state or federal law;

(b) The board received consumer complaints that justify an action under this subsection to protect the safety and interests of consumers;

(c) The pharmacy benefit manager fails to pay an application fee for the license; or

(d) The pharmacy benefit manager fails to comply with a requirement set forth in this section.

(8) If a pharmacy benefit manager acts without registering, it will be subject to a fine of Five Thousand Dollars ($5,000.00) per day for the period it is found to be in violation.

SECTION 4. (1) A pharmacy benefit manager has a fiduciary duty to a health carrier client and shall discharge that duty in accordance with the provisions of state and federal law.

(2) A pharmacy benefit manager shall perform its duties with care, skill, prudence, diligence and professionalism.

(3) A pharmacy benefit manager shall notify a health carrier client in writing of any activity, policy or practice of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the duties imposed in this section.

(4) A pharmacy benefit manager or health carrier shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a covered person regarding:

(a) The cost of a prescription medication to the covered person; or

(b) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including, but not limited to, paying a cash price that is less expensive to the customer than the cost of the prescription under a covered person's health benefit plan.

(5) A pharmacy benefit manager shall not require pharmacy or other provider accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the board or other state or federal entity.

(6) A health carrier or pharmacy benefit manager may not require a covered person to make a payment at the point of sale

for a covered prescription medication in an amount greater than the lesser of:

(a) The applicable copayment for the prescription medication;

(b) The allowable claim amount for the prescription medication;

(c) The amount a covered person would pay for the prescription medication if the covered person purchased the prescription medication without using a health benefit plan or any other source of prescription medication benefits or discounts; or

(d) The amount the pharmacy will be reimbursed for the drug from pharmacy benefit manager or health carrier.

(5) A health carrier or pharmacy benefit manager is prohibited from penalizing, requiring or providing financial incentives, including variations in premiums, deductibles, copayments or coinsurance, to covered persons as incentives to use specific retail, mail order pharmacy or other network pharmacy provider in which a pharmacy benefit manager has an ownership interest or that has an ownership interest in a pharmacy benefit manager.

SECTION 5. (1) Beginning July 1, 2025, and annually thereafter, each licensed pharmacy benefit manager shall submit a transparency report containing data from the prior calendar year to the board. The transparency report shall contain the following information:

(a) The aggregate amount of all rebates that the pharmacy benefit manager received from all pharmaceutical manufacturers for all health carrier clients and for each health carrier client;

(b) The aggregate administrative fees that the pharmacy benefit manager received from all manufacturers for all health carrier clients and for each health carrier client;

(c) The aggregate retained rebates that the pharmacy benefit manager received from all pharmaceutical manufacturers and did not pass through to health carriers;

(d) The aggregate retained rebate percentage as defined in paragraph (i) of Section 2; and

(e) The highest, lowest, and mean aggregate retained rebate percentage for all health carrier clients and for each health carrier client.

(2) A pharmacy benefit manager providing information under this section may designate that material as a trade secret. Disclosure, however, may be ordered by a court of this state for good cause shown or made in a court filing.

(3) Within sixty (60) days of receipt, the board shall publish the transparency report of each pharmacy benefit manager on the board's website in a way that does not violate the state's trade secrets law.

(4) The Attorney General may impose civil fines and penalties of not more than One Thousand Dollars ($1,000.00) per day per violation of this section.

SECTION 6. (1) Retaliation is prohibited.

(a) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any right or remedy under this act. Retaliation prohibited by this section includes, but is not limited to:

(i) Terminating or refusing to renew a contract with the pharmacist or pharmacy;

(ii) Subjecting the pharmacist or pharmacy to an increased frequency of audits, number of claims audited or amount of monies for claims audited; or

(iii) Failing to promptly pay the pharmacist or pharmacy any money owed by the pharmacy benefit manager to the pharmacist or pharmacy.

(b) For the purposes of this section, a pharmacy benefit manager is not considered to have retaliated against a pharmacy if the pharmacy benefit manager:

(i) Takes an action in response to a credible allegation of fraud against the pharmacist or pharmacy; and

(ii) Provides reasonable notice to the pharmacist or pharmacy of the allegation of fraud and the basis of the allegation before initiating an action.

(2) A pharmacy benefit manager or pharmacy benefit manager affiliate shall not penalize or retaliate against a pharmacist, pharmacy or pharmacy employee for exercising any rights under this chapter, initiating any judicial or regulatory actions or discussing or disclosing information pertaining to an agreement with a pharmacy benefit manager or a pharmacy benefit manager affiliate when testifying or otherwise appearing before any governmental agency, legislative member or body or any judicial authority.

(3) The Board of Pharmacy shall have the authority to investigate claims of retaliation. If a pharmacy benefit manager or pharmacy benefit manager affiliate is found to have retaliated against a pharmacist, pharmacy or pharmacy employee in violation of the provisions of this section, the board may revoke or suspend the license of the pharmacy benefit manager or pharmacy benefit manager affiliate.

SECTION 7. Section 73-21-73, Mississippi Code of 1972, is brought forward as follows:

73-21-73. As used in this chapter, unless the context requires otherwise:

(a) "Administer" means the direct application of a prescription drug pursuant to a lawful order of a practitioner to the body of a patient by injection, inhalation, ingestion or any other means.

(b) "Biological product" means the same as that term is defined in 42 USC Section 262.

(c) "Board of Pharmacy," "Pharmacy Board," "MSBP" or "board" means the State Board of Pharmacy.

(d) "Compounding" means (i) the production, preparation, propagation, conversion or processing of a sterile or nonsterile drug or device either directly or indirectly by extraction from substances of natural origin or independently by means of chemical or biological synthesis or from bulk chemicals or the preparation, mixing, measuring, assembling, packaging or labeling of a drug or device as a result of a practitioner's prescription drug order or initiative based on the practitioner/patient/pharmacist relationship in the course of professional practice, or (ii) for the purpose of, as an incident to, research, teaching or chemical analysis and not for sale or dispensing. Compounding also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine regularly observed prescribing patterns.

(e) "Continuing education unit" means ten (10) clock hours of study or other such activity as may be approved by the board, including, but not limited to, all programs which have been approved by the American Council on Pharmaceutical Education.

(f) "Deliver" or "delivery" means the actual, constructive or attempted transfer in any manner of a drug or device from one (1) person to another, whether or not for a

consideration, including, but not limited to, delivery by mailing or shipping.

(g) "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component part or accessory which is required under federal or state law to be prescribed by a practitioner and dispensed by a pharmacist.

(h) "Dispense" or "dispensing" means the interpretation of a valid prescription of a practitioner by a pharmacist and the subsequent preparation of the drug or device for administration to or use by a patient or other individual entitled to receive the drug.

(i) "Distribute" means the delivery of a drug or device other than by administering or dispensing to persons other than the ultimate consumer.

(j) "Drug" means:

(i) Articles recognized as drugs in the official United States Pharmacopeia, official National Formulary, official Homeopathic Pharmacopeia, other drug compendium or any supplement to any of them;

(ii) Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;

(iii) Articles other than food intended to affect the structure or any function of the body of man or other animals; and

(iv) Articles intended for use as a component of any articles specified in subparagraph (i), (ii) or (iii) of this paragraph.

(k) "Drugroom" means a business, which does not require the services of a pharmacist, where prescription drugs or prescription devices are bought, sold, maintained or provided to consumers.

(l) "Extern" means a student in the professional program of a school of pharmacy accredited by the American Council on Pharmaceutical Education who is making normal progress toward completion of a professional degree in pharmacy.

(m) "Foreign pharmacy graduate" means a person whose undergraduate pharmacy degree was conferred by a recognized school of pharmacy outside of the United States, the District of Columbia and Puerto Rico. Recognized schools of pharmacy are those colleges and universities listed in the World Health Organization's World Directory of Schools of Pharmacy, or otherwise approved by the Foreign Pharmacy Graduate Examination Committee (FPGEC) certification program as established by the National Association of Boards of Pharmacy.

(n) "Generic equivalent drug product" means a drug product which (i) contains the identical active chemical

ingredient of the same strength, quantity and dosage form; (ii) is of the same generic drug name as determined by the United States Adoptive Names and accepted by the United States Food and Drug Administration; and (iii) conforms to such rules and regulations as may be adopted by the board for the protection of the public to assure that such drug product is therapeutically equivalent.

(o) "Interchangeable biological product" or "I.B." means a biological product that the federal Food and Drug Administration:

(i) Has licensed and determined as meeting the standards for interchangeability under 42 USC Section 262(k)(4); or

(ii) Has determined is therapeutically equivalent as set forth in the latest edition of or supplement to the federal Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations.

(p) "Internet" means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocol to such protocol, to communicate information of all kinds by wire or radio.

(q) "Interested directly" means being employed by, having full or partial ownership of, or control of, any facility permitted or licensed by the Mississippi State Board of Pharmacy.

(r) "Interested indirectly" means having a spouse who is employed by any facility permitted or licensed by the Mississippi State Board of Pharmacy.

(s) "Intern" means a person who has graduated from a school of pharmacy but has not yet become licensed as a pharmacist.

(t) "Manufacturer" means a person, business or other entity engaged in the production, preparation, propagation, conversion or processing of a prescription drug or device, if such actions are associated with promotion and marketing of such drugs or devices.

(u) "Manufacturer's distributor" means any person or business who is not an employee of a manufacturer, but who distributes sample drugs or devices, as defined under subsection (i) of this section, under contract or business arrangement for a manufacturer to practitioners.

(v) "Manufacturing" of prescription products means the production, preparation, propagation, conversion or processing of a drug or device, either directly or indirectly, by extraction from substances from natural origin or independently by means of chemical or biological synthesis, or from bulk chemicals and includes any packaging or repackaging of the substance(s) or

labeling or relabeling of its container, if such actions are associated with promotion and marketing of such drug or devices.

(w) "Misappropriation of a prescription drug" means to illegally or unlawfully convert a drug, as defined in subsection (i) of this section, to one's own use or to the use of another.

(x) "Nonprescription drugs" means nonnarcotic medicines or drugs that may be sold without a prescription and are prepackaged and labeled for use by the consumer in accordance with the requirements of the statutes and regulations of this state and the federal government.

(y) "Person" means an individual, corporation, partnership, association or any other legal entity.

(z) "Pharmacist" means an individual health care provider licensed by this state to engage in the practice of pharmacy. This recognizes a pharmacist as a learned professional who is authorized to provide patient services.

(aa) "Pharmacy" means any location for which a pharmacy permit is required and in which prescription drugs are maintained, compounded and dispensed for patients by a pharmacist. This definition includes any location where pharmacy-related services are provided by a pharmacist.

(bb) "Prepackaging" means the act of placing small precounted quantities of drug products in containers suitable for dispensing or administering in anticipation of prescriptions or orders.

(cc) "Unlawful or unauthorized possession" means physical holding or control by a pharmacist of a controlled substance outside the usual and lawful course of employment.

(dd) "Practice of pharmacy" means a health care service that includes, but is not limited to, the compounding, dispensing, and labeling of drugs or devices; interpreting and evaluating prescriptions; administering and distributing drugs and devices; the compounding, dispensing and labeling of drugs and devices; maintaining prescription drug records; advising and consulting concerning therapeutic values, content, hazards and uses of drugs and devices; initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved by the board; selecting drugs; participating in drug utilization reviews; storing prescription drugs and devices; ordering lab work in accordance with written guidelines or protocols as defined by paragraph (nn) of this section; providing pharmacotherapeutic consultations; supervising supportive personnel and such other acts, services, operations or transactions necessary or incidental to the conduct of the foregoing.

(ee) "Practitioner" means a physician, dentist, veterinarian, or other health care provider authorized by law to diagnose and prescribe drugs.

(ff) "Prescription" means a written, verbal or electronically transmitted order issued by a practitioner for a

drug or device to be dispensed for a patient by a pharmacist. "Prescription" includes a standing order issued by a practitioner to an individual pharmacy that authorizes the pharmacy to dispense an opioid antagonist to certain persons without the person to whom the opioid antagonist is dispensed needing to have an individual prescription, as authorized by Section 41-29-319(3).

(gg) "Prescription drug" or "legend drug" means a drug which is required under federal law to be labeled with either of the following statements prior to being dispensed or delivered:

(i) "Caution: Federal law prohibits dispensing without prescription," or

(ii) "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian"; or a drug which is required by any applicable federal or state law or regulation to be dispensed on prescription only or is restricted to use by practitioners only.

(hh) "Product selection" means the dispensing of a generic equivalent drug product or an interchangeable biological product in lieu of the drug product ordered by the prescriber.

(ii) "Provider" or "primary health care provider" includes a pharmacist who provides health care services within his or her scope of practice pursuant to state law and regulation.

(jj) "Registrant" means a pharmacy or other entity which is registered with the Mississippi State Board of Pharmacy to buy, sell or maintain controlled substances.

(kk) "Repackager" means a person registered by the federal Food and Drug Administration as a repackager who removes a prescription drug product from its marketed container and places it into another, usually of smaller size, to be distributed to persons other than the consumer.

(ll) "Reverse distributor" means a business operator that is responsible for the receipt and appropriate return or disposal of unwanted, unneeded or outdated stocks of controlled or uncontrolled drugs from a pharmacy.

(mm) "Supportive personnel" or "pharmacist technician" means those individuals utilized in pharmacies whose responsibilities are to provide nonjudgmental technical services concerned with the preparation and distribution of drugs under the direct supervision and responsibility of a pharmacist.

(nn) "Written guideline or protocol" means an agreement in which any practitioner authorized to prescribe drugs delegates to a pharmacist authority to conduct specific prescribing functions in an institutional setting, or with the practitioner's individual patients, provided that a specific protocol agreement between the practitioner and the pharmacist is signed and filed as required by law or by rule or regulation of the board.

(oo) "Wholesaler" means a person who buys or otherwise acquires prescription drugs or prescription devices for resale or distribution, or for repackaging for resale or distribution, to persons other than consumers.

(pp) "Pharmacy benefit manager" has the same meaning as defined in Section 73-21-153.

SECTION 8. Section 73-21-83, Mississippi Code of 1972, is brought forward as follows:

73-21-83. (1) The board shall be responsible for the control and regulation of the practice of pharmacy, to include the regulation of pharmacy externs or interns and pharmacist technicians, in this state, the regulation of the wholesaler distribution of drugs and devices as defined in Section 73-21-73, the distribution of sample drugs or devices by manufacturer's distributors as defined in Section 73-21-73 by persons other than the original manufacturer or distributor in this state and the regulation of pharmacy benefit managers as defined in Section 73-21-153.

(2) A license for the practice of pharmacy shall be obtained by all persons prior to their engaging in the practice of pharmacy. However, the provisions of this chapter shall not apply to physicians, dentists, veterinarians, osteopaths or other practitioners of the healing arts who are licensed under the laws of the State of Mississippi and are authorized to dispense and administer prescription drugs in the course of their professional practice.

(3) The initial licensure fee shall be set by the board but shall not exceed Two Hundred Dollars ($200.00), except the initial

licensure fee for pharmacy benefit managers shall be set by the board but shall not exceed Five Hundred Dollars ($500.00).

(4) All students actively enrolled in a professional school of pharmacy accredited by the American Council on Pharmaceutical Education who are making satisfactory progress toward graduation and who act as an extern or intern under the direct supervision of a pharmacist in a location permitted by the Board of Pharmacy must obtain a pharmacy student registration prior to engaging in such activity. The student registration fee shall be set by the board but shall not exceed One Hundred Dollars ($100.00).

(5) All persons licensed to practice pharmacy prior to July 1, 1991, by the State Board of Pharmacy under Section 73-21-89 shall continue to be licensed under the provisions of Section 73-21-91.

SECTION 9. Section 73-21-91, Mississippi Code of 1972, is brought forward as follows:

73-21-91. (1) Every pharmacist shall renew his license annually. To renew his license, a pharmacist shall:

(a) Submit an application for renewal on the form prescribed by the board;

(b) Submit satisfactory evidence of the completion in the last licensure period of such continuing education units as shall be required by the board, but in no case less than one (1) continuing education unit in the last licensure period;

(c) (i) Pay any renewal fees as required by the board, not to exceed One Hundred Dollars ($100.00) for each annual licensing period, provided that the board may add a surcharge of not more than Five Dollars ($5.00) to a license renewal fee to fund a program to aid impaired pharmacists or pharmacy students. Any pharmacist license renewal received postmarked after December 31 of the renewal period will be returned and a Fifty Dollar ($50.00) late renewal fee will be assessed before renewal.

(ii) The license fee for a pharmacy benefit manager shall be set by the board, but shall not exceed Five Hundred Dollars ($500.00). Any license renewal received postmarked after December 31 of the renewal period will be returned and a Five Hundred Dollar ($500.00) late renewal fee will be assessed before renewal.

(2) Any pharmacist who has defaulted in license renewal may be reinstated within two (2) years upon payment of renewal fees in arrears and presentation of evidence of the required continuing education. Any pharmacist defaulting in license renewal for a period in excess of two (2) years shall be required to successfully complete the examination given by the board pursuant to Section 73-21-85 before being eligible for reinstatement as a pharmacist in Mississippi, or shall be required to appear before the board to be examined for his competence and knowledge of the practice of pharmacy, and may be required to submit evidence of continuing education. If the person is found fit by the board to

practice pharmacy in this state, the board may reinstate his license to practice pharmacy upon payment of all renewal fees in arrears.

(3) Each application or filing made under this section shall include the social security number(s) of the applicant in accordance with Section 93-11-64.

SECTION 10. Section 73-21-151, Mississippi Code of 1972, is brought forward as follows:

73-21-151. Sections 73-21-151 through 73-21-163 shall be known as the "Pharmacy Benefit Prompt Pay Act."

SECTION 11. Section 73-21-153, Mississippi Code of 1972, is brought forward as follows:

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

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

(b) "Commissioner" means the Mississippi Commissioner of Insurance.

(c) "Day" means a calendar day, unless otherwise defined or limited.

(d) "Electronic claim" means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a pharmacy benefit manager and approved by the department.

(e) "Electronic adjudication" means the process of electronically receiving, reviewing and accepting or rejecting an electronic claim.

(f) "Enrollee" means an individual who has been enrolled in a pharmacy benefit management plan.

(g) "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(h) "Pharmacy benefit manager" shall have the same definition as provided in Section 73-21-179. However, through June 30, 2014, the term "pharmacy benefit manager" shall not include an insurance company that provides an integrated health benefit plan and that does not separately contract for pharmacy benefit management services. From and after July 1, 2014, the term "pharmacy benefit manager" shall not include an insurance company unless the insurance company is providing services as a pharmacy benefit manager as defined in Section 73-21-179, in which case the insurance company shall be subject to Sections 73-21-151 through 73-21-159 only for those pharmacy benefit manager

services. In addition, the term "pharmacy benefit manager" shall not include the pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan or the Mississippi Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

(i) "Pharmacy benefit manager affiliate" means 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 benefit manager.

(j) "Pharmacy benefit management plan" shall have the same definition as provided in Section 73-21-179.

(k) "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

(l) "Uniform claim form" means a form prescribed by rule by the State Board of Pharmacy; however, for purposes of Sections 73-21-151 through 73-21-159, the board shall adopt the same definition or rule where the State Department of Insurance has adopted a rule covering the same type of claim. The board may modify the terminology of the rule and form when necessary to comply with the provisions of Sections 73-21-151 through 73-21-159.

(m) "Plan sponsors" means the employers, insurance companies, unions and health maintenance organizations that

contract with a pharmacy benefit manager for delivery of prescription services.

SECTION 12. Section 73-21-155, Mississippi Code of 1972, is brought forward as follows:

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

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

(3) (a) All benefits payable under a pharmacy benefit management plan shall be paid within seven (7) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days

after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within seven (7) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefit manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

(b) A clean claim does not include any of the following:

(i) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

(ii) Claims which are submitted fraudulently or that are based upon material misrepresentations;

(iii) Claims that require information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits or subrogation provisions under the plan sponsor's health insurance plan; or

(iv) Claims submitted by a pharmacist or pharmacy more than thirty (30) days after the date of service; if the pharmacist or pharmacy does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the pharmacist or pharmacy to the insured.

(c) Not later than seven (7) days after the date the pharmacy benefit manager actually receives an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating

documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the pharmacy benefit manager shall be paid within twenty (20) days after receipt.

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

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

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

(c) If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the pharmacy benefit manager must pay the pharmacy

(where the claim is owed to the pharmacy) or the patient (where the claim is owed to a patient) interest on accrued benefits at the rate of one and one-half percent (1-1/2%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

(d) Any pharmacy benefit manager and a pharmacy may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (3) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (4)(c) of this section shall apply.

(e) The State Board of Pharmacy may adopt rules and regulations necessary to ensure compliance with this subsection.

(5) (a) For purposes of this subsection (5), "network pharmacy" means a licensed pharmacy in this state that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate. A network pharmacy or pharmacist may decline to provide a brand name drug, multisource

generic drug, or service, if the network pharmacy or pharmacist is paid less than that network pharmacy's acquisition cost for the product. If the network pharmacy or pharmacist declines to provide such drug or service, the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug or service may be filled.

(b) The State Board of Pharmacy shall adopt rules and regulations necessary to implement and ensure compliance with this subsection, including, but not limited to, rules and regulations that address access to pharmacy services in rural or underserved areas in cases where a network pharmacy or pharmacist declines to provide a drug or service under paragraph (a) of this subsection. The board shall promulgate the rules and regulations required by this paragraph (b) not later than October 1, 2016.

(6) A pharmacy benefit manager shall not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated.

SECTION 13. Section 73-21-156, Mississippi Code of 1972, is brought forward as follows:

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

(a) "Maximum allowable cost list" means a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, setting the maximum allowable payment to a

pharmacy or pharmacist for a generic drug, brand-name drug, biologic product or other prescription drug. The term "maximum allowable cost list" includes without limitation:

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

(ii) Average manufacturer price;

(iii) Average wholesale price;

(iv) Brand effective rate or generic effective rate;

(v) Discount indexing;

(vi) Federal upper limits;

(vii) Wholesale acquisition cost; and

(viii) Any other term that a pharmacy benefit manager or a health care insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.

(b) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice.

(2) Before a pharmacy benefit manager places or continues a particular drug on a maximum allowable cost list, the drug:

(a) If the drug is a generic equivalent drug product as defined in 73-21-73, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the

"Orange Book" or "Green Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference approved by the board;

(b) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Mississippi; and

(c) Shall not be obsolete.

(3) A pharmacy benefit manager shall:

(a) Provide access to its maximum allowable cost list to each pharmacy subject to the maximum allowable cost list;

(b) Update its maximum allowable cost list on a timely basis, but in no event longer than three (3) calendar days; and

(c) Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list.

(4) A pharmacy benefit manager shall:

(a) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge a maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

(i) Not meeting the requirements of this section; or

(ii) Being below the pharmacy acquisition cost.

(b) The reasonable administrative appeal procedure shall include the following:

(i) A dedicated telephone number, email address and website for the purpose of submitting administrative appeals;

(ii) The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefit management plan or through a pharmacy service administrative organization; and

(iii) A period of less than thirty (30) business days to file an administrative appeal.

(c) The pharmacy benefit manager shall respond to the challenge under paragraph (a) of this subsection (4) within thirty (30) business days after receipt of the challenge.

(d) If a challenge is made under paragraph (a) of this subsection (4), the pharmacy benefit manager shall within thirty (30) business days after receipt of the challenge either:

(i) If the appeal is upheld:

1. Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;

2. Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

3. Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and

4. Make the change under item 1 of this subparagraph (i) effective for each similarly situated pharmacy as defined by the payor subject to the maximum allowable cost list; or

(ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Mississippi that have the drug currently in stock at a price below the maximum allowable cost as listed on the maximum allowable cost list; or

(iii) If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit manager shall adjust the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

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

(b) The amount shall be calculated on a per unit basis based on the same brand and generic product identifier or brand and generic code number.

SECTION 14. Section 73-21-157, Mississippi Code of 1972, is brought forward as follows:

73-21-157. (1) Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license to do business from the board. To obtain a license, the applicant shall submit an application to the board on a form to be prescribed by the board.

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

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

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

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

(4) (a) Any information required to be submitted to the board pursuant to licensure application that is considered proprietary by a pharmacy benefit manager shall be marked as confidential when submitted to the board. All such information shall not be subject to the provisions of the federal Freedom of

Information Act or the Mississippi Public Records Act and shall not be released by the board unless subject to an order from a court of competent jurisdiction. The board shall destroy or delete or cause to be destroyed or deleted all such information thirty (30) days after the board determines that the information is no longer necessary or useful.

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

(c) All employees of the board who have access to the information described in paragraph (a) of this subsection shall be fingerprinted, and the board shall submit a set of fingerprints for each employee to the Department of Public Safety for the purpose of conducting a criminal history records check. If no disqualifying record is identified at the state level, the Department of Public Safety shall forward the fingerprints to the

Federal Bureau of Investigation for a national criminal history records check.

(5) If the pharmacy benefit manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within thirty (30) days of the report being final.

(6) The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However, the board shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by subsection (1) of this section. The board may waive the requirements for filing financial information for the pharmacy benefit manager if an affiliate of the pharmacy benefit manager is already required to file such information under current law with the Commissioner of Insurance and allow the pharmacy benefit manager to file a copy of documents containing such information with the board in lieu of the statement required by this section.

(7) The expense of administering this section shall be assessed annually by the board against all pharmacy benefit managers operating in this state.

(8) A pharmacy benefit manager or third-party payor may not require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in

addition to federal and state requirements for licensure as a pharmacy in this state.

SECTION 15. Section 73-21-159, Mississippi Code of 1972, is brought forward as follows:

73-21-159. (1) In lieu of or in addition to making its own financial examination of a pharmacy benefit manager, the board may accept the report of a financial examination of other persons responsible for the pharmacy benefit manager under the laws of another state certified by the applicable official of such other state.

(2) The board shall coordinate financial examinations of a pharmacy benefit manager that provides pharmacy management benefit plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation. The pharmacy benefit manager being examined shall pay the cost of the examination. The cost of the examination shall be deposited in a special fund that shall provide all expenses for the licensing, supervision and examination of all pharmacy benefit managers subject to regulation under Sections 73-21-71 through 73-21-129 and Sections 73-21-151 through 73-21-163.

(3) The board may provide a copy of the financial examination to the person or entity who provides or operates the health insurance plan or to a pharmacist or pharmacy.

(4) The board is authorized to hire independent financial consultants to conduct financial examinations of a pharmacy

benefit manager and to expend funds collected under this section to pay the costs of such examinations.

SECTION 16. Section 73-21-161, Mississippi Code of 1972, is brought forward as follows:

73-21-161. (1) As used in this section, the term "referral" means:

(a) Ordering of a patient to a pharmacy by a pharmacy benefit manager affiliate either orally or in writing, including online messaging;

(b) Offering or implementing plan designs that require patients to use affiliated pharmacies; or

(c) Patient or prospective patient specific advertising, marketing, or promotion of a pharmacy by an affiliate.

The term "referral" does not include a pharmacy's inclusion by a pharmacy benefit manager affiliate in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the affiliate includes information regarding eligible nonaffiliate pharmacies in those communications and the information provided is accurate.

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

(a) Making referrals;

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

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

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

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

(5) In addition to any other remedy provided by law, a violation of this section by a pharmacy shall be grounds for

disciplinary action by the board under its authority granted in this chapter.

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

SECTION 17. Section 73-21-163, Mississippi Code of 1972, is brought forward as follows:

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

(2) The board may impose a monetary penalty on a pharmacy benefit manager or a pharmacy benefit manager affiliate for noncompliance with the provisions of the Sections 73-21-151 through 73-21-163, in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five

Thousand Dollars ($25,000.00) per violation. Each day a violation continues for the same brand or generic product identifier or brand or generic code number is a separate violation. The board shall prepare a record entered upon its minutes that states the basic facts upon which the monetary penalty was imposed. Any penalty collected under this subsection (2) shall be deposited into the special fund of the board.

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

(4) When payment of a monetary penalty assessed and levied by the board against a licensee, registrant or permit holder in accordance with this section is not paid by the licensee, registrant or permit holder when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the licensee,

registrant or permit holder, or if the licensee, registrant or permit holder is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record and make its determination thereon in accordance with the provisions of Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

(5) The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given violation of Sections 73-21-151 through 73-21-163. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

SECTION 18. Section 73-21-175, Mississippi Code of 1972, is brought forward as follows:

73-21-175. Sections 73-21-175 through 73-21-189 shall be known as "The Pharmacy Audit Integrity Act."

SECTION 19. Section 73-21-177, Mississippi Code of 1972, is brought forward as follows:

73-21-177. The purpose of Sections 73-21-175 through 73-21-189 is to establish minimum and uniform standards and criteria for the audit of pharmacy records by or on behalf of certain entities.

SECTION 20. Section 73-21-179, Mississippi Code of 1972, is brought forward as follows:

73-21-179. For purposes of Sections 73-21-175 through 73-21-189:

(a) "Entity" means a pharmacy benefit manager, a managed care company, a health plan sponsor, an insurance company, a third-party payor, or any company, group or agent that represents or is engaged by those entities.

(b) "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(c) "Individual prescription" means the original prescription for a drug signed by the prescriber, and excludes refills referenced on the prescription.

(d) "Pharmacy benefit manager" means a business that administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. Pharmacy benefit managers may also provide some, all, but may not be limited to, the following services either directly or through outsourcing or contracts with other entities:

(i) Adjudicate drug claims or any portion of the transaction.

(ii) Contract with retail and mail pharmacy networks.

(iii) Establish payment levels for pharmacies.

(iv) Develop formulary or drug list of covered therapies.

(v) Provide benefit design consultation.

(vi) Manage cost and utilization trends.

(vii) Contract for manufacturer rebates.

(viii) Provide fee-based clinical services to improve member care.

(ix) Third-party administration.

(e) "Pharmacy benefit management plan" means an arrangement for the delivery of pharmacist's services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist's services for an enrollee on a prepaid or insured basis that (i) contains one or

more incentive arrangements intended to influence the cost or level of pharmacist's services between the plan sponsor and one or more pharmacies with respect to the delivery of pharmacist's services; and (ii) requires or creates benefit payment differential incentives for enrollees to use under contract with the pharmacy benefit manager.

(f) "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

SECTION 21. Section 73-21-181, Mississippi Code of 1972, is brought forward as follows:

73-21-181. Sections 73-21-175 through 73-21-189 shall apply to any audit of the records of a pharmacy conducted by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department.

SECTION 22. Section 73-21-183, Mississippi Code of 1972, is brought forward as follows:

73-21-183. (1) The entity conducting an audit shall follow these procedures:

(a) The pharmacy contract must identify and describe in detail the audit procedures;

(b) The entity conducting the on-site audit must give the pharmacy written notice at least two (2) weeks before

conducting the initial on-site audit for each audit cycle, and the pharmacy shall have at least fourteen (14) days to respond to any desk audit requirements;

(c) The entity conducting the on-site or desk audit shall not interfere with the delivery of pharmacist services to a patient and shall utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

(d) Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;

(e) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not constitute fraud; however, those claims may be subject to recoupment. No such claim shall be subject to criminal penalties without proof of intent to commit fraud;

(f) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;

(g) A finding of an overpayment or an underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills

for similar drugs, except that recoupment shall be based on the actual overpayment or underpayment;

(h) A finding of an overpayment shall not include the dispensing fee amount unless a prescription was not dispensed;

(i) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;

(j) The period covered by an audit may not exceed two (2) years from the date the claim was submitted to or adjudicated by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefit manager, a health program administered by a department of the state or any entity that represents those companies, groups, or department;

(k) An audit may not be initiated or scheduled during the first five (5) calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;

(l) Any prescription that complies with state law and rule requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions;

(m) An exit interview that provides a pharmacy with an opportunity to respond to questions and comment on and clarify findings must be conducted at the end of an audit. The time of the interview must be agreed to by the pharmacy;

(n) Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan or insurer. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a particular pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan;

(o) The parameters of an audit must comply with consumer-oriented parameters based on manufacturer listings or recommendations for the following:

(i) The day supply for eyedrops must be calculated so that the consumer pays only one (1) thirty-day copayment if the bottle of eyedrops is intended by the manufacturer to be a thirty-day supply;

(ii) The day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment;

(iii) The day supply for a topical product must be determined by the judgment of the pharmacist based upon the treated area;

(p) (i) Where an audit is for a specifically identified problem that has been disclosed to the pharmacy, the

audit shall be limited to claims that are identified by prescription number;

(ii) For an audit other than described in subparagraph (i) of this paragraph (p), an audit shall be limited to one hundred (100) individual prescriptions that have been randomly selected;

(iii) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site;

(iv) Except for audits initiated under paragraph (i) of this subsection, an entity shall not initiate an audit of a pharmacy more than one (1) time in any quarter;

(r) A recoupment shall not be based on:

(i) Documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the State Board of Pharmacy; or

(ii) A requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the State Board of Pharmacy;

(s) Except for Medicare claims, approval of drug, prescriber or patient eligibility upon adjudication of a claim shall not be reversed unless the pharmacy or pharmacist obtained the adjudication by fraud or misrepresentation of claim elements; and

(t) A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

(2) The entity must provide the pharmacy with a written report of the audit and comply with the following requirements:

(a) The preliminary audit report must be delivered to the pharmacy within one hundred twenty (120) days after conclusion of the audit, with a reasonable extension to be granted upon request;

(b) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit, with a reasonable extension to be granted upon request;

(c) A final audit report shall be delivered to the pharmacy within one hundred eighty (180) days after receipt of the preliminary audit report or final appeal, as provided for in Section 73-21-185, whichever is later;

(d) The audit report must be signed by the auditor;

(e) Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185. If the identified discrepancy for an individual audit exceeds Twenty-five Thousand Dollars

($25,000.00), future payments in excess of that amount to the pharmacy may be withheld pending finalization of the audit;

(f) Interest shall not accrue during the audit period; and

(g) Each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor.

SECTION 23. Section 73-21-185, Mississippi Code of 1972, is brought forward as follows:

73-21-185. (1) Each entity conducting an audit shall establish a written appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(2) If, following the appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or that portion without the necessity of any further action.

(3) If, following the appeal, any of the issues raised in the appeal are not resolved to the satisfaction of either party, that party may ask for mediation of those unresolved issues. A certified mediator shall be chosen by agreement of the parties from the Court Annexed Mediators List maintained by the Mississippi Supreme Court.

SECTION 24. Section 73-21-187, Mississippi Code of 1972, is brought forward as follows:

73-21-187. Notwithstanding any other provision in Sections 73-21-175 through 73-21-189, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits. An extrapolation audit means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

SECTION 25. Section 73-21-189, Mississippi Code of 1972, is brought forward as follows:

73-21-189. Sections 73-21-175 through 73-21-189 do not apply to any audit, review or investigation that involves alleged fraud, willful misrepresentation or abuse.

SECTION 26. Section 73-21-191, Mississippi Code of 1972, is brought forward as follows:

73-21-191. (1) The State Board of Pharmacy may impose a monetary penalty on pharmacy benefit managers for noncompliance with the provisions of the Pharmacy Audit Integrity Act, Sections 73-21-175 through 73-21-189, in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five Thousand Dollars ($25,000.00) per violation. The board shall prepare a record entered upon its minutes which states the basic facts upon which the monetary penalty was imposed. Any penalty collected under this subsection (1) shall be deposited into the special fund of the board.

(2) The board may assess a monetary penalty for those reasonable costs that are expended by the board in the investigation and conduct of a proceeding if the board imposes a monetary penalty under subsection (1) of this section. A monetary penalty assessed and levied under this section shall be paid to the board by the licensee, registrant or permit holder upon the expiration of the period allowed for appeal of those penalties under Section 73-21-101, or may be paid sooner if the licensee, registrant or permit holder elects. Money collected by the board under this subsection (2) shall be deposited to the credit of the special fund of the board.

(3) When payment of a monetary penalty assessed and levied by the board against a licensee, registrant or permit holder in accordance with this section is not paid by the licensee, registrant or permit holder when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the licensee, registrant or permit holder, or if the licensee, registrant or permit holder is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record

and make its determination thereon in accordance with the provisions of Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

(4) The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given violation of board regulations and laws governing the practice of pharmacy. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

SECTION 27. Section 73-21-201, Mississippi Code of 1972, is brought forward as follows:

73-21-201. Sections 73-21-201 through 73-21-205 shall be known as the "Prescription Drugs Consumer Affordable Alternative Payment Options Act."

SECTION 28. Section 73-21-203, Mississippi Code of 1972, is brought forward as follows:

73-21-203. **Definitions.** For the purposes of Sections 73-21-201 through 73-21-205:

(a) "Board" shall have the same definition as provided in Section 73-21-73.

(b) "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

(c) "Pharmacy benefit manager" shall have the same definition as provided in Section 73-21-179.

SECTION 29. Section 73-21-205, Mississippi Code of 1972, is brought forward as follows:

73-21-205. (1) (a) Pharmacists may provide additional information to a patient to allow them an opportunity to consider affordable alternative payment options when acquiring their prescription medication.

(b) Any provision of any contract or agreement contrary to the provisions of Sections 73-21-201 through 73-21-205 shall be considered in violation of public policy and shall be void.

(2) Compliance with this section shall not constitute a violation of any contract or provision of any agreement to which the pharmacist or pharmacy is a party.

(3) Neither the board, any pharmacy benefit manager nor any third party shall penalize a pharmacist for acting or failing to act under this section, nor shall a pharmacist or his agents or employees be liable for any act or failure to act under this section.

SECTION 30. This act shall take effect and be in force from and after July 1, 2025.