MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative Turner To: Drug Policy

HOUSE BILL NO. 1708

AN ACT TO AMEND SECTION 25-15-301, MISSISSIPPI CODE OF 1972, TO MAKE CERTAIN REVISIONS RELATED TO THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE MANAGEMENT BOARD; TO PROVIDE THAT WHEN A PROPOSAL IS UNDER THE BOARD'S EVALUATION FOR PHARMACY BENEFITS OR THE MANAGEMENT THEREOF, THE EXECUTIVE DIRECTOR OF THE MISSISSIPPI BOARD OF PHARMACY SHALL BE ONE OF THE MEMBERS OF THE EVALUATION COMMITTEE OF THE BOARD; TO AMEND SECTION 25-15-303, MISSISSIPPI CODE OF 1972, TO INCLUDE THE EXECUTIVE DIRECTOR OF THE BOARD OF PHARMACY AS A MEMBER OF THE MANAGEMENT BOARD; TO CREATE NEW SECTION 25-15-305, MISSISSIPPI CODE OF 1972, TO PROVIDE CERTAIN DEFINITIONS RELATED TO THE ACT, INCLUDING THE DEFINITIONS OF CLEAN CLAIMS, PHARMACY BENEFIT PLAN, PHARMACY BENEFIT MANAGEMENT PLAN, AND REBATE; TO PROVIDE THAT THE ACT SHALL ONLY APPLY TO THE PHARMACY BENEFIT MANAGER AND ITS AFFILIATE THAT ADMINISTER THE STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN; TO CREATE NEW SECTION 25-15-307, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A PHARMACY BENEFIT MANAGER SHALL NOT REIMBURSE A PHARMACY OR PHARMACIST FOR A PRESCRIPTION DRUG OR PHARMACIST SERVICE IN A NET AMOUNT LESS THAN THE NATIONAL AVERAGE DRUG ACQUISITION COST FOR THE PRESCRIPTION DRUG OR PHARMACIST SERVICE IN EFFECT AT THE TIME THAT THE DRUG OR SERVICE IS ADMINISTERED OR DISPENSED, PLUS A PROFESSIONAL DISPENSING FEE AT LEAST EQUAL TO THE PROFESSIONAL DISPENSING FEE PAID BY THE MISSISSIPPI DIVISION OF MEDICAID FOR OUTPATIENT DRUGS; TO PROHIBIT PHARMACY BENEFIT MANAGERS FROM CHARGING A PLAN SPONSOR MORE FOR A PRESCRIPTION DRUG THAN THE NET AMOUNT IT PAYS A PHARMACY FOR THE PRESCRIPTION DRUG; TO REQUIRE PHARMACY BENEFIT MANAGERS TO PAY CLEAN CLAIMS WITHIN A CERTAIN TIME CONSTRAINT; TO PROVIDE CERTAIN EXCEPTIONS FROM THIS TIME CONSTRAINT; TO PROVIDE THAT IF THE BOARD FINDS THAT ANY PHARMACY BENEFIT MANAGER, AGENT OR OTHER PARTY RESPONSIBLE FOR REIMBURSEMENT FOR PRESCRIPTION DRUGS AND OTHER PRODUCTS HAS NOT PAID NINETY-FIVE PERCENT OF CLEAN CLAIMS RECEIVED FROM ALL PHARMACIES IN A CALENDAR QUARTER, HE SHALL BE SUBJECT TO ADMINISTRATIVE PENALTY OF NOT MORE THAN $25,000.00 TO BE ASSESSED

BY THE BOARD; TO AUTHORIZE THE BOARD TO ADOPT RULES AND REGULATIONS NECESSARY TO ENSURE COMPLIANCE WITH THIS ACT; TO AUTHORIZE A NETWORK PHARMACY OR PHARMACIST TO 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 COST FOR THE PRESCRIPTION; TO CREATE NEW SECTION 25-15-309, MISSISSIPPI CODE OF 1972, TO SET CERTAIN REQUIREMENTS RELATED TO PHARMACY BENEFIT MANAGERS, INCLUDING THAT THE PHARMACY BENEFIT MANAGER MUST PROVIDE A REASONABLE ADMINISTRATIVE APPEAL PROCEDURE; TO AUTHORIZE THE BOARD TO AUDIT PHARMACY BENEFIT MANAGERS; TO REQUIRE A PHARMACY BENEFIT MANAGER TO REIMBURSE A PHARMACY OR PHARMACIST AN AMOUNT LESS THAN THE AMOUNT THAT THE PHARMACY BENEFIT MANAGER REIMBURSES A PHARMACY BENEFIT MANAGER AFFILIATE FOR PROVIDING THE SAME PHARMACIST SERVICES; TO CREATE NEW SECTION 25-15-311, MISSISSIPPI CODE OF 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS TO OBTAIN A LICENSE FROM THE BOARD OF PHARMACY; TO CREATE NEW SECTION 25-15-313, MISSISSIPPI CODE OF 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS TO PASS ON TO THE STATE HEALTH INSURANCE PLAN ONE HUNDRED PERCENT OF ALL REBATES AND OTHER PAYMENTS THAT IT RECEIVES DIRECTLY OR INDIRECTLY FROM PHARMACEUTICAL MANUFACTURERS IN CONNECTION WITH CLAIMS OR PLAN ADMINISTRATION ON BEHALF OF THE PLAN; TO PROHIBIT A PHARMACY BENEFIT MANAGER OR THIRD-PARTY PAYOR FROM CHARGING OR CAUSING A PATIENT TO PAY A COPAYMENT THAT EXCEEDS THE TOTAL REIMBURSEMENT PAID BY THE PHARMACY BENEFIT MANAGER TO THE PHARMACY; TO CREATE NEW SECTION 25-15-315, MISSISSIPPI CODE OF 1972, TO PROHIBIT A PHARMACY, PHARMACY BENEFIT MANAGER, OR PHARMACY BENEFIT MANAGER AFFILIATE FROM TAKING CERTAIN ACTIONS, INCLUDING MAKING REFERRALS OR INTERFERING WITH A PATIENT'S RIGHT TO CHOOSE THEIR PHARMACY; TO CREATE NEW SECTION 25-15-317, MISSISSIPPI CODE OF 1972, TO PROHIBIT PHARMACY BENEFIT MANAGERS FROM RETALIATING AGAINST A PHARMACIST OR PHARMACY BASED ON THE PHARMACIST'S OR PHARMACY'S EXERCISE OF ANY RIGHT OR REMEDY UNDER THIS ACT; TO CREATE NEW SECTION 25-15-319, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE BOARD TO BRING AN ACTION AGAINST A PHARMACY BENEFIT MANAGER OR PHARMACY BENEFIT MANAGER AFFILIATE TO RESTRAIN BY TEMPORARY OR PERMANENT INJUNCTION THE USE OF ANY METHOD THAT IS PROHIBITED BY THIS ACT; TO AUTHORIZE THE BOARD TO IMPOSE A MONETARY PENALTY ON ANY PHARMACY BENEFIT MANAGER FOUND TO BE IN NONCOMPLIANCE; TO CREATE NEW SECTION 25-15-321, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT ON THE REQUEST BY ANY AGENCY OF THE STATE OF MISSISSIPPI, OR ANY POLITICAL SUBDIVISION OF THE STATE OR ANY OTHER PUBLIC ENTITY, A PHARMACY BENEFIT MANAGER SHALL DELIVER OR OTHERWISE MAKE AVAILABLE TO THE REQUESTING AGENCY OR ENTITY, IN ITS ENTIRETY AND WITH NO REDACTION, ANY THIRD PARTY AGGREGATOR CONTRACTS OR CONTRACTS RELATING TO PHARMACY BENEFIT MANAGER SERVICES; TO PROVIDE THAT ANY ENTITY THAT DOES NOT COMPLY WITH THIS SECTION SHALL BE BARRED FOR FIVE YEARS FROM DOING BUSINESS IN THE STATE; TO BRING FORWARD SECTIONS 73-21-73, 73-21-83, 73-21-91, 73-21-153, 73-21-155, 73-21-156, 73-21-157, 73-21-159, 73-21-161, 73-21-163, 73-21-177, 73-21-179, 73-21-181, 73-21-183, 73-21-185, 73-21-187,

73-21-189, 73-21-191, 73-21-201, 73-21-203, 73-21-205, 83-9-6, 83-9-6.1, 83-9-6.2, MISSISSIPPI CODE OF 1972, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 25-15-301, Mississippi Code of 1972, is amended as follows:

25-15-301. (1) The board may contract the administration and service of the self-insured program to a third party. Whenever the board chooses to contract with an administrator for the insurance plan established by Section 25-15-3 et seq., or components thereof, it shall comply with the procedures set forth in this section:

(a) If the board determines that it should contract out the administration of the plan to an administrator, it shall cause to be prepared a request for proposals. This request for proposals shall be prepared for distribution to any interested party. Notice of the board's intention to seek proposals shall be published in a newspaper of general circulation at least one (1) time per week for three (3) weeks before closing the period for interested parties to respond. Additional forms of notice may also be used. The newspaper notice shall inform the interested parties of the service to be contracted, existence of a request for proposals, how it can be obtained, when a proposal must be submitted, and to whom the proposal must be submitted. All requests for proposals shall describe clearly what service is to be contracted, and shall fully explain the criteria upon which an

evaluation of proposals shall be based. The criteria to be used for evaluations shall, at minimum, include:

(i) The administrator's proven ability to handle large group accident and health insurance plans;

(ii) The efficiency of the claims-paying procedures;

(iii) An estimate of the total charges for administering the plan.

(b) All proposals submitted by interested parties shall be evaluated by an internal review committee which shall apply the same criteria to all proposals when conducting an evaluation. The committee shall consist of at least three (3) members of the board. <u>When the proposal under evaluation is for pharmacy benefits or the management thereof, the Executive Director of the Mississippi Board of Pharmacy shall be one (1) of the members of the evaluation committee.</u> The results and recommendations of the evaluation shall be presented to the board for review. All evaluations presented to the board shall be retained by the board for at least three (3) years. The board may accept or reject any recommendation of the review committee, or it may conduct further inquiry into the proposals. Any further inquiry shall be clearly documented and all methods and recommendations shall be retained by the board and shall spread upon its minutes its choice of administrator and its reasons for making the choice.

(c) (i) The board shall be responsible for preparing a contract that shall be in accordance with all provisions of this section and all other provisions of law. The contract shall also include a requirement that the contractor shall consent to an evaluation of his performance. Such evaluation shall occur after the first six (6) months of the contract, and shall be reviewed at times the board determines to be necessary. The contract shall clearly describe the standards upon which the contractor shall be evaluated. Evaluations shall include, but not be limited to, efficiency in claims processing, including the processing pending claims.

(ii) The PEER Committee, at the request of the House or Senate Appropriations Committee or the House or Senate Insurance Committee and with funds specifically appropriated by the Legislature for such purpose, shall contract with an accounting firm or with other professionals to conduct a compliance audit of any administrator responsible for administering the insurance plan established by Section 25-15-3 et seq.<u>, or components thereof.</u> Such audit shall review the administrator's compliance with the performance standards required for inclusion in the administrator's contract. Such audit shall be delivered to the Legislature no later than January 1.

(2) Contracts for the administration of the insurance plan established in Section 25-15-3 et seq. shall commence at the beginning of the calendar year and shall end on the last day of a

calendar year. This shall not apply to contracts provided for in subsection (3) of this section.

(3) If the board determines that it is necessary to not renew the contract of an administrator, or finds it necessary to terminate a contract with or without cause as provided for in the contract of the administrator, the board is authorized to select an administrator without complying with the bid requirements in subsections (1) and (2) of this section. Such contracts shall be for the balance of the calendar year in which the nonrenewal or termination occurred, and may be for an additional calendar year if the board determines that the best interests of the plan members are served by such. Any contract negotiated on an interim basis shall include a detailed transition plan which shall ensure the orderly transfer of responsibilities between administrators and shall include, but not be limited to, provisions regarding the transfer of records, files and tapes.

(4) Except for contracts executed under the authority of subsection (3) of this section, the board shall select administrators at least six (6) months before the expiration of the current administrator's contract. The period between the selection of the new administrator and the effective date of the new contract shall be known as the transition period. Whenever the newly selected administrator is an entity different from the entity performing the administrator's function, it shall be the duty of the board to prepare a detailed transition plan which

shall insure the orderly transfer of responsibilities between administrators. This plan shall be effective during the transition period, and shall include, but not be limited to, provisions regarding the transfer of records, files and tapes. Further, the plan shall detail the steps necessary to transfer records and responsibilities and set deadlines for when such steps should be completed. The board shall include in all requests for proposals, contracts with administrators, and all other contracts, provisions requiring the cooperation of administrators and contractors in any future transition of responsibilities, and their cooperation with the board and other contractors with respect to ongoing coordination and delivery of health plan services. The board shall furnish the Legislature, Governor and advisory council with copies of all transition plans and keep them informed of progress on such plans.

(5) No brokerage fees shall be paid for the securing or executing of any contracts pertaining to the insurance plan established by Section 25-15-3 et seq.<u>, or components thereof</u>, whether fully insured or self-insured.

(6) Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the board or participant, or both. Any corporation, association, company or individual that contracts with the board for the administration or

service of the self-insured plan shall allow, upon notice by the board, the board or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the board. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by the board and such information shall be compiled in a manner that will provide a clear audit trail.

SECTION 2. Section 25-15-303, Mississippi Code of 1972, is amended as follows:

25-15-303. (1) There is created the State and School Employees Health Insurance Management Board, which shall administer the State and School Employees Life and Health Insurance Plan provided for under Section 25-15-3 et seq. The State and School Employees Health Insurance Management Board, hereafter referred to as the "board," shall also be responsible for administering all procedures for selecting third-party administrators provided for in Section 25-15-301.

(2) The board shall consist of the following:

(a) The Chairman of the Workers' Compensation Commission or his or her designee;

(b) The State Personnel Director, or his or her designee;

(c) The Commissioner of Insurance, or his or her designee;

(d) The Commissioner of Higher Education, or his or her designee;

(e) The State Superintendent of Public Education, or his or her designee;

(f) The Executive Director of the Department of Finance and Administration, or his or her designee;

(g) The Executive Director of the Mississippi Community College Board, or his or her designee;

(h) The Executive Director of the Public Employees' Retirement System, or his or her designee;

(i) Two (2) appointees of the Governor whose terms shall be concurrent with that of the Governor, one (1) of whom shall have experience in providing actuarial advice to companies that provide health insurance to large groups and one (1) of whom shall have experience in the day-to-day management and administration of a large self-funded health insurance group;

(j) The Chairman of the Senate Insurance Committee, or his or her designee;

(k) The Chairman of the House of Representatives Insurance Committee, or his or her designee;

(l) The Chairman of the Senate Appropriations Committee, or his or her designee; *** * ***

(m) The Chairman of the House of Representatives Appropriations Committee, or his or her designee *** * ***; and

(n) The Executive Director of the Mississippi Board of Pharmacy, or his or her designee.

The legislators, or their designees, shall serve as ex officio, nonvoting members of the board.

The Executive Director of the Department of Finance and Administration shall be the chairman of the board.

(3) The board shall meet at least monthly and maintain minutes of the meetings. A quorum shall consist of a majority of the authorized voting membership of the board. The board shall have the sole authority to promulgate rules and regulations governing the operations of the insurance plans and shall be vested with all legal authority necessary and proper to perform this function including, but not limited to:

(a) Defining the scope and coverages provided by the insurance plan;

(b) Seeking proposals for services or insurance through competitive processes where required by law and selecting service providers or insurers under procedures provided for by law; and

(c) Developing and adopting strategic plans and budgets for the insurance plan.

The department shall employ a State Insurance Administrator, who shall be responsible for the day-to-day management and administration of the insurance plan. The Department of Finance

and Administration shall provide to the board on a full-time basis personnel and technical support necessary and sufficient to effectively and efficiently carry out the requirements of this section.

(4) Members of the board shall not receive any compensation or per diem, but may receive travel reimbursement provided for under Section 25-3-41 except that the legislators shall receive per diem and expenses, which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the board shall be paid while the Legislature is in session.

SECTION 3. The following shall be codified as Section 25-15-305, Mississippi Code of 1972:

25-15-305. For the purposes of Section 25-15-301 et seq., the following words and phrases shall have the meanings defined herein unless the context clearly indicates otherwise:

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

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

(c) "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.

(d) "Electronic adjudication" means the process of electronically receiving and reviewing an electronic claim and either accepting and providing payment remittance advice for the electronic claim or rejecting the electronic claim.

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

(f) "Fund" means the special fund that shall be created by the board into which all monies collected through fines, penalties, audit and other expenses incurred in the administration of the pharmacy benefits management plan shall be deposited, and which shall be used for expenses for the regulation, supervision and examination of all pharmacy benefit managers subject to regulation under Sections 1 through 11 of this act.

(g) "Pharmacy benefit 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) "Payment remittance advice" means the claim detail that the pharmacy receives when successfully processing an electronic or paper claim. The claim detail shall contain, but is not limited to:

(i) The amount that the pharmacy benefit manager will reimburse for product ingredient;

(ii) The amount that the pharmacy benefit manager will reimburse for product dispensing fee; and

(iii) The amount that the pharmacy benefit manager dictates the patient must pay.

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

(k) "Pharmacy benefit manager" includes those entities defined as a pharmacy benefit manager in Section 73-21-179 and also includes those entities sponsoring or providing cash discount cards as defined in Section 83-9-6.1; provided, however, that for the purposes of this act, the term "pharmacy benefit manager" shall only include the pharmacy benefit manager and its affiliates that administer the insurance plan established by Section 25-15-3 et seq. 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.

(l) "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 or participant on a prepaid or insured basis or otherwise 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.

(m) "Pharmacy benefit manager affiliate" means an entity that directly or indirectly, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager.

(n) "Pharmacy services administrative organization" means any entity that contracts with a pharmacy or pharmacist to assist with third-party payor interactions and that may provide a variety of other administrative services, including contracting with pharmacy benefit managers on behalf of pharmacies and managing pharmacies' claims payments for third-party payors.

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

(p) "Rebate" means any payments and price concessions that accrue to a pharmacy benefit manager or its plan sponsor client, directly or indirectly, including through an affiliate, subsidiary, third party or intermediary, including off-shore group purchasing organizations, from a pharmaceutical manufacturer, its affiliate, subsidiary, third party or intermediary, including, but not limited to, payments, discounts, administration fees, credits, incentives or penalties associated directly or indirectly in any way with claims administered on behalf of a plan sponsor.

(q) "Uniform claim form" means a form prescribed by rule of the State Department of Insurance 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 3 through 11 of this act.

(r) "Wholesale acquisition cost" means the wholesale acquisition cost of the drug as defined in 42 USC Section 1395w-3a(c)(6)(B).

(s) "Board" means the State and School Employees Health Insurance Management Board.

SECTION 4. The following shall be codified as Section 25-15-307, Mississippi Code of 1972:

25-15-307. (1) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist for a prescription drug or pharmacist service in a net amount less than the national average drug acquisition cost for the prescription drug or pharmacist service in effect at the time that the drug or service is administered or dispensed, plus a professional dispensing fee at least equal to the professional dispensing fee paid by the Mississippi Division of Medicaid for outpatient drugs. If the national average drug acquisition cost is not available at the time that a drug is administered or dispensed, a pharmacy benefit manager shall not reimburse in a net amount that is less than the wholesale acquisition cost of the drug as defined in 42 USC Section 1395w-3a(c)(6)(B), plus a professional dispensing fee at least equal to the professional dispensing fee paid by the Mississippi Division of Medicaid for outpatient drugs. The net amount shall include all transaction fees, adjudication fees, price concessions, effective rate reconciliations and all other revenue and credits passing from the pharmacy to the pharmacy benefit manager. If neither of these reimbursement amounts is available at the time that the drug is administered or dispensed, the pharmacy benefit manager shall reimburse the pharmacy for the drug or service administered or dispensed for the pharmacy's usual and customary charge for the service or drug, plus a professional dispensing fee at least equal to the professional dispensing fee paid by the Mississippi Division of Medicaid for outpatient drugs.

(2) A pharmacy benefit manager shall be prohibited from charging a plan sponsor more for a prescription drug than the net amount it pays a pharmacy for the prescription drug as provided in subsection (1) of this section. Separately identified administrative fees or costs are exempt from this requirement, if mutually agreed upon in writing by the payor and pharmacy benefit manager.

(3) Any contract that provides for less than reimbursement provided in subsection (1) of this section violates the public policy of the state and is void.

(4) (a) All benefits payable under a pharmacy benefit management plan shall be paid within seven (7) days after receipt of a clean electronic claim where the claim was electronically adjudicated, 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 conditions, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan.

(b) If an electronic claim is denied, the pharmacy benefit manager shall notify 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. If a written claim is denied, the pharmacy benefit manager shall notify the pharmacy or pharmacies no later than thirty-five (35) days of receipt of such claim.

The pharmacy benefit manager shall provide the pharmacist or pharmacy 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.

(c) A claim for pharmacist services may not be retroactively denied or reduced after adjudication of the claim unless the:

(i) Original claim was submitted fraudulently;

(ii) Original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services;

(iii) Pharmacist services were not rendered by the pharmacy or pharmacist; or

(iv) Adjustment was agreed upon by the pharmacy before the denial or reduction.

(5) 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 received from all pharmacies in a calendar quarter, he or she shall be subject to administrative penalty of not more than Twenty-five Thousand Dollars ($25,000.00) to be assessed by the board.

(a) Examinations to determine compliance with this section 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 and deposited into a special fund that is created in the State Treasury, which shall be used by the board, upon appropriation by the Legislature, to support the operations of the board relating to the regulation of pharmacy benefit managers.

(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 shall 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 (4) 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 paragraph (c) of this subsection shall apply.

(e) The board may adopt rules and regulations necessary to ensure compliance with this subsection.

(6) (a) For purposes of this subsection (6), "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 cost for the prescription. 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 board shall adopt rules and regulations as 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.

(7) 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 5. The following shall be codified as Section 25-15-309, Mississippi Code of 1972:

25-15-309. (1) A pharmacy benefit manager shall:

(a) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge reimbursement for a specific drug or drugs as being below the reimbursement rate required by Section 73-21-155(1).

(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 forty-five (45) business days to file an administrative appeal.

(c) The pharmacy benefit manager shall respond to the challenge under paragraph (a) of this subsection (1) within forty-five (45) business days after receipt of the challenge.

(d) If a challenge is made under paragraph (a) of this subsection (1), the pharmacy benefit manager shall, within forty-five (45) business days after receipt of the challenge either:

(i) Uphold the appeal and:

1. Make the change to the reimbursement rate;

2. Reimburse the corrected rate within three (3) business days and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question, if necessary;

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; or

(ii) Deny the appeal and provide the challenging pharmacy or pharmacist the National Drug Code and the national

average drug acquisition or wholesale acquisition cost of the drug, as applicable.

(2) The board may conduct an audit or audits of appeals denied under the provisions of subsection (1) of this section to ensure compliance with its requirements. In conducting audits, the board is empowered to request production of documents pertaining to compliance with the provisions of this section, and documents so requested shall be produced within seven (7) days of the request unless extended by the board or its duly authorized staff.

(a) The pharmacy benefit manager being audited shall pay all costs of such audit. The cost of the audit examination shall be deposited into the special fund created in Section 73-21-155, and shall be used by the board, upon appropriation of the Legislature, to support the operations of the board relating to the regulation of pharmacy benefit managers.

(b) The board is authorized to hire independent consultants to conduct appeal audits of a pharmacy benefit manager and expend funds collected under this section to pay the cost of performing audit examination services.

(3) (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 6. The following shall be codified as Section 25-15-311, Mississippi Code of 1972:

25-15-311. (1) Before beginning to do business as a pharmacy benefit manager under this act, a pharmacy benefit manager shall obtain a license to do business from the Mississippi Board of Pharmacy.

(2) Unless otherwise specifically provided in this act, the pharmacy benefit manager shall comply with all provisions of the Pharmacy Benefit Prompt Pay Act as set out in Sections 73-21-151 through 73-21-163, all provisions of the Pharmacy Audit Integrity Act as set out in Sections 73-21-175 through 73-21-191, and all provisions of the Prescription Drugs Consumer Affordable Alternative Payment Options Act as set out in Sections 73-21-201 through 73-21-205.

SECTION 7. The following shall be codified as Section 25-15-313, Mississippi Code of 1972:

25-15-313. (1) In addition to the requirements of Section 25-15-301(6), a pharmacy benefit manager shall pass on to the plan one hundred percent (100%) of all rebates and other payments that it receives directly or indirectly from pharmaceutical manufacturers in connection with claims or plan administration on behalf of the plan. In addition, a pharmacy benefit manager shall

report annually to the plan the aggregate amount of all rebates and other payments that the pharmacy benefit manager received from pharmaceutical manufacturers in connection with claims administered on behalf of the plan.

(2) A pharmacy benefit manager or third-party payor may not charge or cause a patient to pay a copayment that exceeds the total reimbursement paid by the pharmacy benefit manager to the pharmacy.

SECTION 8. The following shall be codified as Section 25-15-315, Mississippi Code of 1972:

25-15-315. (1) As used in this section, the term "referral" means:

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

(b) Requiring a patient to use an affiliate pharmacy of another pharmacy benefit manager;

(c) Offering or implementing plan designs that require patients to use affiliated pharmacies or affiliated pharmacies of another pharmacy benefit manager or that penalize a patient, including requiring a patient to pay the full cost for a prescription or a higher cost-share, when a patient chooses not to use an affiliate pharmacy or the affiliate pharmacy of another pharmacy benefit manager; or

(d) Patient or prospective patient specific advertising, marketing, or promotion of a pharmacy by a pharmacy benefit manager or pharmacy benefit manager affiliate.

The term "referral" does not include a pharmacy's inclusion by a pharmacy benefit manager or a pharmacy benefit manager affiliate in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the pharmacy benefit manager or a pharmacy benefit manager 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;

(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 a pharmacy benefit manager or pharmacy benefit manager affiliate; or

(d) Interfering with the patient's right to choose the patient's pharmacy or provider of choice, including inducement, required referrals or offering financial or other incentives or measures that would constitute a violation of Section 83-9-6.

(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 9. The following shall be codified as Section 25-15-317, Mississippi Code of 1972:

25-15-317. (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 chapter. 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.

SECTION 10. The following shall be codified as Section 25-15-319, Mississippi Code of 1972:

25-15-319. (1) 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 by the provisions of this act 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 the provisions of this act 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 this act 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 that a violation continues 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 created in Section 3 of this act, and shall be used by the board to support the operations of the board relating to the regulation, supervision and examination of pharmacy benefit managers.

(3) For the purposes of conducting investigations, the board, through its chairman, may conduct examinations of a pharmacy benefit manager or pharmacy benefit manager affiliate and may also issue subpoenas to any individual, pharmacy, pharmacy benefit manager, or any other entity having documents or records that it deems relevant to the investigation. The board may contract with qualified impartial outside sources to assist in examinations to determine noncompliance with the provisions of this act. Money collected by the board under subsection (2) of this section may be used to pay the cost of conducting or contracting for such examinations.

(4) 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 pharmacy benefit manager or pharmacy benefit manager affiliate upon the expiration of forty-five (45) days or may be paid sooner if the pharmacy benefit manager or pharmacy benefit manager affiliate elects. Any penalty collected by the board under this subsection (4) shall be deposited into the special fund of the board created in Section 3 of this act.

(5) When payment of a monetary penalty assessed and levied by the board against a pharmacy benefit manager or pharmacy benefit manager affiliate in accordance with this section is not paid by the pharmacy benefit manager or pharmacy benefit manager affiliate 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 pharmacy benefit manager or pharmacy benefit manager affiliate, or if the pharmacy benefit manager or pharmacy benefit manager affiliate 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. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

(6) The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given violation of the provisions of this act. 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 11. The following shall be codified as Section 25-15-321, Mississippi Code of 1972:

25-15-321. (1) Upon the request by any agency of the State of Mississippi, or any political subdivision of the state or any other public entity, a pharmacy benefit manager shall deliver or otherwise make available to the requesting agency or entity, in its entirety and with no redaction, any third-party aggregator contracts or contracts relating to pharmacy benefit management services between a pharmacy benefit manager and the entity, as well as any contracts between the entity and a pharmacy services administrative organization.

(2) Any person, firm, corporation, partnership, association or other type of business entity that does not comply with this

section shall be barred for a period of five (5) years from the date of the original request for the contract from doing business with the State of Mississippi or any political subdivision or any other public entity thereof.

SECTION 12. 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 13. 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 14. 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 15. 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 16. 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 17. 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 18. 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 19. 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 20. 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 21. 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 22. 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 23. 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 24. 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 25. 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 26. 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 27. 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 28. 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 29. 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 30. 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 31. 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 32. 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 33. Section 83-9-6, Mississippi Code of 1972, is brought forward as follows:

83-9-6. (1) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services.

(2) As used in this section:

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

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

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

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

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

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

(3) A health insurance plan, policy, employee benefit plan or health maintenance organization may not:

(a) Prohibit or limit any person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of his choice who has agreed to participate in the plan according to the terms offered by the insurer;

(b) Deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;

(c) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class or copayment level under the health benefit plan when receiving services from a contract provider;

(d) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;

(e) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area;

(f) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or

(g) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more

restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service.

(4) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent or owner, may not waive, discount, rebate or distort a copayment of any insurer, policy or plan or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the State Board of Pharmacy.

(5) If a health benefit plan providing reimbursement to Mississippi residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit

plan at least sixty (60) days before the effective date of the plan or before July 1, 1995, whichever comes first. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

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

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

(8) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in

this state that is contrary to this section shall, to the extent of the conflict, be void.

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

SECTION 34. Section 83-9-6.1, Mississippi Code of 1972, is brought forward as follows:

83-9-6.1. (1) As used in this section:

(a) "Cash discount card" means a card, other than the program identification card of a member or participant of a prescription drug program, that allows the holder to obtain a discount on a prescription drug when paying for the prescription at the point-of-sale.

(b) "Prescription drug program" means a program or plan that provides coverages and benefits for prescription drugs for members or participants in the program, whether the program is a separate program or part of a health benefit plan.

(2) Any entity that administers a prescription drug program through a network of participating pharmacies for the benefit of any resident of the State of Mississippi shall not issue or distribute any cash discount card that the participating pharmacies must accept or honor as a condition or requirement of participation in the prescription drug program, or that the participating pharmacies must accept or honor if they accept or

honor program identification cards held by members or participants of any prescription drug program administered by the entity, unless the entity pays a portion of the cost of the discount given by the pharmacy for prescriptions purchased with the use of the cash discount card.

(3) Any person or entity that is not subject to subsection (2) of this section shall not issue or distribute any cash discount card to any resident of the State of Mississippi unless the person or entity pays a portion of the cost of the discount given by the pharmacy for prescriptions purchased with the use of the cash discount card.

(4) Any provision in any prescription drug program or health benefit plan that is executed, delivered, renewed or otherwise contracted for in this state that is not in compliance with this section shall be void to the extent of the noncompliance.

(5) The provisions of this section shall not apply to the issuers of Medicare Supplement Insurance policies.

(6) The Office of Attorney General, Consumer Protection Division, shall enforce the provisions of this section.

SECTION 35. Section 83-9-6.2, Mississippi Code of 1972, is brought forward as follows:

83-9-6.2. (1) Every health benefit plan that provides coverage for prescription drugs or devices, or that administers such a plan, including, but not limited to, health maintenance organizations and third-party administrators for self-insured

plans, shall issue to each insured a card or other technology containing standardized pharmacy benefit identification information. The card shall contain at a minimum the following information:

(a) The card issuer's name or logo on the front of the card;

(b) The cardholder's name and identification number, which shall be displayed on the front side of the card;

(c) The American National Standards Institute Issuer Identification Number assigned to the administrator or pharmacy benefit manager of the plan, when required for proper claims adjudication;

(d) The processor's control number, when required for proper claims adjudication;

(e) The insured's group number, when required for proper claims adjudication;

(f) The name and address of the benefits administrator or other entity responsible for prescription claims submission, adjudication or pharmacy provider correspondence for prescription benefits; and

(g) A help desk telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

(2) This section does not require a health benefit plan to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the health

benefit plan if the identification card contains the elements required by subsection (1) of this section.

(3) In order to ensure that insurance identification cards issued under this section contain accurate and updated information, each health benefit plan shall provide each subscriber with a new insurance identification card within a reasonable time after any information required for proper claims adjudication is changed.

(4) As used in this section, "health benefit plan" means any hospital or medical policy or certificate, hospital or medical service contract or health maintenance organization, a plan provided by a fully insured multiple employer welfare arrangement or any other entity providing a plan of health insurance subject to the jurisdiction of the Commissioner of Insurance and to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by the Health Insurance Portability and Accountability Act of 1996. A health benefit plan does not include the following:

(a) Accident;

(b) Credit;

(c) Disability income;

(d) Long-term or nursing home care;

(e) Specified disease;

(f) Dental or vision;

(g) Coverage issued as a supplement to liability insurance;

(h) Medical payments under automobile or homeowners;

(i) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability or equivalent self-insurance; and

(j) Hospital income or indemnity.

(5) The Commissioner of Insurance may issue any rules or regulations necessary to implement the provisions of this section, and he may use the standards produced by the National Council for Prescription Drugs Programs as a guide in developing such rules and regulations.

(6) This section applies to plans that are delivered, issued for delivery or renewed on or after January 1, 2003. For purposes of this section, renewal of a health benefit policy, contract or plan is presumed to occur on the anniversary date.

SECTION 36. This act shall take effect and be in force from and after July 1, 2024.