

By: Representative Turner

To: Drug Policy

HOUSE BILL NO. 1708

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



35 BY THE BOARD; TO AUTHORIZE THE BOARD TO ADOPT RULES AND
36 REGULATIONS NECESSARY TO ENSURE COMPLIANCE WITH THIS ACT; TO
37 AUTHORIZE A NETWORK PHARMACY OR PHARMACIST TO DECLINE TO PROVIDE A
38 BRAND NAME DRUG, MULTISOURCE GENERIC DRUG, OR SERVICE, IF THE
39 NETWORK PHARMACY OR PHARMACIST IS PAID LESS THAN THAT NETWORK
40 PHARMACY'S COST FOR THE PRESCRIPTION; TO CREATE NEW SECTION
41 25-15-309, MISSISSIPPI CODE OF 1972, TO SET CERTAIN REQUIREMENTS
42 RELATED TO PHARMACY BENEFIT MANAGERS, INCLUDING THAT THE PHARMACY
43 BENEFIT MANAGER MUST PROVIDE A REASONABLE ADMINISTRATIVE APPEAL
44 PROCEDURE; TO AUTHORIZE THE BOARD TO AUDIT PHARMACY BENEFIT
45 MANAGERS; TO REQUIRE A PHARMACY BENEFIT MANAGER TO REIMBURSE A
46 PHARMACY OR PHARMACIST AN AMOUNT LESS THAN THE AMOUNT THAT THE
47 PHARMACY BENEFIT MANAGER REIMBURSES A PHARMACY BENEFIT MANAGER
48 AFFILIATE FOR PROVIDING THE SAME PHARMACIST SERVICES; TO CREATE
49 NEW SECTION 25-15-311, MISSISSIPPI CODE OF 1972, TO REQUIRE
50 PHARMACY BENEFIT MANAGERS TO OBTAIN A LICENSE FROM THE BOARD OF
51 PHARMACY; TO CREATE NEW SECTION 25-15-313, MISSISSIPPI CODE OF
52 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS TO PASS ON TO THE STATE
53 HEALTH INSURANCE PLAN ONE HUNDRED PERCENT OF ALL REBATES AND OTHER
54 PAYMENTS THAT IT RECEIVES DIRECTLY OR INDIRECTLY FROM
55 PHARMACEUTICAL MANUFACTURERS IN CONNECTION WITH CLAIMS OR PLAN
56 ADMINISTRATION ON BEHALF OF THE PLAN; TO PROHIBIT A PHARMACY
57 BENEFIT MANAGER OR THIRD-PARTY PAYOR FROM CHARGING OR CAUSING A
58 PATIENT TO PAY A COPAYMENT THAT EXCEEDS THE TOTAL REIMBURSEMENT
59 PAID BY THE PHARMACY BENEFIT MANAGER TO THE PHARMACY; TO CREATE
60 NEW SECTION 25-15-315, MISSISSIPPI CODE OF 1972, TO PROHIBIT A
61 PHARMACY, PHARMACY BENEFIT MANAGER, OR PHARMACY BENEFIT MANAGER
62 AFFILIATE FROM TAKING CERTAIN ACTIONS, INCLUDING MAKING REFERRALS
63 OR INTERFERING WITH A PATIENT'S RIGHT TO CHOOSE THEIR PHARMACY; TO
64 CREATE NEW SECTION 25-15-317, MISSISSIPPI CODE OF 1972, TO
65 PROHIBIT PHARMACY BENEFIT MANAGERS FROM RETALIATING AGAINST A
66 PHARMACIST OR PHARMACY BASED ON THE PHARMACIST'S OR PHARMACY'S
67 EXERCISE OF ANY RIGHT OR REMEDY UNDER THIS ACT; TO CREATE NEW
68 SECTION 25-15-319, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE
69 BOARD TO BRING AN ACTION AGAINST A PHARMACY BENEFIT MANAGER OR
70 PHARMACY BENEFIT MANAGER AFFILIATE TO RESTRAIN BY TEMPORARY OR
71 PERMANENT INJUNCTION THE USE OF ANY METHOD THAT IS PROHIBITED BY
72 THIS ACT; TO AUTHORIZE THE BOARD TO IMPOSE A MONETARY PENALTY ON
73 ANY PHARMACY BENEFIT MANAGER FOUND TO BE IN NONCOMPLIANCE; TO
74 CREATE NEW SECTION 25-15-321, MISSISSIPPI CODE OF 1972, TO PROVIDE
75 THAT ON THE REQUEST BY ANY AGENCY OF THE STATE OF MISSISSIPPI, OR
76 ANY POLITICAL SUBDIVISION OF THE STATE OR ANY OTHER PUBLIC ENTITY,
77 A PHARMACY BENEFIT MANAGER SHALL DELIVER OR OTHERWISE MAKE
78 AVAILABLE TO THE REQUESTING AGENCY OR ENTITY, IN ITS ENTIRETY AND
79 WITH NO REDACTION, ANY THIRD PARTY AGGREGATOR CONTRACTS OR
80 CONTRACTS RELATING TO PHARMACY BENEFIT MANAGER SERVICES; TO
81 PROVIDE THAT ANY ENTITY THAT DOES NOT COMPLY WITH THIS SECTION
82 SHALL BE BARRED FOR FIVE YEARS FROM DOING BUSINESS IN THE STATE;
83 TO BRING FORWARD SECTIONS 73-21-73, 73-21-83, 73-21-91, 73-21-153,
84 73-21-155, 73-21-156, 73-21-157, 73-21-159, 73-21-161, 73-21-163,
85 73-21-177, 73-21-179, 73-21-181, 73-21-183, 73-21-185, 73-21-187,



86 73-21-189, 73-21-191, 73-21-201, 73-21-203, 73-21-205, 83-9-6,
87 83-9-6.1, 83-9-6.2, MISSISSIPPI CODE OF 1972, FOR THE PURPOSE OF
88 POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

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

92 25-15-301. (1) The board may contract the administration
93 and service of the self-insured program to a third party.
94 Whenever the board chooses to contract with an administrator for
95 the insurance plan established by Section 25-15-3 et seq., or
96 components thereof, it shall comply with the procedures set forth
97 in this section:

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



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

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

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

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

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



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

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

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



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

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

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



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

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

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



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

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

222 25-15-303. (1) There is created the State and School
223 Employees Health Insurance Management Board, which shall
224 administer the State and School Employees Life and Health
225 Insurance Plan provided for under Section 25-15-3 et seq. The
226 State and School Employees Health Insurance Management Board,
227 hereafter referred to as the "board," shall also be responsible
228 for administering all procedures for selecting third-party
229 administrators provided for in Section 25-15-301.

230 (2) The board shall consist of the following:

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

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



- 235 (c) The Commissioner of Insurance, or his or her
236 designee;
- 237 (d) The Commissioner of Higher Education, or his or her
238 designee;
- 239 (e) The State Superintendent of Public Education, or
240 his or her designee;
- 241 (f) The Executive Director of the Department of Finance
242 and Administration, or his or her designee;
- 243 (g) The Executive Director of the Mississippi Community
244 College Board, or his or her designee;
- 245 (h) The Executive Director of the Public Employees'
246 Retirement System, or his or her designee;
- 247 (i) Two (2) appointees of the Governor whose terms
248 shall be concurrent with that of the Governor, one (1) of whom
249 shall have experience in providing actuarial advice to companies
250 that provide health insurance to large groups and one (1) of whom
251 shall have experience in the day-to-day management and
252 administration of a large self-funded health insurance group;
- 253 (j) The Chairman of the Senate Insurance Committee, or
254 his or her designee;
- 255 (k) The Chairman of the House of Representatives
256 Insurance Committee, or his or her designee;
- 257 (l) The Chairman of the Senate Appropriations
258 Committee, or his or her designee; * * *



259 (m) The Chairman of the House of Representatives
260 Appropriations Committee, or his or her designee * * *; and
261 (n) The Executive Director of the Mississippi Board of
262 Pharmacy, or his or her designee.

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

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

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

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

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

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

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



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

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

296 **SECTION 3.** The following shall be codified as Section
297 25-15-305, Mississippi Code of 1972:

298 25-15-305. For the purposes of Section 25-15-301 et seq.,
299 the following words and phrases shall have the meanings defined
300 herein unless the context clearly indicates otherwise:

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

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



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

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

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

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

327 (g) "Pharmacy benefit plan" means benefits consisting
328 of prescription drugs, other products and supplies, and pharmacist
329 services provided directly, through insurance or reimbursement, or
330 otherwise and including items and services paid for as
331 prescription drugs, other products and supplies, and pharmacist
332 services under any hospital or medical service policy or
333 certificate, hospital or medical service plan contract, preferred



334 provider organization agreement, or health maintenance
335 organization contract offered by a health insurance issuer.

336 (h) "Payment remittance advice" means the claim detail
337 that the pharmacy receives when successfully processing an
338 electronic or paper claim. The claim detail shall contain, but is
339 not limited to:

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

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

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

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

349 (k) "Pharmacy benefit manager" includes those entities
350 defined as a pharmacy benefit manager in Section 73-21-179 and
351 also includes those entities sponsoring or providing cash discount
352 cards as defined in Section 83-9-6.1; provided, however, that for
353 the purposes of this act, the term "pharmacy benefit manager"
354 shall only include the pharmacy benefit manager and its affiliates
355 that administer the insurance plan established by Section 25-15-3
356 et seq. The term "pharmacy benefit manager" shall not include an
357 insurance company unless the insurance company is providing



358 services as a pharmacy benefit manager as defined in Section
359 73-21-179.

360 (1) "Pharmacy benefit management plan" means an
361 arrangement for the delivery of pharmacist's services in which a
362 pharmacy benefit manager undertakes to administer the payment or
363 reimbursement of any of the costs of pharmacist's services for an
364 enrollee or participant on a prepaid or insured basis or otherwise
365 that:

366 (i) Contains one or more incentive arrangements
367 intended to influence the cost or level of pharmacist's services
368 between the plan sponsor and one or more pharmacies with respect
369 to the delivery of pharmacist's services; and

370 (ii) Requires or creates benefit payment
371 differential incentives for enrollees to use under contract with
372 the pharmacy benefit manager.

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

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



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

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

396 (q) "Uniform claim form" means a form prescribed by
397 rule of the State Department of Insurance covering the same type
398 of claim. The board may modify the terminology of the rule and
399 form when necessary to comply with the provisions of Sections 3
400 through 11 of this act.

401 (r) "Wholesale acquisition cost" means the wholesale
402 acquisition cost of the drug as defined in 42 USC Section
403 1395w-3a(c)(6)(B).

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

406 **SECTION 4.** The following shall be codified as Section
407 25-15-307, Mississippi Code of 1972:



408 25-15-307. (1) A pharmacy benefit manager shall not
409 reimburse a pharmacy or pharmacist for a prescription drug or
410 pharmacist service in a net amount less than the national average
411 drug acquisition cost for the prescription drug or pharmacist
412 service in effect at the time that the drug or service is
413 administered or dispensed, plus a professional dispensing fee at
414 least equal to the professional dispensing fee paid by the
415 Mississippi Division of Medicaid for outpatient drugs. If the
416 national average drug acquisition cost is not available at the
417 time that a drug is administered or dispensed, a pharmacy benefit
418 manager shall not reimburse in a net amount that is less than the
419 wholesale acquisition cost of the drug as defined in 42 USC
420 Section 1395w-3a(c)(6)(B), plus a professional dispensing fee at
421 least equal to the professional dispensing fee paid by the
422 Mississippi Division of Medicaid for outpatient drugs. The net
423 amount shall include all transaction fees, adjudication fees,
424 price concessions, effective rate reconciliations and all other
425 revenue and credits passing from the pharmacy to the pharmacy
426 benefit manager. If neither of these reimbursement amounts is
427 available at the time that the drug is administered or dispensed,
428 the pharmacy benefit manager shall reimburse the pharmacy for the
429 drug or service administered or dispensed for the pharmacy's usual
430 and customary charge for the service or drug, plus a professional
431 dispensing fee at least equal to the professional dispensing fee
432 paid by the Mississippi Division of Medicaid for outpatient drugs.



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

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

443 (4) (a) All benefits payable under a pharmacy benefit
444 management plan shall be paid within seven (7) days after receipt
445 of a clean electronic claim where the claim was electronically
446 adjudicated, and shall be paid within thirty-five (35) days after
447 receipt of due written proof of a clean claim where claims are
448 submitted in paper format. Benefits due under the plan and claims
449 are overdue if not paid within seven (7) days or thirty-five (35)
450 days, whichever is applicable, after the pharmacy benefit manager
451 receives a clean claim containing necessary information essential
452 for the pharmacy benefit manager to administer preexisting
453 conditions, coordination of benefits and subrogation provisions
454 under the plan sponsor's health insurance plan.

455 (b) If an electronic claim is denied, the pharmacy
456 benefit manager shall notify the pharmacist or pharmacy of the
457 reasons why the claim or portion thereof is not clean and will not



458 be paid and what substantiating documentation and information is
459 required to adjudicate the claim as clean. If a written claim is
460 denied, the pharmacy benefit manager shall notify the pharmacy or
461 pharmacies no later than thirty-five (35) days of receipt of such
462 claim.

463 The pharmacy benefit manager shall provide the pharmacist or
464 pharmacy the reasons why the claim or portion thereof is not clean
465 and will not be paid and what substantiating documentation and
466 information is required to adjudicate the claim as clean. Any
467 claim or portion thereof resubmitted with the supporting
468 documentation and information requested by the pharmacy benefit
469 manager shall be paid within twenty (20) days after receipt.

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

473 (i) Original claim was submitted fraudulently;

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

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

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

481 (5) If the board finds that any pharmacy benefit manager,
482 agent or other party responsible for reimbursement for



483 prescription drugs and other products and supplies has not paid
484 ninety-five percent (95%) of clean claims received from all
485 pharmacies in a calendar quarter, he or she shall be subject to
486 administrative penalty of not more than Twenty-five Thousand
487 Dollars (\$25,000.00) to be assessed by the board.

488 (a) Examinations to determine compliance with this
489 section may be conducted by the board. The board may contract
490 with qualified impartial outside sources to assist in examinations
491 to determine compliance. The expenses of any such examinations
492 shall be paid by the pharmacy benefit manager examined and
493 deposited into a special fund that is created in the State
494 Treasury, which shall be used by the board, upon appropriation by
495 the Legislature, to support the operations of the board relating
496 to the regulation of pharmacy benefit managers.

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

501 (c) If the claim is not denied for valid and proper
502 reasons by the end of the applicable time period prescribed in
503 this provision, the pharmacy benefit manager shall pay the
504 pharmacy (where the claim is owed to the pharmacy) or the patient
505 (where the claim is owed to a patient) interest on accrued
506 benefits at the rate of one and one-half percent (1-1/2%) per
507 month accruing from the day after payment was due on the amount of



508 the benefits that remain unpaid until the claim is finally settled
509 or adjudicated. Whenever interest due pursuant to this provision
510 is less than One Dollar (\$1.00), such amount shall be credited to
511 the account of the person or entity to whom such amount is owed.

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

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

524 (6) (a) For purposes of this subsection (6), "network
525 pharmacy" means a licensed pharmacy in this state that has a
526 contract with a pharmacy benefit manager to provide covered drugs
527 at a negotiated reimbursement rate. A network pharmacy or
528 pharmacist may decline to provide a brand name drug, multisource
529 generic drug, or service, if the network pharmacy or pharmacist is
530 paid less than that network pharmacy's cost for the prescription.
531 If the network pharmacy or pharmacist declines to provide such
532 drug or service, the pharmacy or pharmacist shall provide the



533 customer with adequate information as to where the prescription
534 for the drug or service may be filled.

535 (b) The board shall adopt rules and regulations as
536 necessary to implement and ensure compliance with this subsection,
537 including, but not limited to, rules and regulations that address
538 access to pharmacy services in rural or underserved areas in cases
539 where a network pharmacy or pharmacist declines to provide a drug
540 or service under paragraph (a) of this subsection.

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

545 **SECTION 5.** The following shall be codified as Section
546 25-15-309, Mississippi Code of 1972:

547 25-15-309. (1) A pharmacy benefit manager shall:

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

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

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

556 (ii) The ability to submit an administrative
557 appeal directly to the pharmacy benefit manager regarding the



558 pharmacy benefit management plan or through a pharmacy service
559 administrative organization; and

560 (iii) A period of less than forty-five (45)
561 business days to file an administrative appeal.

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

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

569 (i) Uphold the appeal and:

570 1. Make the change to the reimbursement rate;

571 2. Reimburse the corrected rate within three

572 (3) business days and permit the challenging pharmacy or

573 pharmacist to reverse and rebill the claim in question, if

574 necessary;

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

577 4. Make the change under item 1. of this

578 subparagraph (i) effective for each similarly situated pharmacy;

579 or

580 (ii) Deny the appeal and provide the challenging

581 pharmacy or pharmacist the National Drug Code and the national



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

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

592 (a) The pharmacy benefit manager being audited shall
593 pay all costs of such audit. The cost of the audit examination
594 shall be deposited into the special fund created in Section
595 73-21-155, and shall be used by the board, upon appropriation of
596 the Legislature, to support the operations of the board relating
597 to the regulation of pharmacy benefit managers.

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

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



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

609 **SECTION 6.** The following shall be codified as Section
610 25-15-311, Mississippi Code of 1972:

611 25-15-311. (1) Before beginning to do business as a
612 pharmacy benefit manager under this act, a pharmacy benefit
613 manager shall obtain a license to do business from the Mississippi
614 Board of Pharmacy.

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

623 **SECTION 7.** The following shall be codified as Section
624 25-15-313, Mississippi Code of 1972:

625 25-15-313. (1) In addition to the requirements of Section
626 25-15-301(6), a pharmacy benefit manager shall pass on to the plan
627 one hundred percent (100%) of all rebates and other payments that
628 it receives directly or indirectly from pharmaceutical
629 manufacturers in connection with claims or plan administration on
630 behalf of the plan. In addition, a pharmacy benefit manager shall



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

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

639 **SECTION 8.** The following shall be codified as Section
640 25-15-315, Mississippi Code of 1972:

641 25-15-315. (1) As used in this section, the term "referral"
642 means:

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

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

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



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

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

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

670 (a) Making referrals;

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



681 (c) Presenting a claim for payment to any individual,
682 third-party payor, affiliate, or other entity for a service
683 furnished pursuant to a referral from a pharmacy benefit manager
684 or pharmacy benefit manager affiliate; or

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

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

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

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

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



705 **SECTION 9.** The following shall be codified as Section
706 25-15-317, Mississippi Code of 1972:

707 25-15-317. (1) Retaliation is prohibited.

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

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

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

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

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

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

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



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

738 **SECTION 10.** The following shall be codified as Section
739 25-15-319, Mississippi Code of 1972:

740 25-15-319. (1) Whenever the board has reason to believe
741 that a pharmacy benefit manager or pharmacy benefit manager
742 affiliate is using, has used, or is about to use any method, act
743 or practice prohibited by the provisions of this act and that
744 proceedings would be in the public interest, it may bring an
745 action in the name of the board against the pharmacy benefit
746 manager or pharmacy benefit manager affiliate to restrain by
747 temporary or permanent injunction the use of such method, act or
748 practice. The action shall be brought in the Chancery Court of
749 the First Judicial District of Hinds County, Mississippi. The
750 court is authorized to issue temporary or permanent injunctions to
751 restrain and prevent violations of the provisions of this act and
752 such injunctions shall be issued without bond.



753 (2) The board may impose a monetary penalty on a pharmacy
754 benefit manager or a pharmacy benefit manager affiliate for
755 noncompliance with the provisions of this act in amounts of not
756 less than One Thousand Dollars (\$1,000.00) per violation and not
757 more than Twenty-five Thousand Dollars (\$25,000.00) per violation.
758 Each day that a violation continues is a separate violation. The
759 board shall prepare a record entered upon its minutes that states
760 the basic facts upon which the monetary penalty was imposed. Any
761 penalty collected under this subsection (2) shall be deposited
762 into the special fund of the board created in Section 3 of this
763 act, and shall be used by the board to support the operations of
764 the board relating to the regulation, supervision and examination
765 of pharmacy benefit managers.

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



777 (4) The board may assess a monetary penalty for those
778 reasonable costs that are expended by the board in the
779 investigation and conduct of a proceeding if the board imposes a
780 monetary penalty under subsection (2) of this section. A monetary
781 penalty assessed and levied under this section shall be paid to
782 the board by the pharmacy benefit manager or pharmacy benefit
783 manager affiliate upon the expiration of forty-five (45) days or
784 may be paid sooner if the pharmacy benefit manager or pharmacy
785 benefit manager affiliate elects. Any penalty collected by the
786 board under this subsection (4) shall be deposited into the
787 special fund of the board created in Section 3 of this act.

788 (5) When payment of a monetary penalty assessed and levied
789 by the board against a pharmacy benefit manager or pharmacy
790 benefit manager affiliate in accordance with this section is not
791 paid by the pharmacy benefit manager or pharmacy benefit manager
792 affiliate when due under this section, the board shall have the
793 power to institute and maintain proceedings in its name for
794 enforcement of payment in the chancery court of the county and
795 judicial district of residence of the pharmacy benefit manager or
796 pharmacy benefit manager affiliate, or if the pharmacy benefit
797 manager or pharmacy benefit manager affiliate is a nonresident of
798 the State of Mississippi, in the Chancery Court of the First
799 Judicial District of Hinds County, Mississippi. When those
800 proceedings are instituted, the board shall certify the record of
801 its proceedings, together with all documents and evidence, to the



802 chancery court and the matter shall be heard in due course by the
803 court, which shall review the record and make its determination
804 thereon. The hearing on the matter may, in the discretion of the
805 chancellor, be tried in vacation.

806 (6) The board shall develop and implement a uniform penalty
807 policy that sets the minimum and maximum penalty for any given
808 violation of the provisions of this act. The board shall adhere
809 to its uniform penalty policy except in those cases where the
810 board specifically finds, by majority vote, that a penalty in
811 excess of, or less than, the uniform penalty is appropriate. That
812 vote shall be reflected in the minutes of the board and shall not
813 be imposed unless it appears as having been adopted by the board.

814 **SECTION 11.** The following shall be codified as Section
815 25-15-321, Mississippi Code of 1972:

816 25-15-321. (1) Upon the request by any agency of the State
817 of Mississippi, or any political subdivision of the state or any
818 other public entity, a pharmacy benefit manager shall deliver or
819 otherwise make available to the requesting agency or entity, in
820 its entirety and with no redaction, any third-party aggregator
821 contracts or contracts relating to pharmacy benefit management
822 services between a pharmacy benefit manager and the entity, as
823 well as any contracts between the entity and a pharmacy services
824 administrative organization.

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



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

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

833 73-21-73. As used in this chapter, unless the context
834 requires otherwise:

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

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

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

843 (d) "Compounding" means (i) the production,
844 preparation, propagation, conversion or processing of a sterile or
845 nonsterile drug or device either directly or indirectly by
846 extraction from substances of natural origin or independently by
847 means of chemical or biological synthesis or from bulk chemicals
848 or the preparation, mixing, measuring, assembling, packaging or
849 labeling of a drug or device as a result of a practitioner's
850 prescription drug order or initiative based on the
851 practitioner/patient/pharmacist relationship in the course of



852 professional practice, or (ii) for the purpose of, as an incident
853 to, research, teaching or chemical analysis and not for sale or
854 dispensing. Compounding also includes the preparation of drugs or
855 devices in anticipation of prescription drug orders based on
856 routine regularly observed prescribing patterns.

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

861 (f) "Deliver" or "delivery" means the actual,
862 constructive or attempted transfer in any manner of a drug or
863 device from one (1) person to another, whether or not for a
864 consideration, including, but not limited to, delivery by mailing
865 or shipping.

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

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



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

879 (j) "Drug" means:

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

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

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

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

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

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



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

910 (n) "Generic equivalent drug product" means a drug
911 product which (i) contains the identical active chemical
912 ingredient of the same strength, quantity and dosage form; (ii) is
913 of the same generic drug name as determined by the United States
914 Adoptive Names and accepted by the United States Food and Drug
915 Administration; and (iii) conforms to such rules and regulations
916 as may be adopted by the board for the protection of the public to
917 assure that such drug product is therapeutically equivalent.

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

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

924 (ii) Has determined is therapeutically equivalent
925 as set forth in the latest edition of or supplement to the federal



926 Food and Drug Administration's Approved Drug Products with
927 Therapeutic Equivalence Evaluations.

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

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

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

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

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

949 (u) "Manufacturer's distributor" means any person or
950 business who is not an employee of a manufacturer, but who



951 distributes sample drugs or devices, as defined under subsection
952 (i) of this section, under contract or business arrangement for a
953 manufacturer to practitioners.

954 (v) "Manufacturing" of prescription products means the
955 production, preparation, propagation, conversion or processing of
956 a drug or device, either directly or indirectly, by extraction
957 from substances from natural origin or independently by means of
958 chemical or biological synthesis, or from bulk chemicals and
959 includes any packaging or repackaging of the substance(s) or
960 labeling or relabeling of its container, if such actions are
961 associated with promotion and marketing of such drug or devices.

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

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

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

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



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

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

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

988 (dd) "Practice of pharmacy" means a health care service
989 that includes, but is not limited to, the compounding, dispensing,
990 and labeling of drugs or devices; interpreting and evaluating
991 prescriptions; administering and distributing drugs and devices;
992 the compounding, dispensing and labeling of drugs and devices;
993 maintaining prescription drug records; advising and consulting
994 concerning therapeutic values, content, hazards and uses of drugs
995 and devices; initiating or modifying of drug therapy in accordance
996 with written guidelines or protocols previously established and
997 approved by the board; selecting drugs; participating in drug
998 utilization reviews; storing prescription drugs and devices;
999 ordering lab work in accordance with written guidelines or
1000 protocols as defined by paragraph (nn) of this section; providing



1001 pharmacotherapeutic consultations; supervising supportive
1002 personnel and such other acts, services, operations or
1003 transactions necessary or incidental to the conduct of the
1004 foregoing.

1005 (ee) "Practitioner" means a physician, dentist,
1006 veterinarian, or other health care provider authorized by law to
1007 diagnose and prescribe drugs.

1008 (ff) "Prescription" means a written, verbal or
1009 electronically transmitted order issued by a practitioner for a
1010 drug or device to be dispensed for a patient by a pharmacist.
1011 "Prescription" includes a standing order issued by a practitioner
1012 to an individual pharmacy that authorizes the pharmacy to dispense
1013 an opioid antagonist to certain persons without the person to whom
1014 the opioid antagonist is dispensed needing to have an individual
1015 prescription, as authorized by Section 41-29-319(3).

1016 (gg) "Prescription drug" or "legend drug" means a drug
1017 which is required under federal law to be labeled with either of
1018 the following statements prior to being dispensed or delivered:

1019 (i) "Caution: Federal law prohibits dispensing
1020 without prescription," or

1021 (ii) "Caution: Federal law restricts this drug to
1022 use by or on the order of a licensed veterinarian"; or a drug
1023 which is required by any applicable federal or state law or
1024 regulation to be dispensed on prescription only or is restricted
1025 to use by practitioners only.



1026 (hh) "Product selection" means the dispensing of a
1027 generic equivalent drug product or an interchangeable biological
1028 product in lieu of the drug product ordered by the prescriber.

1029 (ii) "Provider" or "primary health care provider"
1030 includes a pharmacist who provides health care services within his
1031 or her scope of practice pursuant to state law and regulation.

1032 (jj) "Registrant" means a pharmacy or other entity
1033 which is registered with the Mississippi State Board of Pharmacy
1034 to buy, sell or maintain controlled substances.

1035 (kk) "Repackager" means a person registered by the
1036 federal Food and Drug Administration as a repackager who removes a
1037 prescription drug product from its marketed container and places
1038 it into another, usually of smaller size, to be distributed to
1039 persons other than the consumer.

1040 (ll) "Reverse distributor" means a business operator
1041 that is responsible for the receipt and appropriate return or
1042 disposal of unwanted, unneeded or outdated stocks of controlled or
1043 uncontrolled drugs from a pharmacy.

1044 (mm) "Supportive personnel" or "pharmacist technician"
1045 means those individuals utilized in pharmacies whose
1046 responsibilities are to provide nonjudgmental technical services
1047 concerned with the preparation and distribution of drugs under the
1048 direct supervision and responsibility of a pharmacist.

1049 (nn) "Written guideline or protocol" means an agreement
1050 in which any practitioner authorized to prescribe drugs delegates



1051 to a pharmacist authority to conduct specific prescribing
1052 functions in an institutional setting, or with the practitioner's
1053 individual patients, provided that a specific protocol agreement
1054 between the practitioner and the pharmacist is signed and filed as
1055 required by law or by rule or regulation of the board.

1056 (oo) "Wholesaler" means a person who buys or otherwise
1057 acquires prescription drugs or prescription devices for resale or
1058 distribution, or for repackaging for resale or distribution, to
1059 persons other than consumers.

1060 (pp) "Pharmacy benefit manager" has the same meaning as
1061 defined in Section 73-21-153.

1062 **SECTION 13.** Section 73-21-83, Mississippi Code of 1972, is
1063 brought forward as follows:

1064 73-21-83. (1) The board shall be responsible for the
1065 control and regulation of the practice of pharmacy, to include the
1066 regulation of pharmacy externs or interns and pharmacist
1067 technicians, in this state, the regulation of the wholesaler
1068 distribution of drugs and devices as defined in Section 73-21-73,
1069 the distribution of sample drugs or devices by manufacturer's
1070 distributors as defined in Section 73-21-73 by persons other than
1071 the original manufacturer or distributor in this state and the
1072 regulation of pharmacy benefit managers as defined in Section
1073 73-21-153.

1074 (2) A license for the practice of pharmacy shall be obtained
1075 by all persons prior to their engaging in the practice of



1076 pharmacy. However, the provisions of this chapter shall not apply
1077 to physicians, dentists, veterinarians, osteopaths or other
1078 practitioners of the healing arts who are licensed under the laws
1079 of the State of Mississippi and are authorized to dispense and
1080 administer prescription drugs in the course of their professional
1081 practice.

1082 (3) The initial licensure fee shall be set by the board but
1083 shall not exceed Two Hundred Dollars (\$200.00), except the initial
1084 licensure fee for pharmacy benefit managers shall be set by the
1085 board but shall not exceed Five Hundred Dollars (\$500.00).

1086 (4) All students actively enrolled in a professional school
1087 of pharmacy accredited by the American Council on Pharmaceutical
1088 Education who are making satisfactory progress toward graduation
1089 and who act as an extern or intern under the direct supervision of
1090 a pharmacist in a location permitted by the Board of Pharmacy must
1091 obtain a pharmacy student registration prior to engaging in such
1092 activity. The student registration fee shall be set by the board
1093 but shall not exceed One Hundred Dollars (\$100.00).

1094 (5) All persons licensed to practice pharmacy prior to July
1095 1, 1991, by the State Board of Pharmacy under Section 73-21-89
1096 shall continue to be licensed under the provisions of Section
1097 73-21-91.

1098 **SECTION 14.** Section 73-21-91, Mississippi Code of 1972, is
1099 brought forward as follows:



1100 73-21-91. (1) Every pharmacist shall renew his license
1101 annually. To renew his license, a pharmacist shall:

1102 (a) Submit an application for renewal on the form
1103 prescribed by the board;

1104 (b) Submit satisfactory evidence of the completion in
1105 the last licensure period of such continuing education units as
1106 shall be required by the board, but in no case less than one (1)
1107 continuing education unit in the last licensure period;

1108 (c) (i) Pay any renewal fees as required by the board,
1109 not to exceed One Hundred Dollars (\$100.00) for each annual
1110 licensing period, provided that the board may add a surcharge of
1111 not more than Five Dollars (\$5.00) to a license renewal fee to
1112 fund a program to aid impaired pharmacists or pharmacy students.
1113 Any pharmacist license renewal received postmarked after December
1114 31 of the renewal period will be returned and a Fifty Dollar
1115 (\$50.00) late renewal fee will be assessed before renewal.

1116 (ii) The license fee for a pharmacy benefit
1117 manager shall be set by the board, but shall not exceed Five
1118 Hundred Dollars (\$500.00). Any license renewal received
1119 postmarked after December 31 of the renewal period will be
1120 returned and a Five Hundred Dollar (\$500.00) late renewal fee will
1121 be assessed before renewal.

1122 (2) Any pharmacist who has defaulted in license renewal may
1123 be reinstated within two (2) years upon payment of renewal fees in
1124 arrears and presentation of evidence of the required continuing



1125 education. Any pharmacist defaulting in license renewal for a
1126 period in excess of two (2) years shall be required to
1127 successfully complete the examination given by the board pursuant
1128 to Section 73-21-85 before being eligible for reinstatement as a
1129 pharmacist in Mississippi, or shall be required to appear before
1130 the board to be examined for his competence and knowledge of the
1131 practice of pharmacy, and may be required to submit evidence of
1132 continuing education. If the person is found fit by the board to
1133 practice pharmacy in this state, the board may reinstate his
1134 license to practice pharmacy upon payment of all renewal fees in
1135 arrears.

1136 (3) Each application or filing made under this section shall
1137 include the social security number(s) of the applicant in
1138 accordance with Section 93-11-64.

1139 **SECTION 15.** Section 73-21-153, Mississippi Code of 1972, is
1140 brought forward as follows:

1141 73-21-153. For purposes of Sections 73-21-151 through
1142 73-21-163, the following words and phrases shall have the meanings
1143 ascribed herein unless the context clearly indicates otherwise:

1144 (a) "Board" means the State Board of Pharmacy.

1145 (b) "Commissioner" means the Mississippi Commissioner
1146 of Insurance.

1147 (c) "Day" means a calendar day, unless otherwise
1148 defined or limited.



1149 (d) "Electronic claim" means the transmission of data
1150 for purposes of payment of covered prescription drugs, other
1151 products and supplies, and pharmacist services in an electronic
1152 data format specified by a pharmacy benefit manager and approved
1153 by the department.

1154 (e) "Electronic adjudication" means the process of
1155 electronically receiving, reviewing and accepting or rejecting an
1156 electronic claim.

1157 (f) "Enrollee" means an individual who has been
1158 enrolled in a pharmacy benefit management plan.

1159 (g) "Health insurance plan" means benefits consisting
1160 of prescription drugs, other products and supplies, and pharmacist
1161 services provided directly, through insurance or reimbursement, or
1162 otherwise and including items and services paid for as
1163 prescription drugs, other products and supplies, and pharmacist
1164 services under any hospital or medical service policy or
1165 certificate, hospital or medical service plan contract, preferred
1166 provider organization agreement, or health maintenance
1167 organization contract offered by a health insurance issuer.

1168 (h) "Pharmacy benefit manager" shall have the same
1169 definition as provided in Section 73-21-179. However, through
1170 June 30, 2014, the term "pharmacy benefit manager" shall not
1171 include an insurance company that provides an integrated health
1172 benefit plan and that does not separately contract for pharmacy
1173 benefit management services. From and after July 1, 2014, the



1174 term "pharmacy benefit manager" shall not include an insurance
1175 company unless the insurance company is providing services as a
1176 pharmacy benefit manager as defined in Section 73-21-179, in which
1177 case the insurance company shall be subject to Sections 73-21-151
1178 through 73-21-159 only for those pharmacy benefit manager
1179 services. In addition, the term "pharmacy benefit manager" shall
1180 not include the pharmacy benefit manager of the Mississippi State
1181 and School Employees Health Insurance Plan or the Mississippi
1182 Division of Medicaid or its contractors when performing pharmacy
1183 benefit manager services for the Division of Medicaid.

1184 (i) "Pharmacy benefit manager affiliate" means a
1185 pharmacy or pharmacist that directly or indirectly, through one or
1186 more intermediaries, owns or controls, is owned or controlled by,
1187 or is under common ownership or control with a pharmacy benefit
1188 manager.

1189 (j) "Pharmacy benefit management plan" shall have the
1190 same definition as provided in Section 73-21-179.

1191 (k) "Pharmacist," "pharmacist services" and "pharmacy"
1192 or "pharmacies" shall have the same definitions as provided in
1193 Section 73-21-73.

1194 (l) "Uniform claim form" means a form prescribed by
1195 rule by the State Board of Pharmacy; however, for purposes of
1196 Sections 73-21-151 through 73-21-159, the board shall adopt the
1197 same definition or rule where the State Department of Insurance
1198 has adopted a rule covering the same type of claim. The board may



1199 modify the terminology of the rule and form when necessary to
1200 comply with the provisions of Sections 73-21-151 through
1201 73-21-159.

1202 (m) "Plan sponsors" means the employers, insurance
1203 companies, unions and health maintenance organizations that
1204 contract with a pharmacy benefit manager for delivery of
1205 prescription services.

1206 **SECTION 16.** Section 73-21-155, Mississippi Code of 1972, is
1207 brought forward as follows:

1208 73-21-155. (1) Reimbursement under a contract to a
1209 pharmacist or pharmacy for prescription drugs and other products
1210 and supplies that is calculated according to a formula that uses
1211 Medi-Span, Gold Standard or a nationally recognized reference that
1212 has been approved by the board in the pricing calculation shall
1213 use the most current reference price or amount in the actual or
1214 constructive possession of the pharmacy benefit manager, its
1215 agent, or any other party responsible for reimbursement for
1216 prescription drugs and other products and supplies on the date of
1217 electronic adjudication or on the date of service shown on the
1218 nonelectronic claim.

1219 (2) Pharmacy benefit managers, their agents and other
1220 parties responsible for reimbursement for prescription drugs and
1221 other products and supplies shall be required to update the
1222 nationally recognized reference prices or amounts used for



1223 calculation of reimbursement for prescription drugs and other
1224 products and supplies no less than every three (3) business days.

1225 (3) (a) All benefits payable under a pharmacy benefit
1226 management plan shall be paid within seven (7) days after receipt
1227 of due written proof of a clean claim where claims are submitted
1228 electronically, and shall be paid within thirty-five (35) days
1229 after receipt of due written proof of a clean claim where claims
1230 are submitted in paper format. Benefits due under the plan and
1231 claims are overdue if not paid within seven (7) days or
1232 thirty-five (35) days, whichever is applicable, after the pharmacy
1233 benefit manager receives a clean claim containing necessary
1234 information essential for the pharmacy benefit manager to
1235 administer preexisting condition, coordination of benefits and
1236 subrogation provisions under the plan sponsor's health insurance
1237 plan. A "clean claim" means a claim received by any pharmacy
1238 benefit manager for adjudication and which requires no further
1239 information, adjustment or alteration by the pharmacist or
1240 pharmacies or the insured in order to be processed and paid by the
1241 pharmacy benefit manager. A claim is clean if it has no defect or
1242 impropriety, including any lack of substantiating documentation,
1243 or particular circumstance requiring special treatment that
1244 prevents timely payment from being made on the claim under this
1245 subsection. A clean claim includes resubmitted claims with
1246 previously identified deficiencies corrected.



1247 (b) A clean claim does not include any of the
1248 following:
1249 (i) A duplicate claim, which means an original
1250 claim and its duplicate when the duplicate is filed within thirty
1251 (30) days of the original claim;
1252 (ii) Claims which are submitted fraudulently or
1253 that are based upon material misrepresentations;
1254 (iii) Claims that require information essential
1255 for the pharmacy benefit manager to administer preexisting
1256 condition, coordination of benefits or subrogation provisions
1257 under the plan sponsor's health insurance plan; or
1258 (iv) Claims submitted by a pharmacist or pharmacy
1259 more than thirty (30) days after the date of service; if the
1260 pharmacist or pharmacy does not submit the claim on behalf of the
1261 insured, then a claim is not clean when submitted more than thirty
1262 (30) days after the date of billing by the pharmacist or pharmacy
1263 to the insured.
1264 (c) Not later than seven (7) days after the date the
1265 pharmacy benefit manager actually receives an electronic claim,
1266 the pharmacy benefit manager shall pay the appropriate benefit in
1267 full, or any portion of the claim that is clean, and notify the
1268 pharmacist or pharmacy (where the claim is owed to the pharmacist
1269 or pharmacy) of the reasons why the claim or portion thereof is
1270 not clean and will not be paid and what substantiating
1271 documentation and information is required to adjudicate the claim



1272 as clean. Not later than thirty-five (35) days after the date the
1273 pharmacy benefit manager actually receives a paper claim, the
1274 pharmacy benefit manager shall pay the appropriate benefit in
1275 full, or any portion of the claim that is clean, and notify the
1276 pharmacist or pharmacy (where the claim is owed to the pharmacist
1277 or pharmacy) of the reasons why the claim or portion thereof is
1278 not clean and will not be paid and what substantiating
1279 documentation and information is required to adjudicate the claim
1280 as clean. Any claim or portion thereof resubmitted with the
1281 supporting documentation and information requested by the pharmacy
1282 benefit manager shall be paid within twenty (20) days after
1283 receipt.

1284 (4) If the board finds that any pharmacy benefit manager,
1285 agent or other party responsible for reimbursement for
1286 prescription drugs and other products and supplies has not paid
1287 ninety-five percent (95%) of clean claims as defined in subsection
1288 (3) of this section received from all pharmacies in a calendar
1289 quarter, he shall be subject to administrative penalty of not more
1290 than Twenty-five Thousand Dollars (\$25,000.00) to be assessed by
1291 the State Board of Pharmacy.

1292 (a) Examinations to determine compliance with this
1293 subsection may be conducted by the board. The board may contract
1294 with qualified impartial outside sources to assist in examinations
1295 to determine compliance. The expenses of any such examinations
1296 shall be paid by the pharmacy benefit manager examined.



1297 (b) Nothing in the provisions of this section shall
1298 require a pharmacy benefit manager to pay claims that are not
1299 covered under the terms of a contract or policy of accident and
1300 sickness insurance or prepaid coverage.

1301 (c) If the claim is not denied for valid and proper
1302 reasons by the end of the applicable time period prescribed in
1303 this provision, the pharmacy benefit manager must pay the pharmacy
1304 (where the claim is owed to the pharmacy) or the patient (where
1305 the claim is owed to a patient) interest on accrued benefits at
1306 the rate of one and one-half percent (1-1/2%) per month accruing
1307 from the day after payment was due on the amount of the benefits
1308 that remain unpaid until the claim is finally settled or
1309 adjudicated. Whenever interest due pursuant to this provision is
1310 less than One Dollar (\$1.00), such amount shall be credited to the
1311 account of the person or entity to whom such amount is owed.

1312 (d) Any pharmacy benefit manager and a pharmacy may
1313 enter into an express written agreement containing timely claim
1314 payment provisions which differ from, but are at least as
1315 stringent as, the provisions set forth under subsection (3) of
1316 this section, and in such case, the provisions of the written
1317 agreement shall govern the timely payment of claims by the
1318 pharmacy benefit manager to the pharmacy. If the express written
1319 agreement is silent as to any interest penalty where claims are
1320 not paid in accordance with the agreement, the interest penalty
1321 provision of subsection (4)(c) of this section shall apply.



1322 (e) The State Board of Pharmacy may adopt rules and
1323 regulations necessary to ensure compliance with this subsection.

1324 (5) (a) For purposes of this subsection (5), "network
1325 pharmacy" means a licensed pharmacy in this state that has a
1326 contract with a pharmacy benefit manager to provide covered drugs
1327 at a negotiated reimbursement rate. A network pharmacy or
1328 pharmacist may decline to provide a brand name drug, multisource
1329 generic drug, or service, if the network pharmacy or pharmacist is
1330 paid less than that network pharmacy's acquisition cost for the
1331 product. If the network pharmacy or pharmacist declines to
1332 provide such drug or service, the pharmacy or pharmacist shall
1333 provide the customer with adequate information as to where the
1334 prescription for the drug or service may be filled.

1335 (b) The State Board of Pharmacy shall adopt rules and
1336 regulations necessary to implement and ensure compliance with this
1337 subsection, including, but not limited to, rules and regulations
1338 that address access to pharmacy services in rural or underserved
1339 areas in cases where a network pharmacy or pharmacist declines to
1340 provide a drug or service under paragraph (a) of this subsection.
1341 The board shall promulgate the rules and regulations required by
1342 this paragraph (b) not later than October 1, 2016.

1343 (6) A pharmacy benefit manager shall not directly or
1344 indirectly retroactively deny or reduce a claim or aggregate of
1345 claims after the claim or aggregate of claims has been
1346 adjudicated.



1347 **SECTION 17.** Section 73-21-156, Mississippi Code of 1972, is
1348 brought forward as follows:

1349 73-21-156. (1) As used in this section, the following terms
1350 shall be defined as provided in this subsection:

1351 (a) "Maximum allowable cost list" means a listing of
1352 drugs or other methodology used by a pharmacy benefit manager,
1353 directly or indirectly, setting the maximum allowable payment to a
1354 pharmacy or pharmacist for a generic drug, brand-name drug,
1355 biologic product or other prescription drug. The term "maximum
1356 allowable cost list" includes without limitation:

1357 (i) Average acquisition cost, including national
1358 average drug acquisition cost;

1359 (ii) Average manufacturer price;

1360 (iii) Average wholesale price;

1361 (iv) Brand effective rate or generic effective
1362 rate;

1363 (v) Discount indexing;

1364 (vi) Federal upper limits;

1365 (vii) Wholesale acquisition cost; and

1366 (viii) Any other term that a pharmacy benefit
1367 manager or a health care insurer may use to establish
1368 reimbursement rates to a pharmacist or pharmacy for pharmacist
1369 services.



1370 (b) "Pharmacy acquisition cost" means the amount that a
1371 pharmaceutical wholesaler charges for a pharmaceutical product as
1372 listed on the pharmacy's billing invoice.

1373 (2) Before a pharmacy benefit manager places or continues a
1374 particular drug on a maximum allowable cost list, the drug:

1375 (a) If the drug is a generic equivalent drug product as
1376 defined in 73-21-73, shall be listed as therapeutically equivalent
1377 and pharmaceutically equivalent "A" or "B" rated in the United
1378 States Food and Drug Administration's most recent version of the
1379 "Orange Book" or "Green Book" or have an NR or NA rating by
1380 Medi-Span, Gold Standard, or a similar rating by a nationally
1381 recognized reference approved by the board;

1382 (b) Shall be available for purchase by each pharmacy in
1383 the state from national or regional wholesalers operating in
1384 Mississippi; and

1385 (c) Shall not be obsolete.

1386 (3) A pharmacy benefit manager shall:

1387 (a) Provide access to its maximum allowable cost list
1388 to each pharmacy subject to the maximum allowable cost list;

1389 (b) Update its maximum allowable cost list on a timely
1390 basis, but in no event longer than three (3) calendar days; and

1391 (c) Provide a process for each pharmacy subject to the
1392 maximum allowable cost list to receive prompt notification of an
1393 update to the maximum allowable cost list.

1394 (4) A pharmacy benefit manager shall:



1395 (a) Provide a reasonable administrative appeal
1396 procedure to allow pharmacies to challenge a maximum allowable
1397 cost list and reimbursements made under a maximum allowable cost
1398 list for a specific drug or drugs as:

1399 (i) Not meeting the requirements of this section;

1400 or

1401 (ii) Being below the pharmacy acquisition cost.

1402 (b) The reasonable administrative appeal procedure
1403 shall include the following:

1404 (i) A dedicated telephone number, email address
1405 and website for the purpose of submitting administrative appeals;

1406 (ii) The ability to submit an administrative
1407 appeal directly to the pharmacy benefit manager regarding the
1408 pharmacy benefit management plan or through a pharmacy service
1409 administrative organization; and

1410 (iii) A period of less than thirty (30) business
1411 days to file an administrative appeal.

1412 (c) The pharmacy benefit manager shall respond to the
1413 challenge under paragraph (a) of this subsection (4) within thirty
1414 (30) business days after receipt of the challenge.

1415 (d) If a challenge is made under paragraph (a) of this
1416 subsection (4), the pharmacy benefit manager shall within thirty
1417 (30) business days after receipt of the challenge either:

1418 (i) If the appeal is upheld:



1419 1. Make the change in the maximum allowable
1420 cost list payment to at least the pharmacy acquisition cost;
1421 2. Permit the challenging pharmacy or
1422 pharmacist to reverse and rebill the claim in question;
1423 3. Provide the National Drug Code that the
1424 increase or change is based on to the pharmacy or pharmacist; and
1425 4. Make the change under item 1 of this
1426 subparagraph (i) effective for each similarly situated pharmacy as
1427 defined by the payor subject to the maximum allowable cost list;
1428 or

1429 (ii) If the appeal is denied, provide the
1430 challenging pharmacy or pharmacist the National Drug Code and the
1431 name of the national or regional pharmaceutical wholesalers
1432 operating in Mississippi that have the drug currently in stock at
1433 a price below the maximum allowable cost as listed on the maximum
1434 allowable cost list; or

1435 (iii) If the National Drug Code provided by the
1436 pharmacy benefit manager is not available below the pharmacy
1437 acquisition cost from the pharmaceutical wholesaler from whom the
1438 pharmacy or pharmacist purchases the majority of prescription
1439 drugs for resale, then the pharmacy benefit manager shall adjust
1440 the maximum allowable cost as listed on the maximum allowable cost
1441 list above the challenging pharmacy's pharmacy acquisition cost
1442 and permit the pharmacy to reverse and rebill each claim affected



1443 by the inability to procure the drug at a cost that is equal to or
1444 less than the previously challenged maximum allowable cost.

1445 (5) (a) A pharmacy benefit manager shall not reimburse a
1446 pharmacy or pharmacist in the state an amount less than the amount
1447 that the pharmacy benefit manager reimburses a pharmacy benefit
1448 manager affiliate for providing the same pharmacist services.

1449 (b) The amount shall be calculated on a per unit basis
1450 based on the same brand and generic product identifier or brand
1451 and generic code number.

1452 **SECTION 18.** Section 73-21-157, Mississippi Code of 1972, is
1453 brought forward as follows:

1454 73-21-157. (1) Before beginning to do business as a
1455 pharmacy benefit manager, a pharmacy benefit manager shall obtain
1456 a license to do business from the board. To obtain a license, the
1457 applicant shall submit an application to the board on a form to be
1458 prescribed by the board.

1459 (2) Each pharmacy benefit manager providing pharmacy
1460 management benefit plans in this state shall file a statement with
1461 the board annually by March 1 or within sixty (60) days of the end
1462 of its fiscal year if not a calendar year. The statement shall be
1463 verified by at least two (2) principal officers and shall cover
1464 the preceding calendar year or the immediately preceding fiscal
1465 year of the pharmacy benefit manager.

1466 (3) The statement shall be on forms prescribed by the board
1467 and shall include:



1468 (a) A financial statement of the organization,
1469 including its balance sheet and income statement for the preceding
1470 year; and

1471 (b) Any other information relating to the operations of
1472 the pharmacy benefit manager required by the board under this
1473 section.

1474 (4) (a) Any information required to be submitted to the
1475 board pursuant to licensure application that is considered
1476 proprietary by a pharmacy benefit manager shall be marked as
1477 confidential when submitted to the board. All such information
1478 shall not be subject to the provisions of the federal Freedom of
1479 Information Act or the Mississippi Public Records Act and shall
1480 not be released by the board unless subject to an order from a
1481 court of competent jurisdiction. The board shall destroy or
1482 delete or cause to be destroyed or deleted all such information
1483 thirty (30) days after the board determines that the information
1484 is no longer necessary or useful.

1485 (b) Any person who knowingly releases, causes to be
1486 released or assists in the release of any such information shall
1487 be subject to a monetary penalty imposed by the board in an amount
1488 not exceeding Fifty Thousand Dollars (\$50,000.00) per violation.
1489 When the board is considering the imposition of any penalty under
1490 this paragraph (b), it shall follow the same policies and
1491 procedures provided for the imposition of other sanctions in the
1492 Pharmacy Practice Act. Any penalty collected under this paragraph



1493 (b) shall be deposited into the special fund of the board and used
1494 to support the operations of the board relating to the regulation
1495 of pharmacy benefit managers.

1496 (c) All employees of the board who have access to the
1497 information described in paragraph (a) of this subsection shall be
1498 fingerprinted, and the board shall submit a set of fingerprints
1499 for each employee to the Department of Public Safety for the
1500 purpose of conducting a criminal history records check. If no
1501 disqualifying record is identified at the state level, the
1502 Department of Public Safety shall forward the fingerprints to the
1503 Federal Bureau of Investigation for a national criminal history
1504 records check.

1505 (5) If the pharmacy benefit manager is audited annually by
1506 an independent certified public accountant, a copy of the
1507 certified audit report shall be filed annually with the board by
1508 June 30 or within thirty (30) days of the report being final.

1509 (6) The board may extend the time prescribed for any
1510 pharmacy benefit manager for filing annual statements or other
1511 reports or exhibits of any kind for good cause shown. However,
1512 the board shall not extend the time for filing annual statements
1513 beyond sixty (60) days after the time prescribed by subsection (1)
1514 of this section. The board may waive the requirements for filing
1515 financial information for the pharmacy benefit manager if an
1516 affiliate of the pharmacy benefit manager is already required to
1517 file such information under current law with the Commissioner of



1518 Insurance and allow the pharmacy benefit manager to file a copy of
1519 documents containing such information with the board in lieu of
1520 the statement required by this section.

1521 (7) The expense of administering this section shall be
1522 assessed annually by the board against all pharmacy benefit
1523 managers operating in this state.

1524 (8) A pharmacy benefit manager or third-party payor may not
1525 require pharmacy accreditation standards or recertification
1526 requirements inconsistent with, more stringent than, or in
1527 addition to federal and state requirements for licensure as a
1528 pharmacy in this state.

1529 **SECTION 19.** Section 73-21-159, Mississippi Code of 1972, is
1530 brought forward as follows:

1531 73-21-159. (1) In lieu of or in addition to making its own
1532 financial examination of a pharmacy benefit manager, the board may
1533 accept the report of a financial examination of other persons
1534 responsible for the pharmacy benefit manager under the laws of
1535 another state certified by the applicable official of such other
1536 state.

1537 (2) The board shall coordinate financial examinations of a
1538 pharmacy benefit manager that provides pharmacy management benefit
1539 plans in this state to ensure an appropriate level of regulatory
1540 oversight and to avoid any undue duplication of effort or
1541 regulation. The pharmacy benefit manager being examined shall pay
1542 the cost of the examination. The cost of the examination shall be



1543 deposited in a special fund that shall provide all expenses for
1544 the licensing, supervision and examination of all pharmacy benefit
1545 managers subject to regulation under Sections 73-21-71 through
1546 73-21-129 and Sections 73-21-151 through 73-21-163.

1547 (3) The board may provide a copy of the financial
1548 examination to the person or entity who provides or operates the
1549 health insurance plan or to a pharmacist or pharmacy.

1550 (4) The board is authorized to hire independent financial
1551 consultants to conduct financial examinations of a pharmacy
1552 benefit manager and to expend funds collected under this section
1553 to pay the costs of such examinations.

1554 **SECTION 20.** Section 73-21-161, Mississippi Code of 1972, is
1555 brought forward as follows:

1556 73-21-161. (1) As used in this section, the term "referral"
1557 means:

1558 (a) Ordering of a patient to a pharmacy by a pharmacy
1559 benefit manager affiliate either orally or in writing, including
1560 online messaging;

1561 (b) Offering or implementing plan designs that require
1562 patients to use affiliated pharmacies; or

1563 (c) Patient or prospective patient specific
1564 advertising, marketing, or promotion of a pharmacy by an
1565 affiliate.

1566 The term "referral" does not include a pharmacy's inclusion
1567 by a pharmacy benefit manager affiliate in communications to



1568 patients, including patient and prospective patient specific
1569 communications, regarding network pharmacies and prices, provided
1570 that the affiliate includes information regarding eligible
1571 nonaffiliate pharmacies in those communications and the
1572 information provided is accurate.

1573 (2) A pharmacy, pharmacy benefit manager, or pharmacy
1574 benefit manager affiliate licensed or operating in Mississippi
1575 shall be prohibited from:

1576 (a) Making referrals;

1577 (b) Transferring or sharing records relative to
1578 prescription information containing patient identifiable and
1579 prescriber identifiable data to or from a pharmacy benefit manager
1580 affiliate for any commercial purpose; however, nothing in this
1581 section shall be construed to prohibit the exchange of
1582 prescription information between a pharmacy and its affiliate for
1583 the limited purposes of pharmacy reimbursement; formulary
1584 compliance; pharmacy care; public health activities otherwise
1585 authorized by law; or utilization review by a health care
1586 provider; or

1587 (c) Presenting a claim for payment to any individual,
1588 third-party payor, affiliate, or other entity for a service
1589 furnished pursuant to a referral from an affiliate.

1590 (3) This section shall not be construed to prohibit a
1591 pharmacy from entering into an agreement with a pharmacy benefit
1592 manager affiliate to provide pharmacy care to patients, provided



1593 that the pharmacy does not receive referrals in violation of
1594 subsection (2) of this section and the pharmacy provides the
1595 disclosures required in subsection (1) of this section.

1596 (4) If a pharmacy licensed or holding a nonresident pharmacy
1597 permit in this state has an affiliate, it shall annually file with
1598 the board a disclosure statement identifying all such affiliates.

1599 (5) In addition to any other remedy provided by law, a
1600 violation of this section by a pharmacy shall be grounds for
1601 disciplinary action by the board under its authority granted in
1602 this chapter.

1603 (6) A pharmacist who fills a prescription that violates
1604 subsection (2) of this section shall not be liable under this
1605 section.

1606 **SECTION 21.** Section 73-21-163, Mississippi Code of 1972, is
1607 brought forward as follows:

1608 73-21-163. Whenever the board has reason to believe that a
1609 pharmacy benefit manager or pharmacy benefit manager affiliate is
1610 using, has used, or is about to use any method, act or practice
1611 prohibited in Sections 73-21-151 through 73-21-163 and that
1612 proceedings would be in the public interest, it may bring an
1613 action in the name of the board against the pharmacy benefit
1614 manager or pharmacy benefit manager affiliate to restrain by
1615 temporary or permanent injunction the use of such method, act or
1616 practice. The action shall be brought in the Chancery Court of
1617 the First Judicial District of Hinds County, Mississippi. The



1618 court is authorized to issue temporary or permanent injunctions to
1619 restrain and prevent violations of Sections 73-21-151 through
1620 73-21-163 and such injunctions shall be issued without bond.

1621 (2) The board may impose a monetary penalty on a pharmacy
1622 benefit manager or a pharmacy benefit manager affiliate for
1623 noncompliance with the provisions of the Sections 73-21-151
1624 through 73-21-163, in amounts of not less than One Thousand
1625 Dollars (\$1,000.00) per violation and not more than Twenty-five
1626 Thousand Dollars (\$25,000.00) per violation. Each day a violation
1627 continues for the same brand or generic product identifier or
1628 brand or generic code number is a separate violation. The board
1629 shall prepare a record entered upon its minutes that states the
1630 basic facts upon which the monetary penalty was imposed. Any
1631 penalty collected under this subsection (2) shall be deposited
1632 into the special fund of the board.

1633 (3) The board may assess a monetary penalty for those
1634 reasonable costs that are expended by the board in the
1635 investigation and conduct of a proceeding if the board imposes a
1636 monetary penalty under subsection (2) of this section. A monetary
1637 penalty assessed and levied under this section shall be paid to
1638 the board by the licensee, registrant or permit holder upon the
1639 expiration of the period allowed for appeal of those penalties
1640 under Section 73-21-101, or may be paid sooner if the licensee,
1641 registrant or permit holder elects. Any penalty collected by the



1642 board under this subsection (3) shall be deposited into the
1643 special fund of the board.

1644 (4) When payment of a monetary penalty assessed and levied
1645 by the board against a licensee, registrant or permit holder in
1646 accordance with this section is not paid by the licensee,
1647 registrant or permit holder when due under this section, the board
1648 shall have the power to institute and maintain proceedings in its
1649 name for enforcement of payment in the chancery court of the
1650 county and judicial district of residence of the licensee,
1651 registrant or permit holder, or if the licensee, registrant or
1652 permit holder is a nonresident of the State of Mississippi, in the
1653 Chancery Court of the First Judicial District of Hinds County,
1654 Mississippi. When those proceedings are instituted, the board
1655 shall certify the record of its proceedings, together with all
1656 documents and evidence, to the chancery court and the matter shall
1657 be heard in due course by the court, which shall review the record
1658 and make its determination thereon in accordance with the
1659 provisions of Section 73-21-101. The hearing on the matter may,
1660 in the discretion of the chancellor, be tried in vacation.

1661 (5) The board shall develop and implement a uniform penalty
1662 policy that sets the minimum and maximum penalty for any given
1663 violation of Sections 73-21-151 through 73-21-163. The board
1664 shall adhere to its uniform penalty policy except in those cases
1665 where the board specifically finds, by majority vote, that a
1666 penalty in excess of, or less than, the uniform penalty is



1667 appropriate. That vote shall be reflected in the minutes of the
1668 board and shall not be imposed unless it appears as having been
1669 adopted by the board.

1670 **SECTION 22.** Section 73-21-177, Mississippi Code of 1972, is
1671 brought forward as follows:

1672 73-21-177. The purpose of Sections 73-21-175 through
1673 73-21-189 is to establish minimum and uniform standards and
1674 criteria for the audit of pharmacy records by or on behalf of
1675 certain entities.

1676 **SECTION 23.** Section 73-21-179, Mississippi Code of 1972, is
1677 brought forward as follows:

1678 73-21-179. For purposes of Sections 73-21-175 through
1679 73-21-189:

1680 (a) "Entity" means a pharmacy benefit manager, a
1681 managed care company, a health plan sponsor, an insurance company,
1682 a third-party payor, or any company, group or agent that
1683 represents or is engaged by those entities.

1684 (b) "Health insurance plan" means benefits consisting
1685 of prescription drugs, other products and supplies, and pharmacist
1686 services provided directly, through insurance or reimbursement, or
1687 otherwise and including items and services paid for as
1688 prescription drugs, other products and supplies, and pharmacist
1689 services under any hospital or medical service policy or
1690 certificate, hospital or medical service plan contract, preferred



1691 provider organization agreement, or health maintenance
1692 organization contract offered by a health insurance
1693 issuer.

1694 (c) "Individual prescription" means the original
1695 prescription for a drug signed by the prescriber, and excludes
1696 refills referenced on the prescription.

1697 (d) "Pharmacy benefit manager" means a business that
1698 administers the prescription drug/device portion of pharmacy
1699 benefit management plans or health insurance plans on behalf of
1700 plan sponsors, insurance companies, unions and health maintenance
1701 organizations. Pharmacy benefit managers may also provide some,
1702 all, but may not be limited to, the following services either
1703 directly or through outsourcing or contracts with other entities:

1704 (i) Adjudicate drug claims or any portion of the
1705 transaction.

1706 (ii) Contract with retail and mail pharmacy
1707 networks.

1708 (iii) Establish payment levels for pharmacies.

1709 (iv) Develop formulary or drug list of covered
1710 therapies.

1711 (v) Provide benefit design consultation.

1712 (vi) Manage cost and utilization trends.

1713 (vii) Contract for manufacturer rebates.

1714 (viii) Provide fee-based clinical services to
1715 improve member care.



1716 (ix) Third-party administration.

1717 (e) "Pharmacy benefit management plan" means an
1718 arrangement for the delivery of pharmacist's services in which a
1719 pharmacy benefit manager undertakes to administer the payment or
1720 reimbursement of any of the costs of pharmacist's services for an
1721 enrollee on a prepaid or insured basis that (i) contains one or
1722 more incentive arrangements intended to influence the cost or
1723 level of pharmacist's services between the plan sponsor and one or
1724 more pharmacies with respect to the delivery of pharmacist's
1725 services; and (ii) requires or creates benefit payment
1726 differential incentives for enrollees to use under contract with
1727 the pharmacy benefit manager.

1728 (f) "Pharmacist," "pharmacist services" and "pharmacy"
1729 or "pharmacies" shall have the same definitions as provided in
1730 Section 73-21-73.

1731 **SECTION 24.** Section 73-21-181, Mississippi Code of 1972, is
1732 brought forward as follows:

1733 73-21-181. Sections 73-21-175 through 73-21-189 shall apply
1734 to any audit of the records of a pharmacy conducted by a managed
1735 care company, nonprofit hospital or medical service organization,
1736 insurance company, third-party payor, pharmacy benefit manager, a
1737 health program administered by a department of the state or any
1738 entity that represents those companies, groups, or department.

1739 **SECTION 25.** Section 73-21-183, Mississippi Code of 1972, is
1740 brought forward as follows:



1741 73-21-183. (1) The entity conducting an audit shall follow
1742 these procedures:

1743 (a) The pharmacy contract must identify and describe in
1744 detail the audit procedures;

1745 (b) The entity conducting the on-site audit must give
1746 the pharmacy written notice at least two (2) weeks before
1747 conducting the initial on-site audit for each audit cycle, and the
1748 pharmacy shall have at least fourteen (14) days to respond to any
1749 desk audit requirements;

1750 (c) The entity conducting the on-site or desk audit
1751 shall not interfere with the delivery of pharmacist services to a
1752 patient and shall utilize every effort to minimize inconvenience
1753 and disruption to pharmacy operations during the audit process;

1754 (d) Any audit that involves clinical or professional
1755 judgment must be conducted by or in consultation with a
1756 pharmacist;

1757 (e) Any clerical or record-keeping error, such as a
1758 typographical error, scrivener's error, or computer error,
1759 regarding a required document or record shall not constitute
1760 fraud; however, those claims may be subject to recoupment. No
1761 such claim shall be subject to criminal penalties without proof of
1762 intent to commit fraud;

1763 (f) A pharmacy may use the records of a hospital,
1764 physician, or other authorized practitioner of the healing arts
1765 for drugs or medicinal supplies written or transmitted by any



1766 means of communication for purposes of validating the pharmacy
1767 record with respect to orders or refills of a legend or narcotic
1768 drug;

1769 (g) A finding of an overpayment or an underpayment may
1770 be a projection based on the number of patients served having a
1771 similar diagnosis or on the number of similar orders or refills
1772 for similar drugs, except that recoupment shall be based on the
1773 actual overpayment or underpayment;

1774 (h) A finding of an overpayment shall not include the
1775 dispensing fee amount unless a prescription was not dispensed;

1776 (i) Each pharmacy shall be audited under the same
1777 standards and parameters as other similarly situated pharmacies
1778 audited by the entity;

1779 (j) The period covered by an audit may not exceed two
1780 (2) years from the date the claim was submitted to or adjudicated
1781 by a managed care company, nonprofit hospital or medical service
1782 organization, insurance company, third-party payor, pharmacy
1783 benefit manager, a health program administered by a department of
1784 the state or any entity that represents those companies, groups,
1785 or department;

1786 (k) An audit may not be initiated or scheduled during
1787 the first five (5) calendar days of any month due to the high
1788 volume of prescriptions filled in the pharmacy during that time
1789 unless otherwise consented to by the pharmacy;



1790 (l) Any prescription that complies with state law and
1791 rule requirements may be used to validate claims in connection
1792 with prescriptions, refills or changes in prescriptions;

1793 (m) An exit interview that provides a pharmacy with an
1794 opportunity to respond to questions and comment on and clarify
1795 findings must be conducted at the end of an audit. The time of
1796 the interview must be agreed to by the pharmacy;

1797 (n) Unless superseded by state or federal law, auditors
1798 shall only have access to previous audit reports on a particular
1799 pharmacy conducted by the auditing entity for the same pharmacy
1800 benefits manager, health plan or insurer. An auditing vendor
1801 contracting with multiple pharmacy benefits managers or health
1802 insurance plans shall not use audit reports or other information
1803 gained from an audit on a particular pharmacy to conduct another
1804 audit for a different pharmacy benefits manager or health
1805 insurance plan;

1806 (o) The parameters of an audit must comply with
1807 consumer-oriented parameters based on manufacturer listings or
1808 recommendations for the following:

1809 (i) The day supply for eyedrops must be calculated
1810 so that the consumer pays only one (1) thirty-day copayment if the
1811 bottle of eyedrops is intended by the manufacturer to be a
1812 thirty-day supply;



1813 (ii) The day supply for insulin must be calculated
1814 so that the highest dose prescribed is used to determine the day
1815 supply and consumer copayment;

1816 (iii) The day supply for a topical product must be
1817 determined by the judgment of the pharmacist based upon the
1818 treated area;

1819 (p) (i) Where an audit is for a specifically
1820 identified problem that has been disclosed to the pharmacy, the
1821 audit shall be limited to claims that are identified by
1822 prescription number;

1823 (ii) For an audit other than described in
1824 subparagraph (i) of this paragraph (p), an audit shall be limited
1825 to one hundred (100) individual prescriptions that have been
1826 randomly selected;

1827 (iii) If an audit reveals the necessity for a
1828 review of additional claims, the audit shall be conducted on site;

1829 (iv) Except for audits initiated under paragraph
1830 (i) of this subsection, an entity shall not initiate an audit of a
1831 pharmacy more than one (1) time in any quarter;

1832 (r) A recoupment shall not be based on:

1833 (i) Documentation requirements in addition to or
1834 exceeding requirements for creating or maintaining documentation
1835 prescribed by the State Board of Pharmacy; or



1836 (ii) A requirement that a pharmacy or pharmacist
1837 perform a professional duty in addition to or exceeding
1838 professional duties prescribed by the State Board of Pharmacy;

1839 (s) Except for Medicare claims, approval of drug,
1840 prescriber or patient eligibility upon adjudication of a claim
1841 shall not be reversed unless the pharmacy or pharmacist obtained
1842 the adjudication by fraud or misrepresentation of claim elements;
1843 and

1844 (t) A commission or other payment to an agent or
1845 employee of the entity conducting the audit is not based, directly
1846 or indirectly, on amounts recouped.

1847 (2) The entity must provide the pharmacy with a written
1848 report of the audit and comply with the following requirements:

1849 (a) The preliminary audit report must be delivered to
1850 the pharmacy within one hundred twenty (120) days after conclusion
1851 of the audit, with a reasonable extension to be granted upon
1852 request;

1853 (b) A pharmacy shall be allowed at least thirty (30)
1854 days following receipt of the preliminary audit report in which to
1855 produce documentation to address any discrepancy found during the
1856 audit, with a reasonable extension to be granted upon request;

1857 (c) A final audit report shall be delivered to the
1858 pharmacy within one hundred eighty (180) days after receipt of the
1859 preliminary audit report or final appeal, as provided for in
1860 Section 73-21-185, whichever is later;



1861 (d) The audit report must be signed by the auditor;
1862 (e) Recoupments of any disputed funds, or repayment of
1863 funds to the entity by the pharmacy if permitted pursuant to
1864 contractual agreement, shall occur after final internal
1865 disposition of the audit, including the appeals process as set
1866 forth in Section 73-21-185. If the identified discrepancy for an
1867 individual audit exceeds Twenty-five Thousand Dollars
1868 (\$25,000.00), future payments in excess of that amount to the
1869 pharmacy may be withheld pending finalization of the audit;
1870 (f) Interest shall not accrue during the audit period;
1871 and
1872 (g) Each entity conducting an audit shall provide a
1873 copy of the final audit report, after completion of any review
1874 process, to the plan sponsor.

1875 **SECTION 26.** Section 73-21-185, Mississippi Code of 1972, is
1876 brought forward as follows:

1877 73-21-185. (1) Each entity conducting an audit shall
1878 establish a written appeals process under which a pharmacy may
1879 appeal an unfavorable preliminary audit report to the entity.

1880 (2) If, following the appeal, the entity finds that an
1881 unfavorable audit report or any portion thereof is
1882 unsubstantiated, the entity shall dismiss the audit report or that
1883 portion without the necessity of any further action.

1884 (3) If, following the appeal, any of the issues raised in
1885 the appeal are not resolved to the satisfaction of either party,



1886 that party may ask for mediation of those unresolved issues. A
1887 certified mediator shall be chosen by agreement of the parties
1888 from the Court Annexed Mediators List maintained by the
1889 Mississippi Supreme Court.

1890 **SECTION 27.** Section 73-21-187, Mississippi Code of 1972, is
1891 brought forward as follows:

1892 73-21-187. Notwithstanding any other provision in Sections
1893 73-21-175 through 73-21-189, the entity conducting the audit shall
1894 not use the accounting practice of extrapolation in calculating
1895 recoupments or penalties for audits. An extrapolation audit means
1896 an audit of a sample of prescription drug benefit claims submitted
1897 by a pharmacy to the entity conducting the audit that is then used
1898 to estimate audit results for a larger batch or group of claims
1899 not reviewed by the auditor.

1900 **SECTION 28.** Section 73-21-189, Mississippi Code of 1972, is
1901 brought forward as follows:

1902 73-21-189. Sections 73-21-175 through 73-21-189 do not apply
1903 to any audit, review or investigation that involves alleged fraud,
1904 willful misrepresentation or abuse.

1905 **SECTION 29.** Section 73-21-191, Mississippi Code of 1972, is
1906 brought forward as follows:

1907 73-21-191. (1) The State Board of Pharmacy may impose a
1908 monetary penalty on pharmacy benefit managers for noncompliance
1909 with the provisions of the Pharmacy Audit Integrity Act, Sections
1910 73-21-175 through 73-21-189, in amounts of not less than One



1911 Thousand Dollars (\$1,000.00) per violation and not more than
1912 Twenty-five Thousand Dollars (\$25,000.00) per violation. The
1913 board shall prepare a record entered upon its minutes which states
1914 the basic facts upon which the monetary penalty was imposed. Any
1915 penalty collected under this subsection (1) shall be deposited
1916 into the special fund of the board.

1917 (2) The board may assess a monetary penalty for those
1918 reasonable costs that are expended by the board in the
1919 investigation and conduct of a proceeding if the board imposes a
1920 monetary penalty under subsection (1) of this section. A monetary
1921 penalty assessed and levied under this section shall be paid to
1922 the board by the licensee, registrant or permit holder upon the
1923 expiration of the period allowed for appeal of those penalties
1924 under Section 73-21-101, or may be paid sooner if the licensee,
1925 registrant or permit holder elects. Money collected by the board
1926 under this subsection (2) shall be deposited to the credit of the
1927 special fund of the board.

1928 (3) When payment of a monetary penalty assessed and levied
1929 by the board against a licensee, registrant or permit holder in
1930 accordance with this section is not paid by the licensee,
1931 registrant or permit holder when due under this section, the board
1932 shall have the power to institute and maintain proceedings in its
1933 name for enforcement of payment in the chancery court of the
1934 county and judicial district of residence of the licensee,
1935 registrant or permit holder, or if the licensee, registrant or



1936 permit holder is a nonresident of the State of Mississippi, in the
1937 Chancery Court of the First Judicial District of Hinds County,
1938 Mississippi. When those proceedings are instituted, the board
1939 shall certify the record of its proceedings, together with all
1940 documents and evidence, to the chancery court and the matter shall
1941 be heard in due course by the court, which shall review the record
1942 and make its determination thereon in accordance with the
1943 provisions of Section 73-21-101. The hearing on the matter may,
1944 in the discretion of the chancellor, be tried in vacation.

1945 (4) The board shall develop and implement a uniform penalty
1946 policy that sets the minimum and maximum penalty for any given
1947 violation of board regulations and laws governing the practice of
1948 pharmacy. The board shall adhere to its uniform penalty policy
1949 except in those cases where the board specifically finds, by
1950 majority vote, that a penalty in excess of, or less than, the
1951 uniform penalty is appropriate. That vote shall be reflected in
1952 the minutes of the board and shall not be imposed unless it
1953 appears as having been adopted by the board.

1954 **SECTION 30.** Section 73-21-201, Mississippi Code of 1972, is
1955 brought forward as follows:

1956 73-21-201. Sections 73-21-201 through 73-21-205 shall be
1957 known as the "Prescription Drugs Consumer Affordable Alternative
1958 Payment Options Act."

1959 **SECTION 31.** Section 73-21-203, Mississippi Code of 1972, is
1960 brought forward as follows:



1961 73-21-203. **Definitions.** For the purposes of Sections
1962 73-21-201 through 73-21-205:

1963 (a) "Board" shall have the same definition as provided
1964 in Section 73-21-73.

1965 (b) "Pharmacist," "pharmacist services" and "pharmacy"
1966 or "pharmacies" shall have the same definitions as provided in
1967 Section 73-21-73.

1968 (c) "Pharmacy benefit manager" shall have the same
1969 definition as provided in Section 73-21-179.

1970 **SECTION 32.** Section 73-21-205, Mississippi Code of 1972, is
1971 brought forward as follows:

1972 73-21-205. (1) (a) Pharmacists may provide additional
1973 information to a patient to allow them an opportunity to consider
1974 affordable alternative payment options when acquiring their
1975 prescription medication.

1976 (b) Any provision of any contract or agreement contrary
1977 to the provisions of Sections 73-21-201 through 73-21-205 shall be
1978 considered in violation of public policy and shall be void.

1979 (2) Compliance with this section shall not constitute a
1980 violation of any contract or provision of any agreement to which
1981 the pharmacist or pharmacy is a party.

1982 (3) Neither the board, any pharmacy benefit manager nor any
1983 third party shall penalize a pharmacist for acting or failing to
1984 act under this section, nor shall a pharmacist or his agents or



1985 employees be liable for any act or failure to act under this
1986 section.

1987 **SECTION 33.** Section 83-9-6, Mississippi Code of 1972, is
1988 brought forward as follows:

1989 83-9-6. (1) This section shall apply to all health benefit
1990 plans providing pharmaceutical services benefits, including
1991 prescription drugs, to any resident of Mississippi. This section
1992 shall also apply to insurance companies and health maintenance
1993 organizations that provide or administer coverages and benefits
1994 for prescription drugs. This section shall not apply to any
1995 entity that has its own facility, employs or contracts with
1996 physicians, pharmacists, nurses and other health care personnel,
1997 and that dispenses prescription drugs from its own pharmacy to its
1998 employees and dependents enrolled in its health benefit plan; but
1999 this section shall apply to an entity otherwise excluded that
2000 contracts with an outside pharmacy or group of pharmacies to
2001 provide prescription drugs and services.

2002 (2) As used in this section:

2003 (a) "Copayment" means a type of cost sharing whereby
2004 insured or covered persons pay a specified predetermined amount
2005 per unit of service with their insurer paying the remainder of the
2006 charge. The copayment is incurred at the time the service is
2007 used. The copayment may be a fixed or variable amount.



2008 (b) "Contract provider" means a pharmacy granted the
2009 right to provide prescription drugs and pharmacy services
2010 according to the terms of the insurer.

2011 (c) "Health benefit plan" means any entity or program
2012 that provides reimbursement for pharmaceutical services.

2013 (d) "Insurer" means any entity that provides or offers
2014 a health benefit plan.

2015 (e) "Pharmacist" means a pharmacist licensed by the
2016 Mississippi State Board of Pharmacy.

2017 (f) "Pharmacy" means a place licensed by the
2018 Mississippi State Board of Pharmacy.

2019 (3) A health insurance plan, policy, employee benefit plan
2020 or health maintenance organization may not:

2021 (a) Prohibit or limit any person who is a participant
2022 or beneficiary of the policy or plan from selecting a pharmacy or
2023 pharmacist of his choice who has agreed to participate in the plan
2024 according to the terms offered by the insurer;

2025 (b) Deny a pharmacy or pharmacist the right to
2026 participate as a contract provider under the policy or plan if the
2027 pharmacy or pharmacist agrees to provide pharmacy services,
2028 including but not limited to prescription drugs, that meet the
2029 terms and requirements set forth by the insurer under the policy
2030 or plan and agrees to the terms of reimbursement set forth by the
2031 insurer;



2032 (c) Impose upon a beneficiary of pharmacy services
2033 under a health benefit plan any copayment, fee or condition that
2034 is not equally imposed upon all beneficiaries in the same benefit
2035 category, class or copayment level under the health benefit plan
2036 when receiving services from a contract provider;

2037 (d) Impose a monetary advantage or penalty under a
2038 health benefit plan that would affect a beneficiary's choice among
2039 those pharmacies or pharmacists who have agreed to participate in
2040 the plan according to the terms offered by the insurer. Monetary
2041 advantage or penalty includes higher copayment, a reduction in
2042 reimbursement for services, or promotion of one participating
2043 pharmacy over another by these methods;

2044 (e) Reduce allowable reimbursement for pharmacy
2045 services to a beneficiary under a health benefit plan because the
2046 beneficiary selects a pharmacy of his or her choice, so long as
2047 that pharmacy has enrolled with the health benefit plan under the
2048 terms offered to all pharmacies in the plan coverage area;

2049 (f) Require a beneficiary, as a condition of payment or
2050 reimbursement, to purchase pharmacy services, including
2051 prescription drugs, exclusively through a mail-order pharmacy; or

2052 (g) Impose upon a beneficiary any copayment, amount of
2053 reimbursement, number of days of a drug supply for which
2054 reimbursement will be allowed, or any other payment or condition
2055 relating to purchasing pharmacy services from any pharmacy,
2056 including prescription drugs, that is more costly or more



2057 restrictive than that which would be imposed upon the beneficiary
2058 if such services were purchased from a mail-order pharmacy or any
2059 other pharmacy that is willing to provide the same services or
2060 products for the same cost and copayment as any mail order
2061 service.

2062 (4) A pharmacy, by or through a pharmacist acting on its
2063 behalf as its employee, agent or owner, may not waive, discount,
2064 rebate or distort a copayment of any insurer, policy or plan or a
2065 beneficiary's coinsurance portion of a prescription drug coverage
2066 or reimbursement and if a pharmacy, by or through a pharmacist's
2067 acting on its behalf as its employee, agent or owner, provides a
2068 pharmacy service to an enrollee of a health benefit plan that
2069 meets the terms and requirements of the insurer under a health
2070 benefit plan, the pharmacy shall provide its pharmacy services to
2071 all enrollees of that health benefit plan on the same terms and
2072 requirements of the insurer. A violation of this subsection shall
2073 be a violation of the Pharmacy Practice Act subjecting the
2074 pharmacist as a licensee to disciplinary authority of the State
2075 Board of Pharmacy.

2076 (5) If a health benefit plan providing reimbursement to
2077 Mississippi residents for prescription drugs restricts pharmacy
2078 participation, the entity providing the health benefit plan shall
2079 notify, in writing, all pharmacies within the geographical
2080 coverage area of the health benefit plan, and offer to the
2081 pharmacies the opportunity to participate in the health benefit



2082 plan at least sixty (60) days before the effective date of the
2083 plan or before July 1, 1995, whichever comes first. All
2084 pharmacies in the geographical coverage area of the plan shall be
2085 eligible to participate under identical reimbursement terms for
2086 providing pharmacy services, including prescription drugs. The
2087 entity providing the health benefit plan shall, through reasonable
2088 means, on a timely basis and on regular intervals, inform the
2089 beneficiaries of the plan of the names and locations of pharmacies
2090 that are participating in the plan as providers of pharmacy
2091 services and prescription drugs. Additionally, participating
2092 pharmacies shall be entitled to announce their participation to
2093 their customers through a means acceptable to the pharmacy and the
2094 entity providing the health benefit plans. The pharmacy
2095 notification provisions of this section shall not apply when an
2096 individual or group is enrolled, but when the plan enters a
2097 particular county of the state.

2098 (6) A violation of this section creates a civil cause of
2099 action for injunctive relief in favor of any person or pharmacy
2100 aggrieved by the violation.

2101 (7) The Commissioner of Insurance shall not approve any
2102 health benefit plan providing pharmaceutical services which does
2103 not conform to this section.

2104 (8) Any provision in a health benefit plan which is
2105 executed, delivered or renewed, or otherwise contracted for in



2106 this state that is contrary to this section shall, to the extent
2107 of the conflict, be void.

2108 (9) It is a violation of this section for any insurer or any
2109 person to provide any health benefit plan providing for
2110 pharmaceutical services to residents of this state that does not
2111 conform to this section.

2112 **SECTION 34.** Section 83-9-6.1, Mississippi Code of 1972, is
2113 brought forward as follows:

2114 83-9-6.1. (1) As used in this section:

2115 (a) "Cash discount card" means a card, other than the
2116 program identification card of a member or participant of a
2117 prescription drug program, that allows the holder to obtain a
2118 discount on a prescription drug when paying for the prescription
2119 at the point-of-sale.

2120 (b) "Prescription drug program" means a program or plan
2121 that provides coverages and benefits for prescription drugs for
2122 members or participants in the program, whether the program is a
2123 separate program or part of a health benefit plan.

2124 (2) Any entity that administers a prescription drug program
2125 through a network of participating pharmacies for the benefit of
2126 any resident of the State of Mississippi shall not issue or
2127 distribute any cash discount card that the participating
2128 pharmacies must accept or honor as a condition or requirement of
2129 participation in the prescription drug program, or that the
2130 participating pharmacies must accept or honor if they accept or



2131 honor program identification cards held by members or participants
2132 of any prescription drug program administered by the entity,
2133 unless the entity pays a portion of the cost of the discount given
2134 by the pharmacy for prescriptions purchased with the use of the
2135 cash discount card.

2136 (3) Any person or entity that is not subject to subsection
2137 (2) of this section shall not issue or distribute any cash
2138 discount card to any resident of the State of Mississippi unless
2139 the person or entity pays a portion of the cost of the discount
2140 given by the pharmacy for prescriptions purchased with the use of
2141 the cash discount card.

2142 (4) Any provision in any prescription drug program or health
2143 benefit plan that is executed, delivered, renewed or otherwise
2144 contracted for in this state that is not in compliance with this
2145 section shall be void to the extent of the noncompliance.

2146 (5) The provisions of this section shall not apply to the
2147 issuers of Medicare Supplement Insurance policies.

2148 (6) The Office of Attorney General, Consumer Protection
2149 Division, shall enforce the provisions of this section.

2150 **SECTION 35.** Section 83-9-6.2, Mississippi Code of 1972, is
2151 brought forward as follows:

2152 83-9-6.2. (1) Every health benefit plan that provides
2153 coverage for prescription drugs or devices, or that administers
2154 such a plan, including, but not limited to, health maintenance
2155 organizations and third-party administrators for self-insured



2156 plans, shall issue to each insured a card or other technology
2157 containing standardized pharmacy benefit identification
2158 information. The card shall contain at a minimum the following
2159 information:

2160 (a) The card issuer's name or logo on the front of the
2161 card;

2162 (b) The cardholder's name and identification number,
2163 which shall be displayed on the front side of the card;

2164 (c) The American National Standards Institute Issuer
2165 Identification Number assigned to the administrator or pharmacy
2166 benefit manager of the plan, when required for proper claims
2167 adjudication;

2168 (d) The processor's control number, when required for
2169 proper claims adjudication;

2170 (e) The insured's group number, when required for
2171 proper claims adjudication;

2172 (f) The name and address of the benefits administrator
2173 or other entity responsible for prescription claims submission,
2174 adjudication or pharmacy provider correspondence for prescription
2175 benefits; and

2176 (g) A help desk telephone number that pharmacy
2177 providers may call for pharmacy benefit claims assistance.

2178 (2) This section does not require a health benefit plan to
2179 issue an identification card separate from any identification card
2180 issued to an enrollee to evidence coverage under the health



2181 benefit plan if the identification card contains the elements
2182 required by subsection (1) of this section.

2183 (3) In order to ensure that insurance identification cards
2184 issued under this section contain accurate and updated
2185 information, each health benefit plan shall provide each
2186 subscriber with a new insurance identification card within a
2187 reasonable time after any information required for proper claims
2188 adjudication is changed.

2189 (4) As used in this section, "health benefit plan" means any
2190 hospital or medical policy or certificate, hospital or medical
2191 service contract or health maintenance organization, a plan
2192 provided by a fully insured multiple employer welfare arrangement
2193 or any other entity providing a plan of health insurance subject
2194 to the jurisdiction of the Commissioner of Insurance and to the
2195 extent permitted by the Employee Retirement Income Security Act of
2196 1974, as amended, or by the Health Insurance Portability and
2197 Accountability Act of 1996. A health benefit plan does not
2198 include the following:

- 2199 (a) Accident;
- 2200 (b) Credit;
- 2201 (c) Disability income;
- 2202 (d) Long-term or nursing home care;
- 2203 (e) Specified disease;
- 2204 (f) Dental or vision;



2205 (g) Coverage issued as a supplement to liability
2206 insurance;
2207 (h) Medical payments under automobile or homeowners;
2208 (i) Insurance under which benefits are payable with or
2209 without regard to fault and that is required statutorily to be
2210 contained in any liability or equivalent self-insurance; and
2211 (j) Hospital income or indemnity.

2212 (5) The Commissioner of Insurance may issue any rules or
2213 regulations necessary to implement the provisions of this section,
2214 and he may use the standards produced by the National Council for
2215 Prescription Drugs Programs as a guide in developing such rules
2216 and regulations.

2217 (6) This section applies to plans that are delivered, issued
2218 for delivery or renewed on or after January 1, 2003. For purposes
2219 of this section, renewal of a health benefit policy, contract or
2220 plan is presumed to occur on the anniversary date.

2221 **SECTION 36.** This act shall take effect and be in force from
2222 and after July 1, 2024.

