MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Senator(s) Michel, Hopson

To: Insurance

SENATE BILL NO. 2738

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

AUTHORIZE A NETWORK PHARMACY OR PHARMACIST TO DECLINE TO PROVIDE A BRAND NAME DRUG, MULTISOURCE GENERIC DRUG, OR SERVICE, IF THE NETWORK PHARMACY OR PHARMACIST IS PAID LESS THAN THAT NETWORK PHARMACY'S COST FOR THE PRESCRIPTION; TO CREATE NEW SECTION 25-15-309, MISSISSIPPI CODE OF 1972, TO SET CERTAIN REQUIREMENTS RELATED TO PBM, INCLUDING THAT THE PBM MUST PROVIDE A REASONABLE ADMINISTRATIVE APPEAL PROCEDURE; TO AUTHORIZE THE BOARD TO AUDIT PBMS; TO REQUIRE A PBM TO REIMBURSE A PHARMACY OR PHARMACIST AN AMOUNT LESS THAN THE AMOUNT THAT THE PBM REIMBURSES A PBM AFFILIATE FOR PROVIDING THE SAME PHARMACIST SERVICES; TO CREATE NEW SECTION 25-15-311, MISSISSIPPI CODE OF 1972, TO REQUIRE PBMS TO OBTAIN A LICENSE FROM THE BOARD OF PHARMACY; TO CREATE NEW SECTION 25-15-313, MISSISSIPPI CODE OF 1972, TO REQUIRE PBMS TO PASS ON TO THE PLAN 100% OF ALL REBATES AND OTHER PAYMENTS THAT IT RECEIVES DIRECTLY OR INDIRECTLY FROM PHARMACEUTICAL MANUFACTURERS IN CONNECTION WITH CLAIMS OR PLAN ADMINISTRATION ON BEHALF OF THE PLAN; TO PROHIBIT A PBM OR THIRD-PARTY PAYER FROM CHARGING OR CAUSING A PATIENT TO PAY A COPAYMENT THAT EXCEEDS THE TOTAL REIMBURSEMENT PAID BY THE PBM TO THE PHARMACY; TO CREATE NEW SECTION 25-15-315, MISSISSIPPI CODE OF 1972, TO PROHIBIT A PHARMACY, PBM, OR PBM AFFILIATE FROM TAKING CERTAIN ACTIONS, INCLUDING MAKING REFERRALS OR INTERFERING WITH A PATIENT'S RIGHT TO CHOOSE THEIR PHARMACY; TO CREATE NEW SECTION 25-15-317, MISSISSIPPI CODE OF 1972, TO PROHIBIT PBMS FROM RETALIATING AGAINST A PHARMACIST OR PHARMACY BASED ON THE PHARMACIST'S OR PHARMACY'S EXERCISE OF ANY RIGHT OR REMEDY UNDER THIS ACT; TO CREATE NEW SECTION 25-15-319, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE BOARD TO BRING AN ACTION AGAINST A PBM OR PBM AFFILIATE TO RESTRAIN BY TEMPORARY OR PERMANENT INJUNCTION THE USE OF ANY METHOD THAT IS PROHIBITED BY THIS ACT; TO AUTHORIZE THE BOARD TO IMPOSE A MONETARY PENALTY ON ANY PBM FOUND TO BE IN NONCOMPLIANCE; TO CREATE NEW SECTION 25-15-319, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT ON THE REQUEST BY ANY AGENCY OF THE STATE OF MISSISSIPPI, OR ANY POLITICAL SUBDIVISION OF THE STATE OR ANY OTHER PUBLIC ENTITY, A PBM SHALL DELIVER OR OTHERWISE MAKE AVAILABLE TO THE REQUESTING AGENCY OR ENTITY, IN ITS ENTIRETY AND WITH NO REDACTION, ANY THIRD-PARTY AGGREGATOR CONTRACTS OR CONTRACTS RELATING TO PBM SERVICES; TO PROVIDE THAT ANY ENTITY THAT DOES NOT COMPLY WITH THIS SECTION SHALL BE BARRED FOR FIVE YEARS FROM DOING BUSINESS IN THE STATE; AND FOR RELATED PURPOSES.

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

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

25-15-301. (1) The board may contract the administration and service of the self-insured program to a third party.

Whenever the board chooses to contract with an administrator for the insurance plan established by Section 25-15-3 et seq., or components thereof, it shall comply with the procedures set forth in this section:

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

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

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

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

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

(c) (i) The board shall be responsible for preparing a contract that shall be in accordance with all provisions of this section and all other provisions of law. The contract shall also include a requirement that the contractor shall consent to an evaluation of his performance. Such evaluation shall occur after the first six (6) months of the contract, and shall be reviewed at times the board determines to be necessary. The contract shall

clearly describe the standards upon which the contractor shall be evaluated. Evaluations shall include, but not be limited to, efficiency in claims processing, including the processing pending claims.

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

(2) Contracts for the administration of the insurance plan established in Section 25-15-3 et seq. shall commence at the beginning of the calendar year and shall end on the last day of a calendar year. This shall not apply to contracts provided for in subsection (3) of this section.

(3) If the board determines that it is necessary to not renew the contract of an administrator, or finds it necessary to terminate a contract with or without cause as provided for in the contract of the administrator, the board is authorized to select an administrator without complying with the bid requirements in

subsections (1) and (2) of this section. Such contracts shall be for the balance of the calendar year in which the nonrenewal or termination occurred, and may be for an additional calendar year if the board determines that the best interests of the plan members are served by such. Any contract negotiated on an interim basis shall include a detailed transition plan which shall ensure the orderly transfer of responsibilities between administrators and shall include, but not be limited to, provisions regarding the transfer of records, files and tapes.

(4) Except for contracts executed under the authority of subsection (3) of this section, the board shall select administrators at least six (6) months before the expiration of the current administrator's contract. The period between the selection of the new administrator and the effective date of the new contract shall be known as the transition period. Whenever the newly selected administrator is an entity different from the entity performing the administrator's function, it shall be the duty of the board to prepare a detailed transition plan which shall insure the orderly transfer of responsibilities between administrators. This plan shall be effective during the transition period, and shall include, but not be limited to, provisions regarding the transfer of records, files and tapes. Further, the plan shall detail the steps necessary to transfer records and responsibilities and set deadlines for when such steps should be completed. The board shall include in all requests for

proposals, contracts with administrators, and all other contracts, provisions requiring the cooperation of administrators and contractors in any future transition of responsibilities, and their cooperation with the board and other contractors with respect to ongoing coordination and delivery of health plan services. The board shall furnish the Legislature, Governor and advisory council with copies of all transition plans and keep them informed of progress on such plans.

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

(6) Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the board or participant, or both. Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall allow, upon notice by the board, the board or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the board. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by

the board and such information shall be compiled in a manner that will provide a clear audit trail.

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

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

(2) The board shall consist of the following:

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

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

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

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

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

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

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

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

(i) The Executive Director of the Mississippi Board of Pharmacy, or his or her designee;

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

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

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

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

(* * *n) The Chairman of the House of Representatives Appropriations Committee, or his or her designee.

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

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

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

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

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

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

The department shall employ a State Insurance Administrator, who shall be responsible for the day-to-day management and administration of the insurance plan. The Department of Finance and Administration shall provide to the board on a full-time basis personnel and technical support necessary and sufficient to effectively and efficiently carry out the requirements of this section.

(4) Members of the board shall not receive any compensation or per diem, but may receive travel reimbursement provided for under Section 25-3-41 except that the legislators shall receive per diem and expenses, which shall be paid from the contingent

expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the board shall be paid while the Legislature is in session.

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

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

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

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

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

(d) "Electronic adjudication" means the process of electronically receiving and reviewing an electronic claim and

either accepting and providing payment remittance advice for the electronic claim or rejecting the electronic claim.

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

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

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

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

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

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

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

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

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

(l) "Pharmacy benefit management plan" means an arrangement for the delivery of pharmacist's services in which a pharmacy benefit manager undertakes to administer the payment or reimbursement of any of the costs of pharmacist's services for an

enrollee or participant on a prepaid or insured basis or otherwise that:

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

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

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

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

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

(p) "Rebate" means any and all payments and price concessions that accrue to a pharmacy benefits manager or its plan

sponsor client, directly or indirectly, including through an affiliate, subsidiary, third party or intermediary, including off-shore group purchasing organizations, from a pharmaceutical manufacturer, its affiliate, subsidiary, third party or intermediary, including, but not limited to, payments, discounts, administration fees, credits, incentives or penalties associated directly or indirectly in any way with claims administered on behalf of a plan sponsor.

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

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

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

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

25-15-307. (1) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist for a prescription drug or pharmacist service in a net amount less than the national average drug acquisition cost for the prescription drug or pharmacist service in effect at the time that the drug or service is

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

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

mutually agreed upon in writing by the payor and pharmacy benefit manager.

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

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

(b) If an electronic claim is denied, the pharmacy benefit manager shall notify the pharmacist or pharmacy of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. If a written claim is denied, the pharmacy benefit manager shall notify the pharmacy or pharmacies no later than thirty-five (35) days of receipt of such claim.

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

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

(i) Original claim was submitted fraudulently;

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

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

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

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

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

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

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

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

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

(6) (a) For purposes of this subsection (6), "network pharmacy" means a licensed pharmacy in this state that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate. A network pharmacy or pharmacist may decline to provide a brand name drug, multisource generic drug, or service, if the network pharmacy or pharmacist is paid less than that network pharmacy's cost for the prescription. If the network pharmacy or pharmacist declines to provide such drug or service, the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug or service may be filled.

(b) The board shall adopt rules and regulations necessary to implement and ensure compliance with this subsection,

including, but not limited to, rules and regulations that address access to pharmacy services in rural or underserved areas in cases where a network pharmacy or pharmacist declines to provide a drug or service under paragraph (a) of this subsection.

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

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

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

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

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

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

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

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

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

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

(i) Uphold the appeal and:

1. Make the change to the reimbursement rate;

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

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

4. Make the change under item 1 of this subparagraph (i) effective for each similarly situated pharmacy; or

(ii) Deny the appeal and provide the challenging pharmacy or pharmacist the National Drug Code and the national average drug acquisition or wholesale acquisition cost of the drug, as applicable.

(2) The board may conduct an audit or audits of appeals denied under the provisions of subsection (1) of this section to

ensure compliance with its requirements. In conducting audits, the board is empowered to request production of documents pertaining to compliance with the provisions of this section, and documents so requested shall be produced within seven (7) days of the request unless extended by the board or its duly authorized staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Making referrals;

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

(c) Presenting a claim for payment to any individual, third-party payor, affiliate, or other entity for a service

furnished pursuant to a referral from a pharmacy benefit manager or pharmacy benefit manager affiliate; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A pharmacy benefit manager or pharmacy benefit manager affiliate shall not penalize or retaliate against a pharmacist, pharmacy or pharmacy employee for exercising any rights under this chapter, initiating any judicial or regulatory actions or

discussing or disclosing information pertaining to an agreement with a pharmacy benefit manager or a pharmacy benefit manager affiliate when testifying or otherwise appearing before any governmental agency, legislative member or body or any judicial authority.

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

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

(2) The board may impose a monetary penalty on a pharmacy benefit manager or a pharmacy benefit manager affiliate for noncompliance with the provisions of this act in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five Thousand Dollars ($25,000.00) per violation.

Each day that a violation continues is a separate violation. The board shall prepare a record entered upon its minutes that states the basic facts upon which the monetary penalty was imposed. Any penalty collected under this subsection (2) shall be deposited into the special fund of the board created in Section 3 of this act, and shall be used by the board to support the operations of the board relating to the regulation, supervision and examination of pharmacy benefit managers.

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

(4) The board may assess a monetary penalty for those reasonable costs that are expended by the board in the investigation and conduct of a proceeding if the board imposes a monetary penalty under subsection (2) of this section. A monetary penalty assessed and levied under this section shall be paid to the board by the pharmacy benefit manager or pharmacy benefit

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

(5) When payment of a monetary penalty assessed and levied by the board against a pharmacy benefit manager or pharmacy benefit manager affiliate in accordance with this section is not paid by the pharmacy benefit manager or pharmacy benefit manager affiliate when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the pharmacy benefit manager or pharmacy benefit manager affiliate, or if the pharmacy benefit manager or pharmacy benefit manager affiliate is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record and make its determination thereon. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

(6) The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given

violation of the provisions of this act. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

SECTION 11. The following shall be codified as Section 25-15-319, Mississippi Code of 1972:

25-15-320. (1) Upon the request by any agency of the State of Mississippi, or any political subdivision of the state or any other public entity, a pharmacy benefit manager shall deliver or otherwise make available to the requesting agency or entity, in its entirety and with no redaction, any third-party aggregator contracts or contracts relating to pharmacy benefit management services between a pharmacy benefit manager and the entity, as well as any contracts between the entity and a pharmacy services administrative organization.

(2) Any person, firm, corporation, partnership, association or other type of business entity that does not comply with this section shall be barred for a period of five (5) years from the date of the original request for the contract from doing business with the State of Mississippi or any political subdivision or any other public entity thereof.

SECTION 12. This act shall take effect and be in force from and after July 1, 2024.