MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Senator(s) Michel To: Insurance

SENATE BILL NO. 2739

AN ACT TO BRING FORWARD SECTIONS 73-21-151, 73-21-153, 73-21-155, 73-21-156, 73-21-157, 73-21-159, 73-21-161, 73-21-163, 73-21-175, 73-21-177, 73-21-179, 73-21-181, 73-21-183, 73-21-185, 73-21-187, 73-21-189, 73-21-191, 73-21-201, 73-21-203 AND 73-21-205, MISSISSIPPI CODE OF 1972, WHICH PROVIDE FOR THE PHARMACY BENEFIT PROMPT PAY ACT, PHARMACY INTEGRITY ACT, AND PRESCRIPTION DRUGS CONSUMER AFFORDABLE ALTERNATIVE PAYMENT OPTIONS ACT, FOR THE PURPOSE OF POSSIBLE AMENDMENT; TO BRING FORWARD SECTIONS 83-1-101, 83-1-155, 83-5-1, 83-5-3, 83-5-5, 83-9-1 AND 83-9-6, MISSISSIPPI CODE OF 1972, WHICH PROVIDE FOR THE DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT OF INSURANCE, THE JURISDICTION OF THE DEPARTMENT OF INSURANCE, CERTAIN SUPERVISION, NOTICE, APPEALS AND HEARINGS PROVISIONS, AND VARIOUS OTHER REQUIREMENTS, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 73-21-151, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 2. Section 73-21-153, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

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

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

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

(h) "Pharmacy benefit manager" shall have the same definition as provided in Section 73-21-179. However, through June 30, 2014, the term "pharmacy benefit manager" shall not include an insurance company that provides an integrated health benefit plan and that does not separately contract for pharmacy benefit management services. From and after July 1, 2014, the term "pharmacy benefit manager" shall not include an insurance company unless the insurance company is providing services as a pharmacy benefit manager as defined in Section 73-21-179, in which case the insurance company shall be subject to Sections 73-21-151 through 73-21-159 only for those pharmacy benefit manager services. In addition, the term "pharmacy benefit manager" shall not include the pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan or the Mississippi Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

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

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

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

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

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

SECTION 3. Section 73-21-155, Mississippi Code of 1972, is brought forward as follows:

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

prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the nonelectronic claim.

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

(3) (a) All benefits payable under a pharmacy benefit management plan shall be paid within seven (7) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within seven (7) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the

pharmacy benefit manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

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

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

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

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

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

(c) Not later than seven (7) days after the date the pharmacy benefit manager actually receives an electronic claim,

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

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

than Twenty-five Thousand Dollars ($25,000.00) to be assessed by the State Board of Pharmacy.

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

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

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

(d) Any pharmacy benefit manager and a pharmacy may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as

stringent as, the provisions set forth under subsection (3) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (4)(c) of this section shall apply.

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

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

(b) The State Board of Pharmacy shall adopt rules and regulations necessary to implement and ensure compliance with this subsection, including, but not limited to, rules and regulations that address access to pharmacy services in rural or underserved areas in cases where a network pharmacy or pharmacist declines to

provide a drug or service under paragraph (a) of this subsection. The board shall promulgate the rules and regulations required by this paragraph (b) not later than October 1, 2016.

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

SECTION 4. Section 73-21-156, Mississippi Code of 1972, is brought forward as follows:

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

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

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

(ii) Average manufacturer price;

(iii) Average wholesale price;

(iv) Brand effective rate or generic effective rate;

(v) Discount indexing;

(vi) Federal upper limits;

(vii) Wholesale acquisition cost; and

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

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

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

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

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

(c) Shall not be obsolete.

(3) A pharmacy benefit manager shall:

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

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

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

(4) A pharmacy benefit manager shall:

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

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

(ii) Being below the pharmacy acquisition cost.

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

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

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

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

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

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

(i) If the appeal is upheld:

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

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

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

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

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

(iii) If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy

acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit manager shall adjust the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

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

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

SECTION 5. Section 73-21-157, Mississippi Code of 1972, is brought forward as follows:

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

(2) Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1 or within sixty (60) days of the end

of its fiscal year if not a calendar year. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year or the immediately preceding fiscal year of the pharmacy benefit manager.

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

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

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

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

(b) Any person who knowingly releases, causes to be released or assists in the release of any such information shall

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

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

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

(6) The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However,

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

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

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

SECTION 6. Section 73-21-159, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

SECTION 7. Section 73-21-161, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

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

(a) Making referrals;

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

authorized by law; or utilization review by a health care provider; or

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

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

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

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

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

SECTION 8. Section 73-21-163, Mississippi Code of 1972, is brought forward as follows:

73-21-163. Whenever the board has reason to believe that a pharmacy benefit manager or pharmacy benefit manager affiliate is

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

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

(3) The board may assess a monetary penalty for those reasonable costs that are expended by the board in the

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

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

provisions of Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

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

SECTION 9. Section 73-21-175, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 10. Section 73-21-177, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 11. Section 73-21-179, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

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

(ii) Contract with retail and mail pharmacy networks.

(iii) Establish payment levels for pharmacies.

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

(v) Provide benefit design consultation.

(vi) Manage cost and utilization trends.

(vii) Contract for manufacturer rebates.

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

(ix) Third-party administration.

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

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

SECTION 12. Section 73-21-181, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 13. Section 73-21-183, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

audit for a different pharmacy benefits manager or health insurance plan;

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

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

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

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

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

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

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

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

(r) A recoupment shall not be based on:

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

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

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

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

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

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

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

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

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

(e) Recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final internal disposition of the audit, including the appeals process as set forth in Section 73-21-185. If the identified discrepancy for an individual audit exceeds Twenty-five Thousand Dollars ($25,000.00), future payments in excess of that amount to the pharmacy may be withheld pending finalization of the audit;

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

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

SECTION 14. Section 73-21-185, Mississippi Code of 1972, is brought forward as follows:

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

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

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

SECTION 15. Section 73-21-187, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 16. Section 73-21-189, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 17. Section 73-21-191, Mississippi Code of 1972, is brought forward as follows:

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

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

under this subsection (2) shall be deposited to the credit of the special fund of the board.

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

(4) The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given violation of board regulations and laws governing the practice of pharmacy. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the

uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

SECTION 18. Section 73-21-201, Mississippi Code of 1972, is brought forward as follows:

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

SECTION 19. Section 73-21-203, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

SECTION 20. Section 73-21-205, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

SECTION 21. Section 83-1-101, Mississippi Code of 1972, is brought forward as follows:

83-1-101. Notwithstanding any other provision of law to the contrary, and except as provided herein, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the State Insurance Department, unless (a) the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this state, any subdivisions thereof, or the federal government; or (b) the

person or other entity is providing coverage under the Direct Primary Care Act in Sections 83-81-1 through 83-81-11.

SECTION 22. Section 83-1-155, Mississippi Code of 1972, is brought forward as follows:

83-1-155. (1) An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the commissioner's discretion that:

(a) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

(b) The insurer has exceeded its powers granted under its certificate of authority and applicable law;

(c) The insurer has failed to comply with the applicable provisions of the insurance code;

(d) The business of the insurer is being conducted fraudulently; or

(e) The insurer gives its consent.

(2) If the commissioner determines that the conditions set forth in subsection (1) of this section exist, the commissioner shall:

(a) Notify the insurer of such determination;

(b) Furnish to the insurer a written list of the requirements to abate this determination; and

(c) Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of Sections 83-1-151 through 83-1-169.

Such action by the commissioner may be appealed to the Chancery Court of the First Judicial District of Hinds County.

(3) If placed under administrative supervision, the insurer shall have sixty (60) days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of Sections 83-1-151 through 83-1-169.

(4) If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the commissioner may extend such period.

(5) If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

SECTION 23. Section 83-5-1, Mississippi Code of 1972, is brought forward as follows:

83-5-1. All indemnity or guaranty companies, all companies, including those companies defined in Section 83-41-303(n), corporations, partnerships, associations, individuals and fraternal orders, whether domestic or foreign, transacting, or to be admitted to transact, the business of insurance in this state are insurance companies within the meaning of this chapter, and shall be subject to the inspection and supervision of the commissioner.

SECTION 24. Section 83-5-3, Mississippi Code of 1972, is brought forward as follows:

83-5-3. Every insurance company, foreign or domestic, that qualifies to do business in the State of Mississippi shall be required to execute an agreement to be bound by the statute laws of the State of Mississippi pertaining to the periods of limitation prescribed by the statute law of this state.

The insurance commissioner is hereby required, as a condition precedent to authorizing any insurance company to qualify and operate under the laws of this state or to do business in this state, to require said companies to execute an agreement binding said company to conform to and to be bound and regulated by the statute laws of this jurisdiction as defined in the first paragraph.

For purposes of the administration of this section, insurance companies shall consist of all types of insurance companies, both domestic and foreign, that operate in this jurisdiction, including stock companies, mutuals, and fraternal societies and organizations when such fraternal society or organization engages in the insuring of its members or other persons.

SECTION 25. Section 83-5-5, Mississippi Code of 1972, is brought forward as follows:

83-5-5. When consistent with the context and not obviously used in a different sense, the term "company" or "insurance company", as used in this chapter, includes all corporations,

associations, partnerships, or individuals engaged as principals in the business of insurance or guaranteeing the obligations of others.

The word "domestic" designates those companies or other insurers incorporated or formed in this state; and the word "foreign", when used without limitation, includes all those formed by authority of any other state or government, and whose home office is not located in this state.

A contract of insurance is an agreement by which one party for a consideration promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, loss, or injury of something in which the assured or other party has an interest, as an indemnity therefor.

SECTION 26. Section 83-9-1, Mississippi Code of 1972, is brought forward as follows:

83-9-1. The term "policy of accident and sickness insurance," as used in Sections 83-9-1 through 83-9-21, includes any individual or group policy or contract of insurance against loss resulting from sickness or from bodily injury, including dental care expenses resulting from sickness or bodily injury, or death by accident, or accidental means, or both.

SECTION 27. Section 83-9-6, Mississippi Code of 1972, is brought forward as follows:

83-9-6. (1) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including

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

(2) As used in this section:

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

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

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

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

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

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

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

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

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

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

(d) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in

the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;

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

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

(g) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service.

(4) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent or owner, may not waive, discount, rebate or distort a copayment of any insurer, policy or plan or a

beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the State Board of Pharmacy.

(5) If a health benefit plan providing reimbursement to Mississippi residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least sixty (60) days before the effective date of the plan or before July 1, 1995, whichever comes first. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies

that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

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

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

(8) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this state that is contrary to this section shall, to the extent of the conflict, be void.

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

SECTION 28. This act shall take effect and be in force from and after July 1, 2024.