Adopted
SUBSTITUTE NO 1 FOR COMMITTEE AMENDMENT NO 1 PROPOSED TO

House Bill No. 1265

BY: Senator(s) Michel

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

SECTION 1. Section 73-21-153, Mississippi Code of 1972, is amended 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) "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.

(* * *c) "Commissioner" means the Mississippi Commissioner of Insurance.

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

(* * *e) "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.

(* * *f) "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 an electronic claim.

(* * *g) "Enrollee" means an individual who has been enrolled in a pharmacy benefit management plan or a health insurance plan, or both.

(* * *h) "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.

(i) "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" * * * means a business that provides pharmacy benefit management services or administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions, health maintenance organizations or another pharmacy benefit manager. The term "pharmacy benefit manager" shall not include:

(i) An insurance company unless the insurance company is providing services as a pharmacy benefit manager * * *, in which case the insurance company shall be subject to Sections

73-21-151 through * * * 73-21-163 only for those pharmacy benefit manager services * * *; and

(ii) The pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan when performing pharmacy benefit manager services for the plan, or the Mississippi Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

(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, drugs or devices.

(* * *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 benefit management services shall include, but are not limited to, the following services, which may be provided either directly or through outsourcing or contracts:

(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; and

(x) Sponsoring or providing cash discount cards as defined in Section 83-9-6.1.

(o) "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.

(* * *p) "Uniform claim form" means a form prescribed by rule by the State Board of Pharmacy; however, for purposes of Sections 73-21-151 through * * * 73-21-163, 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 * * * 73-21-163.

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

SECTION 2. Section 73-21-155, Mississippi Code of 1972, is amended 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) 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.

(*** * ***3) 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.

(* * *4) (a) All benefits payable * * * from a pharmacy benefit * * * manager 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 * * * 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 * * * within seven (7) days 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.

(* * *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 State Board of Pharmacy.

(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 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. * * *

(* * *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 3. Section 73-21-156, Mississippi Code of 1972, is amended 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 *** * *** 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 * * * or through a pharmacy service administrative organization; and

(iii) A period of no 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 (4) within * * * forty-five (45) 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 * * * forty-five (45) business days after receipt of the challenge either:

(i) * * * Uphold the appeal * * * and:

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 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 as defined by the payor subject to the maximum allowable cost list; or

(ii) * * * Deny the appeal * * * and:

1. 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; * * * and

* * *2. 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 pharmacy benefit manager shall not deny an appeal submitted pursuant to subsection (4) of this section based upon an existing contract with the pharmacy that provides for a reimbursement rate lower than the actual acquisition cost of the pharmacy.

(6) A pharmacy or pharmacist that belongs to a pharmacy services administrative organization shall be provided a true and correct copy of any contract that the pharmacy services administrative organization enters into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

(* * *7) (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.

(8) 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.

(9) As used in the section, "spread pricing" means any amount charged or claimed by a pharmacy benefit manager in excess of the ingredient cost for a dispensed prescription drug plus dispensing fee paid directly or indirectly to any pharmacy, pharmacist, or other provider on behalf of the health benefit plan, less a pharmacy benefit management fee.

(10) No pharmacy benefit manager, carrier, or health benefit plan may, either directly or through an intermediary, agent, or affiliate engage in, facilitate, or enter into a contract with another person involving spread pricing in this state.

(11) A pharmacy benefit manager contract with a carrier or health benefit plan entered into, renewed, or amended on or after the effective date this act must:

(a) Specify all forms of revenue, including pharmacy benefit management fees, to be paid by the carrier or health benefit plan to the pharmacy benefit manager; and

(b) Acknowledge that spread pricing is not permitted in accordance with this section.

SECTION 4. Section 73-21-157, Mississippi Code of 1972, is amended 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. This application shall be renewed annually.

(2) When applying for a license or renewal of a license, each pharmacy benefit manager * * * shall file * * * with the board:

(a) A copy of a certified audit report, if the pharmacy benefit manager has been audited by a certified public accountant within the last twenty-four (24) months; or

(b) If the pharmacy benefit manager has not been audited in the last twenty-four (24) months, a financial statement of the organization, including its balance sheet and income statement for the preceding year, which shall be verified by at least two (2) principal officers; and

* * *

(* * *c) Any other information relating to the operations of the pharmacy benefit manager required by the board.

(* * *3) (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, 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.

(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.

(* * *4) * * * 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.

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

(* * *6) 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 5. The following shall be codified as Section 73-21-158, Mississippi Code of 1972:

73-21-158. (1) Each drug manufacturer shall submit a report to the Commissioner of the Mississippi Department of Insurance no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the prescription drugs sold in or into the state by that drug manufacturer.

(2) Not more than thirty (30) days after an increase in wholesale acquisition cost of forty percent (40%) or greater over

the preceding five (5) calendar years or ten percent (10%) or greater in the preceding twelve (12) months for a prescription drug with a wholesale acquisition cost of Seventy Dollars ($70.00) or more for a manufacturer-packaged drug container, a drug manufacturer shall submit a report to the commissioner. The report must contain the following information:

(a) Name of the drug;

(b) Whether the drug is a brand name or a generic;

(c) The effective date of the change in wholesale acquisition cost;

(d) Aggregate, company-level research and development costs for the previous calendar year;

(e) Aggregate rebate amounts paid to each pharmacy benefits manager for the previous calendar year;

(f) The name of each of the drug manufacturer's drugs approved by the United States food and drug administration in the previous five (5) calendar years;

(g) The name of each of the drug manufacturer's drugs that lost patent exclusivity in the United States in the previous five (5) calendar years; and

(h) A concise statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost, such as raw ingredient shortage or increase in pharmacy benefit manager's rebates.

(2) The quality and types of information and data a drug manufacturer submits to the commissioner pursuant to this section must be the same as the quality and types of information and data the drug manufacturer includes in the drug manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure. A drug manufacturer shall notify the commissioner in writing if the drug manufacturer is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D Program.

(3) The notice must include a concise statement of rationale regarding the factor or factors that caused the new drug to exceed the Medicare Part D Program price. The drug manufacturer shall provide the written notice within three (3) calendar days following the release of the drug in the commercial market. A drug manufacturer may make the notification pending approval by the United States Food and Drug Administration if commercial availability is expected within three (3) calendar days following the approval.

(4) On or before April 1st of each year, a pharmacy benefits manager providing services for a health care plan shall file a report with the commissioner. The report must contain the following information for the previous calendar year:

(a) The aggregated rebates, fees, price protection payments and any other payments collected from each drug manufacturer;

(b) The aggregated dollar amount of rebates, price protection payments, fees, and any other payments collected from each drug manufacturer which were passed to health insurers;

(c) The aggregated fees, price concessions, penalties, effective rates, and any other financial incentive collected from pharmacies which were passed to enrollees at the point of sale;

(d) The aggregated dollar amount of rebates, price protection payments, fees, and any other payments collected from drug manufacturers which were retained as revenue by the pharmacy benefits manager; and

(e) The aggregated rebates passed on to employers.

(5) Reports submitted by pharmacy benefits managers under this section may not disclose the identity of a specific health benefit plan or enrollee, the identity of a drug manufacturer, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

(6) On or before April 1st of each year, each health insurer shall submit a report to the commissioner. The report must contain the following information for the previous two (2) calendar years:

(a) Names of the twenty-five (25) most frequently prescribed drugs across all plans;

(b) Names of the twenty-five (25) prescription drugs dispensed with the highest dollar spend in terms of gross revenue;

(c) Percent of increase in annual net spending for prescription drugs across all plans;

(d) Percent of increase in premiums which is attributable to prescription drugs across all plans;

(e) Percentage of specialty drugs with utilization management requirements across all plans; and

(f) Premium reductions attributable to specialty drug utilization management.

(7) A report submitted by a health insurer may not disclose the identity of a specific health benefit plan or the prices charged for specific prescription drugs or classes of prescription drugs.

SECTION 6. The following shall be codified as Section 73-21-160, Mississippi Code of 1972:

73-21-160. (1) The commissioner shall develop a website to publish information the commissioner receives under this chapter. The commissioner shall make the website available on the commissioner's website with a dedicated link prominently displayed on the home page, or by a separate, easily identifiable internet address.

(2) Within sixty days of receipt of reported information under this chapter, the commissioner shall publish the reported information on the website developed under this section. The information the commissioner publishes may not disclose or tend to disclose trade secret, proprietary, commercial, financial, or confidential information of any pharmacy, pharmacy benefits manager, drug wholesaler, or hospital.

(3) The commissioner may adopt rules to implement this chapter. The commissioner shall develop forms that must be used for reporting required under this chapter. The commissioner may contract for services to implement this chapter.

(4) A report received by the commissioner 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 department unless subject to an order from a court of competent jurisdiction. The department shall destroy or delete or cause to be destroyed or deleted all such information thirty (30) days after the department determines that the information is no longer necessary or useful.

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

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

(a) Ordering of a patient to a pharmacy <u>benefit manager affiliate</u> by a <u>pharmacy benefit manager or a</u> 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 or 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.

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(*** * ***4) 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.

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

(6) This section shall not apply to facilities licensed to fill prescriptions solely for employees of a plan sponsor or employer.

SECTION 8. The following shall be codified as Section 73-21-162, Mississippi Code of 1972:

73-21-162. (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 9. Section 73-21-163, Mississippi Code of 1972, is amended as follows:

73-21-163. (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 in Sections 73-21-151 through 73-21-163 and that proceedings would be in the public interest, board 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 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.

(3) For the purposes of conducting investigations, the board, through its executive director, may conduct examinations of a pharmacy benefit manager 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.

(* * *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 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 (* * *4) shall be deposited into the special fund of the board.

(* * *5) 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.

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

(b) 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 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.

(c) 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 services.

(* * *7) 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 10. The following shall be codified as Section 73-21-164, Mississippi Code of 1972:

73-21-164. (1) Pharmacy benefit managers shall also identify to the board any ownership affiliation of any kind with any pharmacy which, either directly or indirectly, through one or more intermediaries:

(a) Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority;

(b) Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or

(c) Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

(2) A pharmacy benefit manager shall report any change in information required by this act to the board in writing within sixty (60) days after the change occurs.

SECTION 11. Section 73-21-179, Mississippi Code of 1972, is amended 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 provides pharmacy benefit management services or 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. * * *

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 this section, in which case the insurance company shall be subject to Sections 73-21-151 through 73-21-163 only for those pharmacy benefit manager services.

(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 * * *, drugs or devices.

(f) "Pharmacy benefit management services" shall include, but are not limited to, the following services, which may be provided either directly or through outsourcing or contracts with other entities:

(i) Adjudicating drug claims or any portion of the transaction;

(ii) Contracting with retail and mail pharmacy networks;

(iii) Establishing payment levels for pharmacies;

(iv) Developing formulary or drug list of covered therapies;

(v) Providing benefit design consultation;

(vi) Managing cost and utilization trends;

(vii) Contracting for manufacturer rebates;

(viii) Providing fee-based clinical services to improve member care;

(ix) Third-party administration; and

(x) Sponsoring or providing cash discount cards as defined in Section 83-9-6.1.

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

SECTION 12. This act shall take effect and be in force from and after July 1, 2024, and shall stand repealed on June 30, 2027.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

AN ACT TO AMEND SECTION 73-21-153, MISSISSIPPI CODE OF 1972, TO REVISE VARIOUS DEFINITIONS RELATED TO THE PHARMACY BENEFIT PROMPT PAY ACT; TO AMEND SECTION 73-21-155, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT ANY CONTRACT THAT PROVIDES FOR LESS THAN CERTAIN REIMBURSEMENT LEVELS VIOLATES THE PUBLIC POLICY OF THE STATE; TO SET CERTAIN TIMELINES REQUIRED UNDER THE ACT; TO AMEND SECTION 73-21-156, MISSISSIPPI CODE OF 1972, TO SET CERTAIN PROVISIONS RELATED TO APPEALS; TO PROVIDE THAT A PHARMACY OR PHARMACIST THAT BELONGS TO A PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION SHALL BE PROVIDED A TRUE AND CORRECT COPY OF ANY CONTRACT THAT THE PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION ENTERS INTO WITH A PHARMACY BENEFIT MANAGER OR THIRD-PARTY PAYER

ON THE PHARMACY'S OR PHARMACIST'S BEHALF; TO PROVIDE THAT 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; TO PROHIBIT SPREAD PRICING; TO AMEND SECTION 73-21-157, MISSISSIPPI CODE OF 1972, TO REQUIRE CERTAIN LICENSING STANDARDS AND REPORTS; TO ESTABLISH CERTAIN AUDITING STANDARDS RELATED TO THE ACT; TO CREATE NEW SECTION 73-21-158, MISSISSIPPI CODE OF 1972, TO REQUIRE EACH DRUG MANUFACTURER TO SUBMIT A REPORT TO THE COMMISSIONER OF THE DEPARTMENT OF INSURANCE THAT INCLUDES THE CURRENT WHOLESALE ACQUISITION COST; TO REQUIRE SUCH ENTITIES TO PROVIDE THE COMMISSIONER WITH VARIOUS DRUG PRICING INFORMATION WITHIN A CERTAIN TIME; TO REQUIRE PHARMACY BENEFIT MANAGERS TO FILE A REPORT WITH THE COMMISSIONER; TO REQUIRE EACH HEALTH INSURER TO SUBMIT A REPORT TO THE COMMISSIONER THAT INCLUDES CERTAIN DRUG PRESCRIPTION INFORMATION; TO CREATE NEW SECTION 73-21-160, MISSISSIPPI CODE OF 1972, TO REQUIRE THE COMMISSIONER TO DEVELOP A WEBSITE TO PUBLISH INFORMATION RELATED TO THE ACT; TO AMEND SECTION 73-21-161, MISSISSIPPI CODE OF 1972, TO SET CERTAIN STANDARDS RELATED TO PHARMACIES, REFERRALS AND PHARMACY BENEFIT MANAGERS; TO CREATE NEW SECTION 73-21-162, MISSISSIPPI CODE OF 1972, TO PROHIBIT PHARMACY BENEFIT MANAGERS FROM RETALIATING AGAINST PHARMACISTS OR PHARMACIES FOR TAKING CERTAIN ACTIONS; TO AMEND SECTION 73-21-163, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DEPARTMENT TO CONDUCT INVESTIGATIONS, ISSUE SUBPOENAS AND TO CONDUCT AUDITS FOR ACTIONS RELATED TO THE ACT; TO CREATE NEW SECTION 73-21-164, MISSISSIPPI CODE OF 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS TO IDENTIFY OWNERSHIP AFFILIATION OF ANY KIND TO THE BOARD; TO AMEND SECTION 73-21-179, MISSISSIPPI CODE OF 1972, TO REVISE VARIOUS PROVISIONS RELATED TO PHARMACY BENEFIT MANAGERS; AND FOR RELATED PURPOSES.