REPORT OF CONFERENCE COMMITTEE

MR. SPEAKER AND MR. PRESIDENT:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

H. B. No. 1123: Pharmacy benefit managers and pharmacy services administrative organizations; provide certain regulations for.

We, therefore, respectfully submit the following report and recommendation:

1. That the Senate recede from its Amendment No. 1.

2. That the House and Senate adopt the following amendment:

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

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

73-21-151. Sections 73-21-151 through * * * 73-21-169 shall be known as the "Pharmacy Benefit Prompt Pay Act."

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

73-21-153. For purposes of Sections 73-21-151 through * * * 73-21-169, the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Board" means the * * * Mississippi 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 * * * the electronic claim.

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

(* * *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) "Network pharmacy" means a pharmacy licensed by the board and provides pharmacy services to Mississippi consumers and has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate.

(j) "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; and

(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.

(k) "Pharmacist * * *" and "pharmacy" or "pharmacies" shall have the same definition as provided in Section 73-21-73.

(* * *l) "Pharmacy benefit manager" * * * means an entity that provides pharmacy benefit management services. * * * 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 * * * 73-21-169 only for those pharmacy benefit manager services * * *; and

(ii) The Mississippi Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

(* * *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 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.

* * *

(o) "Pharmacy benefit management services" shall include, but is 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; and

(ix) Third-party administration.

(p) "Pharmacist services" means products, goods and services, or any combination of products, goods and services, provided as part of the practice of pharmacy.

(q) "Pharmacy services administrative organization" or "PSAO" means any entity that contracts with a pharmacy or pharmacist to assist with third-party interactions and that may provide a variety of other administrative services, including, but not limited to, contracting with pharmacy benefit managers on behalf of pharmacies and providing pharmacies with credentialing, billing, audit, general business and analytic support. A covered entity as defined in 42 USC Section 256b, including its pharmacy or the transactions related to the 340B drug discount program of any pharmacy contracted with the participating covered entity to dispense drugs purchased through the 340B drug discount program, shall not be considered to be a pharmacy services administrative organization.

(* * *r) "Plan sponsors" means the employers, insurance companies, unions and health maintenance organizations that contract, either directly or indirectly, with a pharmacy

benefit manager for delivery of prescription drugs and/or services.

(s) "Proprietary information" means information on pricing, costs, revenue, taxes, market share, negotiating strategies, customers and personnel that is held by a pharmacy benefit manager, drug manufacturer or PSAO and used for its business purposes.

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

(u) "Spread pricing" means any amount charged or claimed by a pharmacy benefit manager or PSAO 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 or PSAO fee.

(* * *v) "Uniform claim form" means a form prescribed by rule by the * * * board; however, for purposes of Sections

73-21-151 through * * * 73-21-169, 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 * * * 73-21-169.

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

SECTION 3. 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) 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 *** * *** completed billing instrument, paper or electronic, received by a pharmacy benefit manager from a pharmacist or pharmacies or the insured, which is accepted and payment remittance advice is provided by the pharmacy benefit manager. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

(b) 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 * * * pharmacy licensed by the board and provides pharmacy services to Mississippi consumers and 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 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 the drug is a generic equivalent drug product as defined in Section 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 * * * reimbursements made * * * 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 * * * direct telephone number, email address and website for the purpose of submitting administrative appeals;

(ii) The website of the pharmacy benefit manager shall include easily accessible administrative appeal instructions, including listing any required information to be submitted by pharmacies for the purpose of submitting administrative appeals;

(* * *iii) The ability to submit an administrative appeal or a claim appeal report for multiple claims directly to the pharmacy benefit manager * * * or through a * * * PSAO; and

(* * *iv) A period of no less than thirty (30) * * * 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) * * * 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) * * * days after receipt of the challenge either:

(i) * * * Uphold the appeal * * * and adjust the reimbursement paid to the pharmacist or pharmacy to no less than the pharmacy acquisition cost, as documented on the pharmacist's or pharmacy's billing invoice, or as provided in the claim appeal report, and make the * * * adjustment effective for * * * that pharmacist or pharmacy for that appeal. The pharmacy benefit manager shall provide notice on its website that an appeal was made and upheld and that an adjusted reimbursement was made to a pharmacy or pharmacist following the appeal. The notice shall include the National Drug Code, the day of service for which the appeal was made and the challenged rate; or

(ii) * * * Deny the appeal * * * and provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Mississippi that the pharmacy or pharmacist is able to purchase prescription drugs for resale from and 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.

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

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

(6) 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 pharmacy acquisition cost.

(* * *7) * * * 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 * * * drug or drugs. * * * The reimbursement amount for such drug or drugs 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 amended as follows:

73-21-157. (1) Before beginning to do business as a pharmacy benefit manager or PSAO, a pharmacy benefit manager or PSAO 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 license shall be renewed annually.

(2) When applying for a license or renewal of a license, each pharmacy benefit manager * * * or PSAO 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 or PSAO 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.

(* * *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 and PSAOs operating in this state.

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

SECTION 6. The following shall be codified as Section 73-21-158, Mississippi Code of 1972:

73-21-158. (1) No pharmacy benefit manager, PSAO, 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.

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

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

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

(3) Subsections (1) and (2) of this section shall not apply to self-insured plans.

(4) Every pharmacy benefit manager and PSAO shall disclose to the plan sponsor or employer one hundred percent (100%) of all rebates and other payments that the pharmacy benefit manager or PSAO receives directly or indirectly from pharmaceutical manufacturers and/or rebate aggregators in connection with claims administered on behalf of the plan sponsor or employer and the recipients of such rebates. In addition, a pharmacy benefit manager or PSAO shall report annually to each plan sponsor or employer the aggregate amount of all rebates and other payments and the recipients of such rebates unless the contract with the plan sponsor or employer or the health benefit plan already requires these disclosures.

(5) A pharmacy benefit manager or third-party payer shall not charge or cause a patient to pay an amount that exceeds the total amount retained by the pharmacy.

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 "* * *steering" means:

(a) Directing, ordering * * *, or requiring a patient to use a specific affiliate pharmacy * * * or pharmacies, for the purpose of filling a prescription or receiving services or other care from a pharmacist;

(b) Offering or implementing health insurance plan designs that require * * * a beneficiary to * * * utilize an affiliate pharmacy or pharmacies, or that increases costs to a patient, including requiring a patient to pay the full cost for a prescription drug when such patient chooses not to use a pharmacy benefit manager affiliate pharmacy; * * *

(c) * * * Advertising, marketing, or * * * promoting an affiliate * * * pharmacy or pharmacies, over another in-network pharmacy; or

(d) Creating any network or engaging in any practice, including accreditation or credentialing standards, day supply limitations or delivery methods limitations, that exclude an in-network pharmacy or restrict an in-network pharmacy from filling a prescription for a prescription drug; or

(e) Directly or indirectly engaging in any practice that attempts to influence or induce a pharmaceutical manufacturer to limit the distribution of a prescription drug to a small number

of pharmacies or certain types of pharmacies, or to restrict distribution of such drug to nonaffiliate pharmacies.

The term " * * *steering" does not include a pharmacy's inclusion by a pharmacy benefit manager or 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) * * * Steering;

(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 * * * by steering 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 neither the pharmacy * * * nor the pharmacy benefit manager or pharmacy benefit manager affiliate violate subsection (2) of this section and the pharmacy provides the disclosures required in subsection (1) of this section.

* * *

(* * *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.

(7) This section shall not apply to plans governed by the Employee Retirement Income Security Act of 1974 (ERISA).

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, pharmacy benefit manager affiliate or PSAO shall 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, pharmacy benefit manager affiliate or PSAO 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, pharmacy benefit manager affiliate or PSAO 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 * * *, pharmacy benefit manager affiliate or PSAO is using, has used, or is about to use any method, act or practice prohibited in * * * this act and that proceedings would be in the public interest, it may bring an action in the name of the board against the pharmacy benefit manager * * *, pharmacy benefit manager affiliate or PSAO 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 * * * this act and such injunctions shall be issued without bond.

(2) The board may impose a monetary penalty on a pharmacy benefit manager * * *, or a pharmacy benefit manager affiliate or PSAO for noncompliance with the provisions of * * * this act, in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five Thousand Dollars ($25,000.00) per violation. Each day a violation continues for the same brand or generic product identifier or brand or generic code number is a separate violation. Each day that a pharmacy benefit manager or PSAO does business in this state without a license is deemed 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 audits and examinations of a pharmacy benefit manager or PSAO and may also issue subpoenas to any individual, pharmacy, pharmacy benefit manager, PSAO 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) If, after the conclusion of the audit, the pharmacy benefit manager or PSAO was found to be in compliance with all of the requirements of this act, then the board shall pay the costs of the audit. However, the pharmacy benefit manager or PSAO being audited shall pay all costs of such audit if such audit reveals any noncompliance with this act. 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 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 * * * this act. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

SECTION 10. The following shall be codified as Section 73-21-165, Mississippi Code of 1972:

73-21-165. (1) Each drug manufacturer shall submit a report to the board 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; provided, however, the first report due under this subsection shall not be due until October 1, 2025.

(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 board. The report must contain the following information:

(a) The 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 benefit manager or PSAO 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 or PSAO's rebates.

(3) A manufacturer's obligations under this section shall be fully satisfied by the submission of any information and data that a manufacturer includes in the manufacturer's annual consolidated report on Securities and Exchange Form 10-K or any other public disclosure. A drug manufacturer shall notify the board 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.

(4) 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.

(5) On or before October 1st of each year, a pharmacy benefit manager or PSAO providing services for a health care plan shall file a report with the board. The report must contain the following information for the previous state fiscal 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 benefit manager or PSAO; and

(e) The aggregated rebates passed on to employers.

(6) Reports submitted by pharmacy benefit managers and PSAOs 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.

(7) On or before October 1st of each year, each health insurer shall submit a report to the board. 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 spent 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.

(8) 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 11. The following shall be codified as Section 73-21-167, Mississippi Code of 1972:

73-21-167. (1) The board shall develop a website to publish information the board receives under this chapter. The board shall make the website available on the board's website with a dedicated link prominently displayed on the home page, or by a separate, easily identifiable Internet address.

(2) Within sixty (60) days of receipt of reported information under this chapter, the board shall publish the reported information on the website developed under this section. The information the board publishes may not disclose or tend to disclose trade secrets, proprietary, commercial, financial or confidential information of any pharmacy, pharmacy benefit manager, PSAO, drug wholesaler, drug manufacturer or hospital.

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

(4) A report received by the board 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.

SECTION 12. The following shall be codified as Section 73-21-169, Mississippi Code of 1972:

73-21-169. (1) Pharmacy benefit managers and PSAOs 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 or PSAO holding a certificate of authority;

(b) Shares common ownership with a pharmacy benefit manager or PSAO holding a certificate of authority in this state; or

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

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

SECTION 13. If any section, paragraph, sentence, clause, phrase or any part of this act is declared to be unconstitutional

or void, or if for any reason is declared to be invalid or of no effect, the remaining sections, paragraphs, sentences, clauses, phrases or parts thereof shall be deemed void and unenforceable.

SECTION 14. Sections 1 through 12 of this act shall stand repealed on July 1, 2028.

SECTION 15. This act shall take effect and be in force from and after July 1, 2025.

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

AN ACT TO AMEND SECTION 73-21-151, MISSISSIPPI CODE OF 1972, TO REFERENCE NEW SECTIONS IN THE PHARMACY BENEFIT PROMPT PAY ACT; TO AMEND SECTION 73-21-153, MISSISSIPPI CODE OF 1972, TO DEFINE NEW TERMS AND REVISE THE DEFINITIONS OF EXISTING TERMS UNDER THE PHARMACY BENEFIT PROMPT PAY ACT; TO AMEND SECTION 73-21-155, MISSISSIPPI CODE OF 1972, TO CONFORM DEFINITIONS FOR "CLEAN CLAIM" AND "NETWORK PHARMACY"; TO AMEND SECTION 73-21-156, MISSISSIPPI CODE OF 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS TO PROVIDE A REASONABLE ADMINISTRATIVE APPEAL PROCEDURE TO ALLOW PHARMACIES TO CHALLENGE A REIMBURSEMENT FOR A SPECIFIC DRUG OR DRUGS AS BEING BELOW THE REIMBURSEMENT RATE REQUIRED BY THE PRECEDING PROVISION; TO PROVIDE THAT IF THE APPEAL IS UPHELD, THE PHARMACY BENEFIT MANAGER SHALL MAKE THE CHANGE IN THE PAYMENT TO THE REQUIRED REIMBURSEMENT RATE FOR THAT PHARMACY; TO AMEND SECTION 73-21-157, MISSISSIPPI CODE OF 1972, TO REQUIRE A PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION (PSAO) TO BE LICENSED WITH THE MISSISSIPPI BOARD OF PHARMACY; TO REQUIRE A PSAO TO PROVIDE TO A PHARMACY OR PHARMACIST A COPY OF ANY CONTRACT ENTERED INTO ON BEHALF OF THE PHARMACY OR PHARMACIST BY THE PSAO; TO CREATE NEW SECTION 73-21-158, MISSISSIPPI CODE OF 1972, TO PROHIBIT A PHARMACY BENEFIT MANAGER, PSAO, CARRIER OR HEALTH PLAN FROM SPREAD PRICING; TO AMEND SECTION 73-21-161, MISSISSIPPI CODE OF 1972, TO PROHIBIT A PHARMACY BENEFIT MANAGER OR PHARMACY BENEFIT MANAGER AFFILIATES FROM ORDERING A PATIENT TO USE A SPECIFIC PHARMACY OR PHARMACIES, INCLUDING AN AFFILIATE PHARMACY; OFFERING OR IMPLEMENTING PLAN DESIGNS THAT PENALIZE A PATIENT WHEN A PATIENT CHOOSES NOT TO USE A PARTICULAR PHARMACY, INCLUDING AN AFFILIATE PHARMACY; ADVERTISING OR PROMOTING A PHARMACY, INCLUDING AN AFFILIATE PHARMACY, OVER ANOTHER IN-NETWORK PHARMACY; CREATING NETWORK OR ENGAGING IN PRACTICES THAT EXCLUDE AN IN-NETWORK

PHARMACY; ENGAGING IN A PRACTICE THAT ATTEMPTS TO LIMIT THE DISTRIBUTION OF A PRESCRIPTION DRUG TO CERTAIN PHARMACIES; INTERFERING WITH THE PATIENT'S RIGHT TO CHOOSE THE PATIENT'S PHARMACY OR PROVIDER OF CHOICE; TO PROVIDE THAT THIS SECTION DOES NOT APPLY TO FACILITIES LICENSED TO FILL PRESCRIPTIONS SOLELY FOR EMPLOYEES OF A PLAN SPONSOR OR EMPLOYER; TO CREATE NEW SECTION 73-21-162, MISSISSIPPI CODE OF 1972, TO PROHIBIT PHARMACY BENEFIT MANAGERS, PHARMACY BENEFIT MANAGER AFFILIATES AND PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS (PSAOS) FROM PENALIZING OR RETALIATING AGAINST A PHARMACIST, PHARMACY OR PHARMACY EMPLOYEE FOR EXERCISING ANY RIGHTS UNDER THIS ACT, INITIATING ANY JUDICIAL OR REGULATORY ACTIONS, OR APPEARING BEFORE ANY GOVERNMENTAL AGENCY, LEGISLATIVE MEMBER OR BODY OR ANY JUDICIAL AUTHORITY; TO AMEND SECTION 73-21-163, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE BOARD OF PHARMACY, FOR THE PURPOSES OF CONDUCTING INVESTIGATIONS, TO CONDUCT EXAMINATIONS OF A PHARMACY BENEFIT MANAGER OR PSAO AND TO ISSUE SUBPOENAS TO OBTAIN DOCUMENTS OR RECORDS THAT IT DEEMS RELEVANT TO THE INVESTIGATION; TO CREATE NEW SECTION 73-21-165, MISSISSIPPI CODE OF 1972, TO REQUIRE EACH DRUG MANUFACTURER TO SUBMIT A REPORT TO THE BOARD OF PHARMACY THAT INCLUDES THE CURRENT WHOLESALE ACQUISITION COST; TO REQUIRE SUCH ENTITIES TO PROVIDE THE BOARD OF PHARMACY WITH VARIOUS DRUG PRICING INFORMATION WITHIN A CERTAIN TIME; TO REQUIRE PHARMACY BENEFIT MANAGERS AND PSAOS TO FILE A REPORT WITH THE BOARD OF PHARMACY; TO REQUIRE EACH HEALTH INSURER TO SUBMIT A REPORT TO THE BOARD OF PHARMACY THAT INCLUDES CERTAIN DRUG PRESCRIPTION INFORMATION; TO CREATE NEW SECTION 73-21-167, MISSISSIPPI CODE OF 1972, TO REQUIRE THE BOARD OF PHARMACY TO DEVELOP A WEBSITE TO PUBLISH INFORMATION RELATED TO THE ACT; TO CREATE NEW SECTION 73-21-169, MISSISSIPPI CODE OF 1972, TO REQUIRE PHARMACY BENEFIT MANAGERS AND PSAOS TO IDENTIFY OWNERSHIP AFFILIATION OF ANY KIND TO THE BOARD OF PHARMACY; AND FOR RELATED PURPOSES.

CONFEREES FOR THE HOUSE	CONFEREES FOR THE SENATE
X (SIGNED) Zuber	(NOT SIGNED) Bryan
X (SIGNED) Horan	X (SIGNED) Parks
X (SIGNED) Hood	X (SIGNED) Wiggins