FIRST REGULAR SESSION

SENATE BILL NO. 26

102ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR BROWN (16).

1188S.01I KRISTINA MARTIN, Secretary

AN ACT

To amend chapter 376, RSMo, by adding thereto three new sections relating to insurance coverage of pharmacy services.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto three new sections, to be known as sections 376.411, 376.413, and 376.415, to read as follows:

376.411. 1. For purposes of this section, the following terms mean:

(1) "Clinician-administered drug", any legend drug, as defined in section 338.330, that is administered by a health care provider who is authorized to administer the drug;

(2) "Health carrier", the same meaning given to the term in section 376.1350;

(3) "Participating provider", the same meaning given to the term in section 376.1350;

(4) "Pharmacy benefits manager", the same meaning given to the term in section 376.388.

2. A health carrier, a pharmacy benefits manager, or an agent or affiliate of such health carrier or pharmacy benefits manager shall not:

(1) Impose any penalty, impediment, differentiation, or limitation on a participating provider for providing medically necessary clinician-administered drugs regardless of whether the participating provider obtains such drugs

from a provider that is in the network including, but not limited to, refusing to approve or pay or reimbursing less than the contracted payment amount;

(2) Impose any penalty, impediment, differentiation, or limitation on a covered person who is administered medically necessary clinician-administered drugs regardless of whether the participating provider obtains such drugs from a provider that is in the network including, but not limited to, limiting coverage or benefits; requiring an additional fee, higher co-payment, or higher coinsurance amount; or interfering with a patient's ability to obtain a clinician-administered drug from the patient's provider or pharmacy of choice by any means including, but not limited to, inducing, steering, or offering financial or other incentives; or

(3) Impose any penalty, impediment, differentiation, or limitation on any pharmacy, including any class B hospital pharmacy as defined in section 338.220, that is dispensing medically necessary clinician-administered drugs regardless of whether the participating provider obtains such drugs from a provider that is in the network including, but not limited to, requiring a pharmacy to dispense such drugs to a patient with the intention that the patient will transport the medication to a health care provider for administration.

3. The provisions of this section shall not apply if the clinician-administered drug is not otherwise covered by the health carrier or pharmacy benefits manager.

376.413. 1. For purposes of this section, the term "health carrier" shall have the same meaning given to the term in section 376.1350, and the term "pharmacy benefits

manager" shall have the same meaning given to the term in section 376.388.

2. A health carrier, a pharmacy benefits manager, or an agent or affiliate of such health carrier or pharmacy benefits manager shall not:

(1) Discriminate, lower the reimbursement, or impose any separate terms upon an entity in any contract based, in whole or in part, on the entity's participation in the 340B drug pricing program as described in 42 U.S.C. Section 256b including, but not limited to:

(a) Requiring an entity participating in the 340B drug pricing program to reverse, resubmit, or clarify a 340B drug-pricing claim after the initial adjudication unless these actions are in the normal course of pharmacy business and not related to 340B drug pricing;

(b) Requiring a billing modifier to indicate that the drug or claim is a 340B drug-pricing claim or imposing any billing or reporting requirements that identify whether a drug was purchased through the 340B drug pricing program;

(c) Excluding an entity from a network on the basis, in whole or in part, of the entity's participation in the 340B drug pricing program;

(d) Establishing or setting network adequacy requirements based, in whole or in part, on 340B drug pricing program participation by a provider or a pharmacy;

(e) Prohibiting an entity authorized to participate in 340B drug pricing or a pharmacy under contract with an entity authorized to participate in 340B drug pricing from participating in the provider network on the basis, in whole or in part, of participation in 340B drug pricing;

(f) Offering a lower reimbursement for a drug purchased under the 340B drug pricing program than for the same drug not purchased under 340B drug pricing;

(g) Refusing to cover drugs purchased under the 340B drug pricing program; or

(h) Charging more than fair market value or seeking profit sharing in exchange for services involving the 340B drug pricing program; or

(2) Limit a patient's freedom to use an entity that participates in the 340B drug pricing program by any means including, but not limited to, modifying a patient's payment limitations or cost-sharing obligations on the basis of participation, in whole or in part, in the 340B drug pricing program.

3. A pharmacy benefits manager shall not base drug formulary or drug coverage decisions upon the 340B drug-pricing status of a drug, including price or availability, or whether a dispensing entity participates in the 340B drug pricing program.

4. A pharmaceutical manufacturer shall not prohibit an entity from contracting or participating with an entity authorized to participate in the 340B drug pricing program by denying access to drugs that are manufactured by the pharmaceutical manufacturer or by denying the entity the ability to purchase drugs at 340B program pricing by substituting a rebate discount.

5. All pharmacy claims processed by a pharmacy that participates in the 340B drug pricing program are final at the point of adjudication.

376.415. 1. For purposes of this section, the following terms mean:

(1) "Biological product", the same meaning given to the term in 42 U.S.C. Section 262(i);

(2) "Biosimilar", the same meaning given to the term in 42 U.S.C. Section 262(i);

(3) "Health carrier", the same meaning given to the term in section 376.1350;

(4) "Pharmacy benefits manager", the same meaning given to the term in section 376.388;

(5) "Reference product", the same meaning given to the term in 42 U.S.C. Section 262(i).

2. A health carrier, a pharmacy benefits manager, or an agent or affiliate of such health carrier or pharmacy benefits manager that provides coverage for a reference product or a biological product that is biosimilar to the reference product shall provide coverage for the reference product and all biological products that have been deemed biosimilar to the reference product. The scope, extent, and amount of such required coverage shall be the same including, but not limited to, any payment limitations or cost-sharing obligations.

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