

FIRST REGULAR SESSION

SENATE BILL NO. 402

102ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR BERNSKOETTER.

1508S.01I

KRISTINA MARTIN, Secretary

AN ACT

To repeal sections 338.015, 376.387, and 376.388, RSMo, and to enact in lieu thereof five new sections relating to payments for prescription drugs, with penalty provisions.

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

Section A. Sections 338.015, 376.387, and 376.388, RSMo,
2 are repealed and five new sections enacted in lieu thereof, to
3 be known as sections 103.200, 338.015, 376.387, 376.388, and
4 376.414, to read as follows:

**103.200. 1. For purposes of this section, the
2 following terms mean:**

3 **(1) "Pharmacy", the same meaning given to the term in
4 section 338.210;**

5 **(2) "Plan", the Missouri consolidated health care plan
6 as described in section 103.005;**

7 **(3) "Rebate", any discount, negotiated concession, or
8 other payment provided by a pharmaceutical manufacturer,
9 pharmacy, or health benefit plan to an entity to sell,
10 provide, pay, or reimburse a pharmacy or other entity in the
11 state for the dispensation or administration of a
12 prescription drug on behalf of itself or another entity.**

13 **2. Before March 1, 2025, and annually thereafter, the
14 pharmacy benefits manager utilized by the Missouri
15 consolidated health care plan shall file a report with the
16 plan for the immediately preceding calendar year. The**

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

17 report shall contain the following information regarding the
18 plan:

19 (1) The aggregate dollar amount of all rebates that
20 the pharmacy benefits manager collected from pharmaceutical
21 manufacturers that manufactured outpatient prescription
22 drugs that:

23 (a) Were covered by the plan during such calendar
24 year; and

25 (b) Were attributable to patient utilization of such
26 drugs during such calendar year; and

27 (2) The aggregate dollar amount of all rebates,
28 excluding any portion of the rebates received by the plan,
29 concerning drug formularies that the pharmacy benefits
30 manager collected from pharmaceutical manufacturers that
31 manufactured outpatient prescription drugs that:

32 (a) Were covered by the plan during such calendar
33 year; and

34 (b) Were attributable to patient utilization of such
35 drugs by covered persons under the plan during such calendar
36 year.

37 3. In consultation with its pharmacy benefits manager,
38 the plan shall establish a form for reporting the
39 information required under subsection 2 of this section.
40 The form shall be designed to minimize the administrative
41 burden and cost of reporting on the plan and its pharmacy
42 benefits manager.

43 4. No documents, materials, or other information
44 submitted to the plan under subsection 2 of this section
45 shall be subject to disclosure under chapter 610, except to
46 the extent they are included on an aggregated basis in the
47 reports required under subsection 5 of this section. The

48 plan shall not disclose information submitted under
49 subsection 2 of this section in a manner that:

50 (1) Is likely to compromise the financial,
51 competitive, or proprietary nature of such information; or

52 (2) Would enable a third party to identify the value
53 of a rebate provided for a particular outpatient
54 prescription drug or therapeutic class of outpatient
55 prescription drugs.

56 5. (1) Before July 1, 2025, and annually thereafter,
57 the plan shall submit a report to the standing committees of
58 the general assembly having jurisdiction over health
59 insurance matters. The report shall contain an aggregation
60 of the information submitted to the plan under subdivision
61 (1) of subsection 2 of this section for the immediately
62 preceding calendar year and such other information as the
63 plan in its discretion deems relevant for the purposes of
64 this section. The plan shall provide its pharmacy benefits
65 manager and any third party affected by submission of a
66 report required by this subsection with a written notice
67 describing the content of the report.

68 (2) Before July 1, 2025, and annually thereafter, the
69 plan shall prepare a report for the immediately preceding
70 calendar year describing the rebate practices of the plan
71 and its pharmacy benefits manager. The plan shall provide
72 the report to the standing committees of the general
73 assembly having jurisdiction over health insurance matters
74 and the director of the department of commerce and
75 insurance. The report shall contain:

76 (a) An explanation of the manner in which the plan
77 accounted for rebates in calculating premiums for such year;

78 (b) A statement disclosing whether, and describing the
79 manner in which, the plan made rebates available to
80 enrollees at the point of purchase during such year;

81 (c) A statement describing any other manner in which
82 the plan applied rebates during such year; and

83 (d) Such other information as the plan in its
84 discretion deems relevant for the purposes of this section.

85 6. The plan may impose a penalty of no more than seven
86 thousand five hundred dollars on its pharmacy benefits
87 manager for each violation of this section.

338.015. 1. The provisions of sections 338.010 to
2 338.015 shall not be construed to inhibit the patient's
3 freedom of choice to obtain prescription services from any
4 licensed pharmacist or pharmacy. [However, nothing in
5 sections 338.010 to 338.315 abrogates the patient's ability
6 to waive freedom of choice under any contract with regard to
7 payment or coverage of prescription expense.]

8 2. All pharmacists may provide pharmaceutical
9 consultation and advice to persons concerning the safe and
10 therapeutic use of their prescription drugs.

11 3. All patients shall have the right to receive a
12 written prescription from their prescriber to take to the
13 facility of their choice or to have an electronic
14 prescription transmitted to the facility of their choice.

15 4. No pharmacy benefits manager, as defined in section
16 376.388, shall prohibit or redirect by contract, or
17 otherwise penalize or restrict, a covered person, as defined
18 in section 376.387, from obtaining prescription services,
19 consultation, or advice from a contracted pharmacy, as
20 defined in section 376.388.

376.387. 1. For purposes of this section, the
2 following terms shall mean:

3 (1) "Covered person", [the same meaning as such term
4 is defined in section 376.1257] **a policyholder, subscriber,**
5 **enrollee, or other individual who receives prescription drug**
6 **coverage through a pharmacy benefits manager;**

7 (2) "Health benefit plan", the same meaning as such
8 term is defined in section 376.1350;

9 (3) "Health carrier" or "carrier", the same meaning as
10 such term is defined in section 376.1350;

11 (4) "Pharmacy", the same meaning as such term is
12 defined in chapter 338;

13 (5) "Pharmacy benefits manager", the same meaning as
14 such term is defined in section 376.388.

15 2. No pharmacy benefits manager shall include a
16 provision in a contract entered into or modified on or after
17 August 28, 2018, with a pharmacy or pharmacist that requires
18 a covered person to make a payment for a prescription drug
19 at the point of sale in an amount that exceeds the lesser of:

20 (1) The copayment amount as required under the health
21 benefit plan; or

22 (2) The amount an individual would pay for a
23 prescription if that individual paid with cash.

24 3. A pharmacy or pharmacist shall have the right to
25 provide to a covered person information regarding the amount
26 of the covered person's cost share for a prescription drug,
27 the covered person's cost of an alternative drug, and the
28 covered person's cost of the drug without adjudicating the
29 claim through the pharmacy benefits manager. Neither a
30 pharmacy nor a pharmacist shall be proscribed by a pharmacy
31 benefits manager from discussing any such information or
32 from selling a more affordable alternative to the covered
33 person.

34 4. No pharmacy benefits manager shall, directly or
35 indirectly, charge or hold a pharmacist or pharmacy
36 responsible for any fee amount related to a claim that is
37 not known at the time of the claim's adjudication, unless
38 the amount is a result of improperly paid claims [or charges
39 for administering a health benefit plan].

40 5. [This section shall not apply with respect to
41 claims under Medicare Part D, or any other plan administered
42 or regulated solely under federal law, and to the extent
43 this section may be preempted under the Employee Retirement
44 Income Security Act of 1974 for self-funded employer-
45 sponsored health benefit plans.]

46 **6.]** A pharmacy benefits manager shall notify in
47 writing any health carrier with which it contracts if the
48 pharmacy benefits manager has a conflict of interest, any
49 commonality of ownership, or any other relationship,
50 financial or otherwise, between the pharmacy benefits
51 manager and any other health carrier with which the pharmacy
52 benefits manager contracts.

53 **[7.] 6. Any entity that enters into a contract to**
54 **sell, provide, pay, or reimburse a pharmacy in the state for**
55 **prescription drugs on behalf of itself or another entity**
56 **shall define and apply the term "generic", with respect to**
57 **prescription drugs, to mean any "authorized generic drug",**
58 **as defined in 21 CFR 314.3, approved under section 505(c) of**
59 **the Federal Food, Drug, and Cosmetic Act, as amended.**

60 **7. Any entity that enters into a contract to sell,**
61 **provide, pay, or reimburse a pharmacy in the state for**
62 **prescription drugs on behalf of itself or another entity**
63 **shall define and apply the term "rebate" as having the same**
64 **meaning given to the term in section 103.200.**

65 **8. A pharmacy benefits manager that has contracted**
66 **with an entity to provide pharmacy benefit management**
67 **services for such an entity shall owe a fiduciary duty to**
68 **that entity, and shall discharge that duty in accordance**
69 **with federal and state law.**

70 **9.** The department of commerce and insurance shall
71 enforce this section.

 376.388. 1. As used in this section, unless the
2 context requires otherwise, the following terms shall mean:

3 (1) "Contracted pharmacy" [or "pharmacy"], a pharmacy
4 located in Missouri participating in the network of a
5 pharmacy benefits manager through a direct or indirect
6 contract;

7 (2) ["Health carrier", an entity subject to the
8 insurance laws and regulations of this state that contracts
9 or offers to contract to provide, deliver, arrange for, pay
10 for, or reimburse any of the costs of health care services,
11 including a sickness and accident insurance company, a
12 health maintenance organization, a nonprofit hospital and
13 health service corporation, or any other entity providing a
14 plan of health insurance, health benefits, or health
15 services, except that such plan shall not include any
16 coverage pursuant to a liability insurance policy, workers'
17 compensation insurance policy, or medical payments insurance
18 issued as a supplement to a liability policy;

19 (3)] "Maximum allowable cost", the per-unit amount
20 that a pharmacy benefits manager reimburses a pharmacist for
21 a prescription drug, excluding a dispensing or professional
22 fee;

23 [(4)] (3) "Maximum allowable cost list" or "MAC list",
24 a listing of drug products that meet the standard described
25 in this section;

26 [(5)] (4) "Pharmacy", as such term is defined in
27 chapter 338;

28 [(6)] (5) "Pharmacy benefits manager", an entity that
29 [contracts with pharmacies on behalf of health carriers or
30 any health plan sponsored by the state or a political
31 subdivision of the state] **administers or manages a pharmacy
32 benefits plan or program;**

33 (6) "Pharmacy benefits manager affiliate", a pharmacy
34 or pharmacist that directly or indirectly, through one or
35 more intermediaries, owns or controls, is owned or
36 controlled by, or is under common ownership or control with
37 a pharmacy benefits manager;

38 (7) "Pharmacy benefits plan or program", a plan or
39 program that pays for, reimburses, covers the cost of, or
40 otherwise provides for pharmacist services to individuals
41 who reside in or are employed in this state.

42 2. Upon each contract execution or renewal between a
43 pharmacy benefits manager and a pharmacy or between a
44 pharmacy benefits manager and a pharmacy's contracting
45 representative or agent, such as a pharmacy services
46 administrative organization, a pharmacy benefits manager
47 shall, with respect to such contract or renewal:

48 (1) Include in such contract or renewal the sources
49 utilized to determine maximum allowable cost and update such
50 pricing information at least every seven days; and

51 (2) Maintain a procedure to eliminate products from
52 the maximum allowable cost list of drugs subject to such
53 pricing or modify maximum allowable cost pricing at least
54 every seven days, if such drugs do not meet the standards
55 and requirements of this section, in order to remain
56 consistent with pricing changes in the marketplace.

57 3. A pharmacy benefits manager shall reimburse
58 pharmacies for drugs subject to maximum allowable cost
59 pricing that has been updated to reflect market pricing at
60 least every seven days as set forth under subdivision (1) of
61 subsection 2 of this section.

62 4. A pharmacy benefits manager shall not place a drug
63 on a maximum allowable cost list unless there are at least
64 two therapeutically equivalent multisource generic drugs, or
65 at least one generic drug available from at least one
66 manufacturer, generally available for purchase by network
67 pharmacies from national or regional wholesalers.

68 5. **(1)** All contracts between a pharmacy benefits
69 manager and a contracted pharmacy or between a pharmacy
70 benefits manager and a pharmacy's contracting representative
71 or agent, such as a pharmacy services administrative
72 organization, shall include a process to internally appeal,
73 investigate, and resolve disputes regarding maximum
74 allowable cost pricing. The process shall include the
75 following:

76 **[(1)] (a)** The right to appeal shall be limited to
77 fourteen calendar days following the reimbursement of the
78 initial claim; and

79 **[(2)] (b)** A requirement that the pharmacy benefits
80 manager shall respond to an appeal described in this
81 subsection no later than fourteen calendar days after the
82 date the appeal was received by such pharmacy benefits
83 manager.

84 **(2) If a reimbursement to a contracted pharmacy is**
85 **below the pharmacy's cost to purchase the drug, the pharmacy**
86 **benefits manager shall sustain an appeal and increase**
87 **reimbursement to the pharmacy and other contracted**
88 **pharmacies to cover the cost of purchasing the drug.**

89 (3) A pharmacy benefits manager shall not reimburse a
90 pharmacy or pharmacist in the state an amount less than the
91 amount that the pharmacy benefits manager reimburses a
92 pharmacy benefits manager affiliate for providing the same
93 pharmacist services.

94 6. For appeals that are denied, the pharmacy benefits
95 manager shall provide the reason for the denial and identify
96 the national drug code of a drug product that may be
97 purchased by contracted pharmacies at a price at or below
98 the maximum allowable cost and, when applicable, may be
99 substituted lawfully.

100 7. If the appeal is successful, the pharmacy benefits
101 manager shall:

102 (1) Adjust the maximum allowable cost price that is
103 the subject of the appeal effective on the day after the
104 date the appeal is decided;

105 (2) Apply the adjusted maximum allowable cost price to
106 all similarly situated pharmacies as determined by the
107 pharmacy benefits manager; and

108 (3) Allow the pharmacy that succeeded in the appeal to
109 reverse and rebill the pharmacy benefits claim giving rise
110 to the appeal.

111 8. Appeals shall be upheld if:

112 (1) The pharmacy being reimbursed for the drug subject
113 to the maximum allowable cost pricing in question was not
114 reimbursed as required under subsection 3 of this section; or

115 (2) The drug subject to the maximum allowable cost
116 pricing in question does not meet the requirements set forth
117 under subsection 4 of this section.

376.414. 1. For purposes of this section, the
2 **following terms mean:**

3 (1) "340B drug", a drug that is:

4 (a) A covered outpatient drug as defined in Section
5 340B of the Public Health Service Act, 42 U.S.C. Section
6 256b, enacted by Section 602 of the Veterans Health Care Act
7 of 1992, Pub. L. 102-585; and

8 (b) Purchased under an agreement entered into under 42
9 U.S.C. Section 256b;

10 (2) "Covered entity", the same meaning given to the
11 term in Section 340B(a)(4) of the Public Health Service Act,
12 42 U.S.C. Section 256b(a)(4);

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

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

17 (5) "Specified pharmacy", a pharmacy licensed under
18 chapter 338 with which a covered entity has contracted to
19 dispense 340B drugs on behalf of the covered entity
20 regardless of whether the 340B drugs are distributed in
21 person or through the mail.

22 2. A health carrier or pharmacy benefits manager shall
23 not discriminate against a covered entity or a specified
24 pharmacy by doing any of the following:

25 (1) Reimbursing a covered entity or specified pharmacy
26 for a quantity of a 340B drug in an amount less than such
27 health carrier or pharmacy benefits manager would pay to any
28 other similarly situated pharmacy that is not a covered
29 entity or a specified pharmacy for such quantity of such
30 drug on the basis that the entity or pharmacy is a covered
31 entity or specified pharmacy or that the entity or pharmacy
32 dispenses 340B drugs;

33 (2) Imposing any terms or conditions on covered
34 entities or specified pharmacies that differ from such terms
35 or conditions applied to other similarly situated pharmacies

36 that are not covered entities or specified pharmacies on the
37 basis that the entity or pharmacy is a covered entity or
38 specified pharmacy or that the entity or pharmacy dispenses
39 340B drugs including, but not limited to, terms or
40 conditions with respect to any of the following:

41 (a) Fees, chargebacks, clawbacks, adjustments, or
42 other assessments;

43 (b) Professional dispensing fees;

44 (c) Restrictions or requirements regarding
45 participation in standard or preferred pharmacy networks;

46 (d) Requirements relating to the frequency or scope of
47 audits or to inventory management systems using generally
48 accepted accounting principles; and

49 (e) Any other restrictions, conditions, practices, or
50 policies that, as specified by the director of the
51 department of commerce and insurance, interfere with the
52 ability of a covered entity to maximize the value of
53 discounts provided under 42 U.S.C. Section 256b;

54 (3) Interfering with an individual's choice to receive
55 a 340B drug from a covered entity or specified pharmacy,
56 whether in person or via direct delivery, mail, or other
57 form of shipment;

58 (4) Requiring a covered entity or specified pharmacy
59 to identify, either directly or through a third party, 340B
60 drugs; or

61 (5) Refusing to contract with a covered entity or
62 specified pharmacy for reasons other than those that apply
63 equally to entities or pharmacies that are not covered
64 entities or specified pharmacies, or on the basis that:

65 (a) The entity or pharmacy is a covered entity or a
66 specified pharmacy; or

67 (b) The entity or pharmacy is described in any of
68 subparagraphs (A) to (O) of 42 U.S.C. Section 256b(a) (4) .

69 3. The director of the department of commerce and
70 insurance shall impose a civil penalty on any pharmacy
71 benefits manager that violates the requirements of this
72 section. Such penalty shall not exceed five thousand
73 dollars per violation per day.

74 4. The director of the department of commerce and
75 insurance shall promulgate rules to implement the provisions
76 of this section. Any rule or portion of a rule, as that
77 term is defined in section 536.010, that is created under
78 the authority delegated in this section shall become
79 effective only if it complies with and is subject to all of
80 the provisions of chapter 536 and, if applicable, section
81 536.028. This section and chapter 536 are nonseverable and
82 if any of the powers vested with the general assembly
83 pursuant to chapter 536 to review, to delay the effective
84 date, or to disapprove and annul a rule are subsequently
85 held unconstitutional, then the grant of rulemaking
86 authority and any rule proposed or adopted after August 28,
87 2023, shall be invalid and void.

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