FIRST REGULAR SESSION

SENATE BILL NO. 45

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR FITZWATER.

0644S.02I KRISTINA MARTIN, Secretary

AN ACT

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

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2 are repealed and four new sections enacted in lieu thereof, to
3 be known as sections 338.015, 376.387, 376.388, and 376.448, to
4 read as follows:

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**[**. However, nothing in sections 338.010
5 to 338.315 abrogates the patient's ability to waive freedom
6 of choice under any contract with regard to payment or
7 coverage of prescription expense**] or pharmacy.**
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. Notwithstanding any provision of law to the**
16 **contrary, no pharmacy benefits manager, as defined in**
17 **section 376.388, shall prohibit or redirect by contract, or**

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

18 **otherwise penalize or restrict, a covered person, as defined**
19 **in section 376.387, from obtaining prescription services,**
20 **consultation, or advice from a contracted pharmacy, as**
21 **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 **(6) "Pharmacy benefits manager rebate aggregator", any**
16 **entity that negotiates with a pharmaceutical manufacturer on**
17 **behalf of a pharmacy benefits manager for a rebate**;
18 **(7) "Rebate", any discount, negotiated concession, or**
19 **other payment provided by a pharmaceutical manufacturer,**
20 **pharmacy, or health benefit plan to an entity to sell,**
21 **provide, pay, or reimburse a pharmacy or other entity in the**
22 **state for the dispensation or administration of a**
23 **prescription drug on behalf of itself or another entity.**
24 2. No pharmacy benefits manager shall include a
25 provision in a contract entered into or modified on or after
26 August 28, 2018, with a pharmacy or pharmacist that requires
27 a covered person to make a payment for a prescription drug
28 at the point of sale in an amount that exceeds the lesser of:

29 (1) The copayment amount as required under the health
30 benefit plan; or
31 (2) The amount an individual would pay for a
32 prescription if that individual paid with cash.
33 3. A pharmacy or pharmacist shall have the right to:
34 **(1)** Provide to a covered person information regarding
35 the amount of the covered person's cost share for a
36 prescription drug, the covered person's cost of an
37 alternative drug, and the covered person's cost of the drug
38 without adjudicating the claim through the pharmacy benefits
39 manager. Neither a pharmacy nor a pharmacist shall be
40 proscribed by a pharmacy benefits manager from discussing
41 any such information or from selling a more affordable
42 alternative to the covered person**; and**
43 **(2) Provide to a plan sponsor any information related**
44 **to the sponsor's plan that does not disclose information**
45 **about a specific covered person's prescription use.**
46 4. No pharmacy benefits manager shall, directly or
47 indirectly, charge or hold a pharmacist or pharmacy
48 responsible for any fee amount related to a claim that is
49 not known at the time of the claim's adjudication, unless
50 the amount is a result of improperly paid claims **[**or charges
51 for administering a health benefit plan**]**.
52 5. **[**This section shall not apply with respect to
53 claims under Medicare Part D, or any other plan administered
54 or regulated solely under federal law, and to the extent
55 this section may be preempted under the Employee Retirement
56 Income Security Act of 1974 for self-funded employer-
57 sponsored health benefit plans.
58 6.**]** A pharmacy benefits manager shall notify in
59 writing any health carrier with which it contracts if the
60 pharmacy benefits manager has a conflict of interest, any

61 commonality of ownership, or any other relationship,
62 financial or otherwise, between the pharmacy benefits
63 manager and any other health carrier with which the pharmacy
64 benefits manager contracts.
65 **6. Any entity that enters into a contract to sell,**
66 **provide, pay, or reimburse a pharmacy in the state for**
67 **prescription drugs on behalf of itself or another entity**
68 **shall define and apply the term "generic", with respect to**
69 **prescription drugs, to mean any "authorized generic drug",**
70 **as defined in 21 CFR 314.3, approved under section 505(c) of**
71 **the Federal Food, Drug, and Cosmetic Act, as amended.**
72 **7. An entity shall define and apply the term "rebate"**
73 **as having the same meaning given to the term in this section**
74 **if the entity enters into a contract to sell, provide, pay,**
75 **negotiate rebates for, or reimburse a pharmacy, pharmacy**
76 **benefits manager, pharmacy benefits manager affiliate as**
77 **defined in section 376.388, or pharmacy benefits manager**
78 **rebate aggregator for prescription drugs on behalf of itself**
79 **or another entity.**
80 **8. A pharmacy benefits manager that has contracted**
81 **with an entity to provide pharmacy benefits management**
82 **services for such an entity or any person who negotiates**
83 **with a pharmacy benefits manager on behalf of a purchaser of**
84 **health care benefits shall owe a fiduciary duty to that**
85 **entity or purchaser of health care benefits, and shall**
86 **discharge that duty in accordance with federal and state law.**
87 **9. Any entity that enters into a contract to sell,**
88 **provide, pay, or reimburse a pharmacy in the state for**
89 **prescription drugs on behalf of itself or another entity**
90 **shall not prohibit a plan sponsor or a contracted pharmacy,**
91 **as defined in section 376.388, from discussing any health**
92 **benefit plan information or costs.**

93 **10. It shall be unlawful for any pharmacy benefits**
94 **manager or any person acting on its behalf to charge a**
95 **health benefit plan or payer a different amount for a**
96 **prescription drug's ingredient cost or dispensing fee than**
97 **the amount the pharmacy benefits manager reimburses a**
98 **pharmacy for the prescription drug's ingredient cost or**
99 **dispensing fee if the pharmacy benefits manager retains any**
100 **amount of such difference.**
101 **[**7.**] 11.** The department of commerce and insurance
102 shall 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 prescription drugs and pharmacist**
41 **services to individuals who reside in or are employed in**
42 **this state.**
43 2. Upon each contract execution or renewal between a
44 pharmacy benefits manager and a pharmacy or between a
45 pharmacy benefits manager and a pharmacy's contracting
46 representative or agent, such as a pharmacy services
47 administrative organization, a pharmacy benefits manager
48 shall, with respect to such contract or renewal:
49 (1) Include in such contract or renewal the sources
50 utilized to determine maximum allowable cost and update such
51 pricing information at least every seven days; and
52 (2) Maintain a procedure to eliminate products from
53 the maximum allowable cost list of drugs subject to such
54 pricing or modify maximum allowable cost pricing at least

55 every seven days, if such drugs do not meet the standards
56 and requirements of this section, in order to remain
57 consistent with pricing changes in the marketplace.
58 3. A pharmacy benefits manager shall reimburse
59 pharmacies for drugs subject to maximum allowable cost
60 pricing that has been updated to reflect market pricing at
61 least every seven days as set forth under subdivision (1) of
62 subsection 2 of this section.
63 4. A pharmacy benefits manager shall not place a drug
64 on a maximum allowable cost list unless there are at least
65 two therapeutically equivalent multisource generic drugs, or
66 at least one generic drug available from at least one
67 manufacturer, generally available for purchase by network
68 pharmacies from national or regional wholesalers.
69 5. **(1)** All contracts between a pharmacy benefits
70 manager and a contracted pharmacy or between a pharmacy
71 benefits manager and a pharmacy's contracting representative
72 or agent, such as a pharmacy services administrative
73 organization, shall include a process to internally appeal,
74 investigate, and resolve disputes regarding maximum
75 allowable cost pricing. The process shall include the
76 following:
77 **[**(1)**]** **(a)** The right to appeal shall be limited to
78 fourteen calendar days following the reimbursement of the
79 initial claim; and
80 **[**(2)**]** **(b)** A requirement that the pharmacy benefits
81 manager shall respond to an appeal described in this
82 subsection no later than fourteen calendar days after the
83 date the appeal was received by such pharmacy benefits
84 manager.

85 **(2) If a reimbursement to a contracted pharmacy is**
86 **below the pharmacy's cost to purchase and dispense the drug,**
87 **the pharmacy may decline to dispense the prescription.**
88 **(3) A pharmacy benefits manager shall not reimburse a**
89 **pharmacy or pharmacist in the state an amount less than the**
90 **amount that the pharmacy benefits manager reimburses a**
91 **pharmacy benefits manager affiliate for providing the same**
92 **pharmacist services.**
93 6. For appeals that are denied, the pharmacy benefits
94 manager shall provide the reason for the denial and identify
95 the national drug code of a drug product that may be
96 purchased by contracted pharmacies at a price at or below
97 the maximum allowable cost and, when applicable, may be
98 substituted lawfully.
99 7. If the appeal is successful, the pharmacy benefits
100 manager shall:
101 (1) Adjust the maximum allowable cost price that is
102 the subject of the appeal effective on the day after the
103 date the appeal is decided;
104 (2) Apply the adjusted maximum allowable cost price to
105 all similarly situated pharmacies as determined by the
106 pharmacy benefits manager; and
107 (3) Allow the pharmacy that succeeded in the appeal to
108 reverse and rebill the pharmacy benefits claim giving rise
109 to the appeal.
110 8. Appeals shall be upheld if:
111 (1) The pharmacy being reimbursed for the drug subject
112 to the maximum allowable cost pricing in question was not
113 reimbursed as required under subsection 3 of this section; or
114 (2) The drug subject to the maximum allowable cost
115 pricing in question does not meet the requirements set forth
116 under subsection 4 of this section.

376.448. 1. As used in this section, the following
2 **terms mean:**
3 **(1) "Cost-sharing", any co-payment, coinsurance,**
4 **deductible, amount paid by an enrollee for health care**
5 **services in excess of a coverage limitation, or similar**
6 **charge required by or on behalf of an enrollee in order to**
7 **receive a specific health care service covered by a health**
8 **benefit plan, whether covered under medical benefits or**
9 **pharmacy benefits. The term "cost-sharing" shall include**
10 **cost-sharing as defined in 42 U.S.C. Section 18022(c);**
11 **(2) "Enrollee", the same meaning given to the term in**
12 **section 376.1350;**
13 **(3) "Generic drug", the same meaning given to the term**
14 **in 42 CFR 423.4;**
15 **(4) "Health benefit plan", the same meaning given to**
16 **the term in section 376.1350;**
17 **(5) "Health care service", the same meaning given to**
18 **the term in section 376.1350;**
19 **(6) "Health carrier", the same meaning given to the**
20 **term in section 376.1350;**
21 **(7) "Pharmacy benefits manager", the same meaning**
22 **given to the term in section 376.388.**
23 **2. When calculating an enrollee's overall contribution**
24 **to any out-of-pocket maximum or any cost-sharing requirement**
25 **under a health benefit plan, a health carrier or pharmacy**
26 **benefits manager shall include any amounts paid by the**
27 **enrollee or paid on behalf of the enrollee for any**
28 **medication where a generic drug substitute for such**
29 **medication is not available.**
30 **3. No health carrier or pharmacy benefits manager**
31 **shall vary an enrollee's out-of-pocket maximum or any cost**
32 **sharing requirement, or otherwise design benefits in a**

33 manner that takes into account the availability of any cost-
34 sharing assistance program, for any medication where a
35 generic drug substitute for such medication is not available.
36 4. If, under federal law, application of the
37 requirements under subsection 2 or 3 of this section would
38 result in health savings account ineligibility under Section
39 223 of the Internal Revenue Code of 1986, as amended, the
40 requirement under that subsection shall apply to health
41 savings account-qualified high deductible health plans with
42 respect to any cost-sharing of such a plan after the
43 enrollee has satisfied the minimum deductible under Section
44 223, except with respect to items or services that are
45 preventive care under Section 223(c)(2)(C) of the Internal
46 Revenue Code of 1986, as amended, in which case the
47 requirement of that subsection shall apply regardless of
48 whether the minimum deductible under Section 223 has been
49 satisfied.
50 5. Nothing in this section shall prohibit a health
51 carrier or health benefit plan from utilizing step therapy
52 pursuant to section 376.2034.
53 6. The provisions of this section shall not apply to
54 health benefit plans covered under the federal Labor
55 Management Relations Act of 1947, as amended.

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