SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 984 & 968

103RD GENERAL ASSEMBLY

5297S.07C KRISTINA MARTIN, Secretary

AN ACT

To repeal sections 338.600 and 376.387, RSMo, and to enact in lieu thereof four new sections relating to pharmacy benefits managers.

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

Section A. Sections 338.600 and 376.387, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 338.600, 376.387, 376.394, and 376.399, to read as follows:

338.600. 1. **As used in this section, the following terms shall mean:**

(1) "Audit", any review, inspection, investigation, examination, or analysis conducted by a pharmacy benefits manager (PBM) or its representative of a pharmacy's records, claims, practices, or compliance with contractual obligations or legal requirements, which may result in recoupment, repayment demand, chargeback, penalty, or other financial adjustment. Routine verification or inquiry regarding claim elements or documentation shall not constitute an audit; however, no recoupment, repayment demand, chargeback, penalty, or financial adjustment shall be based upon or initiated through such inquiry unless the inquiry is converted to an audit and conducted in compliance with the requirements of this section;

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

(2) "Entity", a managed care company, insurance company or third-party payor, or representative of a managed care company, insurance company or third-party payor, or a pharmacy benefits manager or a subcontractor of a pharmacy benefits manager.

2. Notwithstanding any other provision of law to the contrary, when an audit of the records of a pharmacy licensed in this state is conducted by a managed care company, insurance company, third-party payor, or any entity that represents such companies or groups, such audit shall be conducted in accordance with the following:

(1) The entity conducting the initial on-site audit shall provide the pharmacy with notice at least **[**one week**]** **fourteen days** prior to conducting the initial on-site audit for each audit cycle **and shall specify specific prescriptions to be audited which may or may not include the final two digits of the prescription numbers. The notice required under this subsection shall be in writing and shall be sent by means that allows tracking of delivery to the pharmacist or pharmacy not later than the fourteenth day before the date on which the on-site audit is scheduled to occur. A pharmacy benefit manager is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or other investigative information, including patient referrals, the plan issuer or pharmacy benefit manager suspects the pharmacist or pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business, which cause and suspicion shall be disclosed to pharmacy upon initiation of the audit;**

(2) Any audit which involves clinical judgment shall be conducted by or in consultation with a **[**licensed**]** pharmacist **licensed by the Missouri board of pharmacy, and said pharmacist shall be made available to the audited pharmacy to discuss clinical rationale and Missouri legal requirements;**

(3) Any clerical error, record-keeping error, typographical error, or scrivener's error regarding a required document or record shall not constitute fraud or grounds for recoupment, so long as the prescription was otherwise legally dispensed and the claim was otherwise materially correct; except that, such claims may be otherwise subject to recoupment of overpayments or payment of any discovered underpayment. No claim arising under this subdivision shall be subject to criminal penalties without proof of intent to commit fraud. **The pharmacy shall have the right to submit amended claims within thirty days of the discovery of an error to correct clerical or record keeping errors in lieu of recoupment if the prescription was dispensed according to requirements set forth in state or federal law;**

(4) A pharmacy may use the records of a hospital, physician, or other authorized practitioner of the healing arts involving drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug. Electronically stored images of prescriptions, electronically created annotations and other related supporting documentation shall be considered valid prescription records. Hard copy and electronic signature logs that indicate the delivery of

pharmacy services shall be considered valid proof of receipt of such services by a program enrollee;

(5) A finding of an overpayment or underpayment may be a projection based on the number of patients served and having a similar diagnosis or on the number of similar orders or refills for similar drugs; except that, recoupment of claims shall be based on the actual overpayment or underpayment unless the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy;

(6) Each pharmacy shall be audited under the same standards and parameters as other pharmacies audited by the entity;

(7) A pharmacy shall be allowed at least thirty days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit;

(8) **An audit shall be limited to forty unique prescriptions, with a maximum of two hundred separately adjudicated claims, that have been randomly selected, and such randomness shall be reflected by auditing a similar type of prescriptions as are collectively adjudicated.**

(a) If an audit reveals the necessity for a review of additional claims, the audit shall be conducted on site.

(b) An entity shall not initiate an audit of a pharmacy more than two times in a calendar year, unless fraud is suspected as described in subdivision (1) of this subsection; such audit of pharmacy records includes any prescription information request by an auditing entity that could result in recoupment.

(c) The list of the claims subject to an on-site audit shall be provided in the notice under paragraph (a) of this

subdivision to the pharmacist or pharmacy and shall identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be omitted;

(9) A recoupment shall not be based on a requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the Missouri board of pharmacy;

(10) Recoupment shall only occur following the correction of a claim and shall be limited to amounts adjudicated by a pharmacy benefits manager;

(11) Except for MO HealthNet claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim shall not be reversed unless the pharmacy or pharmacist obtained the adjudication by fraud, waste, or abuse, a misrepresentation of claim elements, or claims that were not properly rendered or billed by a pharmacy or pharmacist, or otherwise in accordance with state pharmacy audit laws.

(a) This subdivision does not preclude a pharmacy benefits manager from engaging in claims reconciliation activities relating to brand effective rates and generic effective rates if:

a. They are identified and agreed to in contract; and

b. The activities do not result in a retroactive reduction or recoupment of payment to the pharmacist or pharmacy for a previously adjudicated covered claim.

(b) A pharmacy benefits manager may not charge a pharmacy or pharmacist a fee relating to the adjudication of a claim;

(12) Any entity conducting an audit shall not be compensated, nor shall any of its employees be compensated, directly or indirectly, based on any amounts recouped;

(13) An entity shall not charge a fee for conducting an on-site or a desk audit unless there is a finding of actual fraud;

(14) The period covered by the audit shall not exceed a two-year period beginning **[**two years prior to the initial date of the on-site portion of the audit unless otherwise provided by contractual agreement or if**] the date the claim was submitted for payment** there has been a previous finding of fraud or as otherwise provided by state or federal law;

[(9)**] (15)** An audit shall not be initiated or scheduled during the first **[**three**] five** business days of any month due to the high volume of prescriptions filled during such time unless otherwise consented to by the pharmacy;

[(10)**] (16)** The preliminary audit report shall be delivered to the pharmacy within one hundred twenty days after conclusion of the audit, with reasonable extensions permitted. A final audit report shall be delivered to the pharmacy within six months of receipt by the pharmacy of the preliminary audit report or final appeal, as provided for in subsection 3 of this section, whichever is later. **Audit reports not delivered to the pharmacy in this time line shall be deemed to have no discrepancies and no recoupment shall be made;**

[(11)**] (17)** Notwithstanding any other provision in this subsection, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits, except as otherwise authorized under subdivision (5) of this subsection;

(18) The days' supply for unit-of-use items, such as topicals, drops, vials, and inhalants, shall not be limited beyond manufacturer recommendations;

(19) If the only commercially available package size exceeds an entity's maximum days' supply, the dispensing of such package size shall be accepted by the entity and shall not be the basis for recoupment;

(20) If the only commercially available package size exceeds an entity's maximum days' supply and the entity accepts the refill of such prescription, the entity shall not recoup such claim as an early refill;

(21) The failure of a pharmacy to collect a copayment shall not be the basis for recoupment if the pharmacy provides documentation of billing of the claim and a reasonable attempt to collect the copayment; and

(22) In a wholesale invoice audit conducted by an entity:

(a) An entity shall not audit the claims of another entity;

(b) The following shall not form the basis for recoupment:

a. The national drug code for the dispensed drug is in a quantity that is a sub-unit or multiple of the purchased drug as reflected on a supporting wholesale invoice;

b. The correct quantity dispensed is reflected on the audited pharmacy claim; or

c. The drug dispensed by the pharmacy on an audited pharmacy claim is identical to the strength and dosage form of the drug purchased;

(c) The entity shall accept as evidence:

a. Supplier invoices issued prior to the date of dispensing the drug underlying the audited claim;

b. Invoices from any supplier authorized by law to transfer ownership of the drug acquired by the audited pharmacy;

c. Copies of supplier invoices in the possession of the audited pharmacy; and

d. Reports required by any state board or agency; and

(d) Within five business days of a request by the audited pharmacy, the entity shall provide supporting documentation provided to the entity by the audited pharmacy's suppliers.

[2.**]** **3.** Recoupments of any disputed moneys shall only occur after final internal disposition of the audit, including the appeals process set forth in subsection 3 of this section. Should the identified discrepancy for an individual audit exceed twenty-five thousand dollars, future payments to the pharmacy in excess of twenty-five thousand dollars may be withheld pending finalization of the audit.

[3.**]** **4.** Each entity conducting an audit shall establish an appeals process, lasting no longer than six months, under which a licensed pharmacy may appeal an unfavorable preliminary audit report to the entity. If, following such appeal, the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or such portion without the necessity of any further proceedings.

[4.**]** **5.** Each entity conducting an audit shall provide a copy of the final audit report, after completion of any appeal process, to the plan sponsor. **Such report shall include the total amount of recoupment returned to the plan sponsor, if any.**

[5.**]** **6.** This section shall not apply to any investigative audit that involves probable fraud, willful misrepresentation, or abuse.

[6.**]** **7.** This section shall not apply to any audit conducted as part of any inspection or investigation conducted by any governmental entity or law enforcement agency.

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

(1) **[**"Covered person", the same meaning as such term is defined in section 376.1257**]** **"Contracted pharmacy", a pharmacy located in Missouri participating in the network of a pharmacy benefits manager through a direct or indirect contract;**

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

(3)**]** "Health carrier" **[**or "carrier", the same meaning as such term is defined in section 376.1350**]**, **an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services, except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;**

(3) "Maximum allowable cost", the per-unit amount that a pharmacy benefits manager reimburses a pharmacist for a

prescription drug, excluding a dispensing or professional fee;

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

[(4)**] (5)** "Pharmacy", the same meaning as such term is defined in chapter 338;

[(5)**] (6)** "Pharmacy benefits manager", **[**the same meaning as such term is defined in section 376.388**] an entity that contracts with pharmacies on behalf of health carriers or health benefit plans to provide prescription drug and pharmacist services;**

(7) "Pharmacy benefits manager affiliate", a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager.

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

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

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

3. A pharmacy or pharmacist shall have the right to provide to a covered person information regarding the amount of the covered person's cost share for a prescription drug, the covered person's cost of an alternative drug, and the covered person's cost of the drug without adjudicating the claim through the pharmacy benefits manager. Neither a

pharmacy nor a pharmacist shall be proscribed by a pharmacy benefits manager from discussing any such information or from selling a more affordable alternative to the covered person.

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

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

6. A pharmacy benefits manager shall notify in writing any health carrier with which it contracts if the pharmacy benefits manager has a conflict of interest, any commonality of ownership, or any other relationship, financial or otherwise, between the pharmacy benefits manager and any other health carrier with which the pharmacy benefits manager contracts.

7. The department of commerce and insurance shall enforce this section**] Upon each contract execution or renewal between a pharmacy benefits manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:**

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

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

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

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

5. All contracts between a pharmacy benefits manager and a contracted pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, shall include a process to internally appeal, investigate, and resolve disputes regarding maximum allowable cost pricing. The process shall include the following:

(1) The right to appeal shall be limited to fourteen calendar days following the reimbursement of the initial claim; and

(2) A requirement that the pharmacy benefits manager shall respond to an appeal described in this subsection no later than fourteen calendar days after the date the appeal was received by such pharmacy benefits manager.

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

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

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

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

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

8. Appeals shall be upheld if:

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

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

9. A pharmacy benefits manager shall provide plan sponsors with such plan sponsor's pharmacy claims data as reasonably requested by a plan sponsor.

10. The pharmacy benefits manager or plan sponsor shall provide the plan sponsor and department of commerce and insurance documentation of any benefit design that encourages or requires enrollees to fill prescriptions at affiliated pharmacies.

11. A pharmacy benefits manager shall exercise good faith and fair dealing in the administration of pharmacy benefits and shall ensure that any conflicts of interest that may clinically or financially impact covered patients or the health benefit plan sponsor in a negative manner are disclosed.

12. All disclosures required under this section shall be provided to the plan sponsor or its authorized agent in a universal manner.

13. If a pharmacy benefits manager or health plan has an affiliated pharmacy or a pharmacy under common ownership, the pharmacy benefits manager shall disclose to the plan sponsor and the department of commerce and insurance:

(1) The amount charged per dosage unit to the affiliated pharmacy; and

(2) The median amount charged per dosage unit at non affiliated, in-network pharmacies.

14. The department of commerce and insurance may audit pharmacy benefits manager to ensure compliance with this section.

376.394. 1. As used in this section, the following terms shall mean:

(1) "Acquisition cost", the set of National Average Drug Acquisition Costs, "NADAC", as calculated by the Centers for Medicare and Medicaid Services and reflected in the most recently released public file;

(2) "Critical access care pharmacy", a Missouri-domiciled pharmacy with a physical location in the state of Missouri that employs less than five hundred employees across common ownership which is:

(a) Located in a county or city with fewer than fifty thousand residents; or

(b) In a county or city with fifty thousand or more residents and in an area within Missouri that is designated as a Primary Care or Mental Health Health Professional Shortage Area (HPSA) or a Medically Underserved Area by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services; or

(c) Any essential pharmacy as defined in Section 1860D-42 of the Social Security Act, 42 U.S.C. 1395-152;

(3) "Similarly situated", a critical access care pharmacy:

(a) That is in any of the pharmacy benefits manager's networks;

(b) That purchases the particular drug or medical product or device to which the finding applies from the same pharmaceutical wholesaler as the pharmacy that prevailed in the appeal; and

(c) To which the pharmacy benefits manager also applies the challenged rate of reimbursement or actual cost.

2. Notwithstanding any provision of law to the contrary, a pharmacy benefits manager shall not reimburse a critical access care pharmacy for a prescription drug or device an amount that is less than the actual cost to that pharmacy for the prescription drug or device.

(1) A pharmacy benefits manager shall establish a process for a pharmacy to appeal a reimbursement for failing

to pay at least the actual cost and dispensing fee to the critical access care pharmacy for the prescription drug or device and shall permit a critical access care pharmacy or its designated agent to file an appeal using the standard appeal form described in this section.

(2) If a critical access care pharmacy chooses to contest a reimbursement for failing to pay at least the actual cost the critical access care pharmacy incurred for a particular drug or medical product or device, then the critical access care pharmacy has the right to designate a pharmacy services administrative organization or other agent to file and handle its appeal.

(3) The department of commerce and insurance shall create and make available to pharmacy benefits managers and covered entities a standard form to be used by a critical access care pharmacy or its designated agent to file an appeal pursuant to this subsection with a pharmacy benefits manager or covered entity.

3. If a critical access care pharmacy or agent acting on behalf of a critical access care pharmacy prevails in an appeal provided for in this section, then within seven business days after notice of the appeal is received by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall:

(1) Make the necessary change to the challenged rate of reimbursement or actual cost;

(2) If the product involved in the appeal is a drug, provide to the critical access care pharmacy or agent the national drug code number for the drug on which the change is based;

(3) Permit the challenging critical access care pharmacy to reverse and rebill the claim upon which the appeal is based;

(4) Pay or waive the cost of any transaction fee required to reverse and rebill the claim;

(5) Reimburse the critical access care pharmacy at least in an amount equal to the critical access care pharmacy's actual cost for the prescription drug or device; and

(6) Apply the findings from the appeal as to the rate of reimbursement and actual cost for the particular drug or medical product or device to other similarly situated critical access care pharmacies.

4. It is a violation of this section if, after an appeal in which a pharmacy or agent acting on behalf of a critical access care pharmacy prevails, a pharmacy benefits manager or covered entity fails to reimburse the critical access care pharmacy at least actual cost.

5. If a critical access care pharmacy or agent acting on behalf of a critical access care pharmacy loses or is denied an appeal provided for in this section, then:

(1) If the product associated with the national drug code number or unique device identifier is available at a cost that is less than the challenged rate of reimbursement from a pharmaceutical wholesaler in this state, then within seven business days after notice of the appeal is received by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall provide the appealing critical access care pharmacy or agent with:

(a) The name of the national or regional pharmaceutical wholesalers operating in this state that have the particular drug or medical product or device currently

in stock at a price that is less than the amount of the challenged rate of reimbursement; and

(b) If the product involved in the appeal is a drug, then the national drug code number for the drug; or

(c) If the product involved is a medical device, then the unique device identifier for the device; and

(2) If the product associated with the national drug code number or unique device identifier is not available at a cost that is less than the challenged rate of reimbursement from the pharmaceutical wholesaler from whom the critical access care pharmacy purchases the majority of prescription pharmaceutical products for resale, then the pharmacy benefits manager shall adjust the challenged rate of reimbursement to an amount equal to or greater than the appealing critical access care pharmacy's actual cost and permit the critical access care pharmacy to reverse and rebill each claim affected by the inability to procure the pharmaceutical product at a cost that is equal to or less than the previously challenged rate of reimbursement. The pharmacy benefits manager shall pay or waive the cost of any transaction fee required to reverse and rebill the claim.

6. The department of commerce and insurance shall enforce this section.

376.399. 1. Health benefit plans beginning on or after January 1, 2027 shall comply with H.R. 7148, the Consolidated Appropriations Act, 2026.

2. For plan years beginning on or after January 1, 2027, no contract or arrangement or renewal or extension of a contract or arrangement, entered into on or after January 1, 2027, for services between a covered plan and a covered service provider, or between a sponsor of a covered plan and a covered service provider, through a health insurance

issuer offering group health insurance coverage, a third-party administrator, an entity providing pharmacy benefit management services, or other entity, for pharmacy benefit management services, is reasonable within the meaning of this section unless such entity providing pharmacy benefit management services:

(1) Remits one hundred percent of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to utilization of drugs or drug spending under such health plan or health insurance coverage, to the group health plan or, in the case of a health insurance issuer offering group health insurance coverage in connection with a group health plan, to the health insurance issuer offering group health insurance coverage on behalf of the plan; and

(2) Does not enter into any contract for pharmacy benefit management services on behalf of such a plan or coverage, with an applicable entity unless one hundred percent of rebates, fees, alternative discounts, and other remuneration received under such contract that are related to the utilization of drugs or drug spending under such group health plan or health insurance coverage are remitted to the group health plan or, in the case of a health insurance issuer offering group health insurance coverage in connection with a group health plan, to the health insurance issuer on behalf of the plan by the entity providing pharmacy benefit management services.

Nothing this subsection shall be construed to affect the term of a contract or arrangement, as in effect on January 1, 2027, except that such subdivision shall apply to any renewal or extension of such a contract or arrangement

entered into on or after such effective date, as so described.

3. With respect to such rebates, fees, alternative discounts, and other remuneration, the rebates, fees, alternative discounts, and other remuneration under this section shall be remitted:

(1) On a quarterly basis, to the group health plan or, in the case of a health insurance issuer offering group health insurance coverage in connection with a group health plan, to the group health insurance issuer on behalf of the plan, not later than ninety days after the end of each quarter; or

(2) In the case of an underpayment in a remittance for a prior quarter, as soon as practicable, but not later than ninety days after notice of the underpayment is first given;

(3) Fully disclosed and enumerated to the group health plan or health insurance issuer; and

(4) Returned to the covered service provider for pharmacy benefit management services on behalf of the group health plan if any audit by a plan sponsor, issuer or a third party designated by a plan sponsor, indicates that the amounts received are in excess of correct amounts after such amounts have been paid to the group health plan, in the amount of such excess.

4. The department of commerce and insurance shall enforce this section and shall have the right to any information in the section from any pharmacy benefits manager under investigation individually or in aggregate per their request.

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