SECOND REGULAR SESSION

SENATE BILL NO. 846

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR BROWN (16).

4549S.02I KRISTINA MARTIN, Secretary

AN ACT

To amend chapter 376, RSMo, by adding thereto eight new sections relating to insurance coverage of health care services, with penalty provisions.

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

Section A. Chapter 376, RSMo, is amended by adding thereto eight new sections, to be known as sections 376.411, 376.415, 376.416, 376.2100, 376.2102, 376.2104, 376.2106, and 376.2108, 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.

376.415. 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.

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

(1) "340B drug", the same meaning given to the term in section 376.414;

(2) "Covered entity", the same meaning given to the term in section 376.414;

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

(4) "Pharmacy", an entity licensed under chapter 338;

(5) "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 discriminate against a covered entity or a pharmacy including, but not limited to, by doing any of the following:

(1) Reimbursing a covered entity or pharmacy for a quantity of a 340B drug in an amount less than it would pay to any other similarly situated pharmacy that is not a covered entity or a pharmacy for such quantity of such drug on the basis that the entity or pharmacy is a covered entity or pharmacy or that the entity or pharmacy dispenses 340B drugs;

(2) Imposing any terms or conditions on covered entities or pharmacies that differ from such terms or conditions applied to other similarly situated pharmacies or entities that are not covered entities on the basis that the entity or pharmacy is a covered entity or pharmacy or that the entity or pharmacy dispenses 340B drugs including, but not limited to, terms or conditions with respect to any of the following:

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

(b) Professional dispensing fees;

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

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

(e) Any other restrictions, conditions, practices, or policies that, as specified by the director of the department of commerce and insurance, interfere with the

ability of a covered entity to maximize the value of discounts provided under 42 U.S.C. Section 256b;

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

(4) Discriminating in reimbursement to a covered entity or pharmacy based on the determination or indication a drug is a 340B drug;

(5) Requiring a covered entity or pharmacy to identify, either directly or through a third party, a 340B drug sooner than forty-five days after the point of sale of the 340B drug;

(6) Refusing to contract with a covered entity or pharmacy for reasons other than those that apply equally to entities that are not covered entities or similarly situated pharmacies, or on the basis that:

(a) The entity is a covered entity; or

(b) The entity or pharmacy is described in any of subparagraphs (A) to (O) of 42 U.S.C. Section 235b(a)(4);

(7) Denying the covered entity the ability to purchase drugs at 340B program pricing by substituting a rebate discount;

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

(9) Requiring a covered entity or pharmacy 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, except as required by federal law.

3. The director of the department of commerce and insurance shall impose a civil penalty on any health carrier, pharmacy benefits manager, or agent or affiliate of such health carrier or pharmacy benefits manager that violates the requirements of this section. Such penalty shall not exceed five thousand dollars per violation per day.

4. The director of the department of commerce and insurance shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2026, shall be invalid and void.

376.2100. 1. Except as otherwise provided in subsection 1 of section 376.2108, as used in sections 376.2100 to 376.2108, terms shall have the same meanings as are ascribed to them under section 376.1350.

2. As used in sections 376.2100 to 376.2108, the following terms mean:

(1) "Evaluation period", any consecutive twelve months;

(2) "Value-based care agreement", a contractual agreement between a health care provider, either directly or

indirectly through a health care provider group or organization, and a health carrier that:

(a) Incentivizes or rewards providers based on one or more of the following:

a. Quality of care;

b. Safety;

c. Patient outcomes;

d. Efficiency;

e. Cost reduction; or

f. Other factors; and

(b) May, but is not required to, include shared financial risk and rewards based on performance metrics.

376.2102. 1. Except as otherwise provided in this section, beginning January 1, 2027, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for a health care service unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of the prior authorization requests submitted by that provider for that health care service.

2. Beginning January 1, 2027, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for any health care services unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of all prior authorization requests submitted by that provider for health care services.

3. (1) Beginning January 1, 2027, a health carrier or utilization review entity may elect to have a hospital, as that term is defined in section 197.020, determine which of the following conditions that such hospital will comply with to obtain an exemption from prior authorization requirements under subsections 1 and 2 of this section:

(a) The hospital entering into, either directly or indirectly through a health care provider group or organization, a value-based care agreement with the health carrier;

(b) The hospital's score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System, 42 CFR Section 412.190, or its successor rating system; or

(c) At least ninety-one percent of the hospital's prior authorization requests submitted for purposes of eligibility for subsections 1 or 2 of this section were approved or would have been approved by the health carrier or utilization review entity.

(2) Critical access hospitals and hospitals that do not participate in the Center for Medicare and Medicaid Services Five-Star Quality Rating System, or its successor rating system, shall be exempt from the provisions of this subsection.

4. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section shall not include:

(1) Pharmacy services, not to exceed the amount of one hundred thousand dollars;

(2) Imaging services, not to exceed the amount of one hundred thousand dollars;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

5. The amount of the limitations described in subdivisions (1) and (2) of subsection 4 of this section shall be increased every year, rounded to the nearest thousand dollars, beginning January 1, 2028, based on the Consumer Price Index for All Urban Consumers for the United States (CPI-U), or its successor index, as such index is defined and officially reported by the United States Department of Labor, or its successor agency.

6. In making a determination under this section, the health carrier or utilization review entity shall not count:

(1) Any prior authorization requests denied by a health carrier or utilization review entity and being appealed by the health care provider; or

(2) Any request made by a health care provider for a service that is not included in the health carrier's benefit plan but shall count as approved any prior authorization request that was denied by a health carrier or utilization review entity but that was subsequently authorized.

7. In making a determination under this section, the health carrier or utilization review entity shall use either the provider's national provider identifier or a taxpayer identification number. Such designation shall remain unless requested to be changed by the provider.

8. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section may be subject to internal auditing of the most recent consecutive six months, up to a maximum of two times per year, by the health carrier or utilization review entity and may be rescinded if:

(1) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of prior authorization requests for a health care service that the provider was exempt from the prior authorization requirement under subsection 1 of this section;

(2) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of all prior authorization requests if the provider was exempt from the prior authorization requirement under subsection 2 of this section; or

(3) There has been an increase in the provision of exempt procedures by a health care provider of more than fifty percent or more than twenty procedures, whichever amount is greater.

9. The exemption described in subsections 1, 2, and 3 of this section shall be null and void upon a determination that the health care provider has been found by a court of law to have civilly or criminally engaged in any fraud or abuse after the exemption is granted by a health carrier or utilization review entity.

10. A health carrier or utilization review entity may require health care providers in the health carrier's or utilization review entity's network to use an online portal to submit requests for prior authorization.

11. No adverse determination shall be finalized under subsections 1, 2, 3, or 8 unless reviewed by a clinical peer.

12. Any patient who has received prior authorization for the coverage of a ninety-day supply of medication whose health coverage plan changes following such authorization shall be permitted a ninety-day grace period from the date

of such change in order to determine whether such patient's new plan covers the previously authorized medication or whether prior authorization is required.

376.2104. 1. The health carrier or utilization review entity shall notify the health care provider no later than twenty-five days after any determination made under section 376.2102. The notification shall include the statistics, data, and any supporting documentation for making the determination for the relevant evaluation period.

2. The health carrier or utilization review entity shall establish a process for health care providers to appeal any determinations made under section 376.2102.

3. The health carrier or utilization review entity shall maintain an online portal to allow health care providers to access all prior authorization decisions, including determinations made under section 376.2102. For health care providers subject to prior authorizations, the portal shall include the status of each prior authorization request, all notifications to the health care provider, the dates the health care provider received such notifications, and any other information relevant to the determination.

376.2106. No health carrier or utilization review entity shall deny or reduce payment to a health care provider for a health care service for which the provider has a prior authorization unless the provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier or utilization review entity with the specific intent to deceive and obtain an unlawful payment from the carrier or entity; or

(2) Failed to substantially perform the health care service.

376.2108. 1. The provisions of sections 376.2100 to 376.2108 shall not apply to MO HealthNet, except that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108.

2. The provisions of sections 376.2100 to 376.2108 shall not apply to health care providers who have not participated in a health benefit plan offered by the health carrier for at least one full evaluation period.

3. Nothing in sections 376.2100 to 376.2108 shall be construed to:

(1) Authorize a health care provider to provide a health care service outside the scope of his or her applicable license; or

(2) Require a health carrier or utilization review entity to pay for a health care service described in subdivision (1) of this subsection.

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