CCS HCS SS SCS SBs 865 & 866 -- HEALTH CARE

This bill modifies various provisions regarding palliative care, the Board of Pharmacy, pharmacists, health insurance, and pharmacy benefit managers.

PALLIATIVE CARE (Sections 191.1075, 191.1080, and 191.1085, RSMo)

This bill establishes the "Missouri Palliative Care and Quality of Life Interdisciplinary Council" within the Department of Health and Senior Services to be a palliative care consumer and professional information and education program to improve quality and delivery of patient-centered and family-focused care in Missouri. Members shall be appointed to the council on or before December 1, 2016. The members include two members of the Senate appointed by the President Pro Tem, two members of the House of Representatives appointed by the Speaker of the House, and other specified members.

The council members must serve a three-year term without compensation, but, subject to appropriations, must be reimbursed for their actual and necessary expenses incurred as a member of the council. The council must consult with and advise the department on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in Missouri and submit an annual report to the General Assembly that includes an assessment of the availability of palliative care in Missouri as specified.

The bill establishes the "Palliative Care Consumer and Professional Information and Education Program" within the department, with the purpose of maximizing the effectiveness of palliative care in Missouri by ensuring that comprehensive and accurate information and education about palliative care is available to the public, health care providers, and health care facilities. The department must publish on its website information and resources, including links to external resources, about palliative care, including specified information.

The bill encourages each hospital in Missouri to have a palliative care presence on its Intranet or Internet website and palliative care patient education information available for distribution to patients.

The department must consult with the council in implementing the provisions of the bill.

These provisions of this bill expire August 28, 2022.

BOARD OF PHARMACY (Section 338.075)

This bill requires all licensees, registrants, and permit holders regulated by the Board of Pharmacy to report to the board any final adverse action taken by another licensing jurisdiction against such person or entity's license, permit, or authorization to practice or operate as a pharmacist, intern pharmacist, pharmacy technician, pharmacy, drug distributor, drug manufacturer, or drug outsourcing facility. Additionally, all licensees, registrants, and permit holders shall report any surrender of a license or authorization to practice while under disciplinary investigation by another jurisdiction, and any exclusion to participate in any government-funded health care program for fraud, abuse, or submission of any false claim, payment, or reimbursement request.

This bill provides that the Board of Pharmacy shall not renew a nonresident pharmacy license if the applicant does not hold a current pharmacy license in the state in which the nonresident pharmacy is located. The board shall not renew an out-of-state wholesale drug distributor, out-of-state pharmacy distributor, or drug distributor license if the applicant does not hold a current license in the state in which the distribution facility is located. If the applicant is a drug distributor registrant, then the entity must be authorized and in good standing with the Food and Drug Administration or within the state where the facility is located in order for the board to renew the registration.

MAINTENANCE MEDICATION (Section 338.202)

This bill requires a health carrier or managed care plan that provides prescription drug coverage in the state to offer medication synchronization services. A health carrier or managed care plan that provides prescription drug coverage shall not charge any amount in excess of the otherwise applicable co-payment for dispensing a prescription drug in a quantity that is less than the prescribed amount and shall provide a full dispensing fee to the pharmacy that dispenses the prescription drug so long as the terms of the medication synchronization services are met.

NONRESIDENT PHARMACY LICENSE RENEWAL (Sections 338.270 and 338.347)

This bill provides that the Board of Pharmacy shall not renew a nonresident pharmacy license if the applicant does not hold a current pharmacy license in the state in which the nonresident pharmacy is located.

Additionally, the board shall not renew an out-of-state wholesale drug distributor, out-of-state pharmacy distributor, or drug distributor license if the applicant does not hold a current license in the state in which the distribution facility is located.

If the applicant is a drug distributor registrant, then the entity must be authorized and in good standing with the Food and Drug Administration or within the state where the facility is located in order for the board to renew the registration.

UNIFORMITY IN INSURANCE AND FINANCIAL SERVICES REGULATION (Section 374.185)

This bill adds the U.S. Department of Health and Human Services to the list of entities the Director of the Department of Insurance, Financial Institutions, and Professional Registration may cooperate with to regulate insurance and financial services.

PRESCRIPTION DRUG COVERAGE (Section 376.379)

The bill requires health carriers or managed care plans offering health benefit plans with prescription drug coverage to offer medication synchronization services that aligns prescription refill dates. Charging more than the normal co-payment is prohibited for quantities less than prescribed.

PHARMACY BENEFIT MANAGERS (Section 376.388)

This bill requires each contract between a pharmacy benefit manager (PBM) and a pharmacy or pharmacy's contracting representative to include sources utilized to determine maximum allowable cost and update such pricing information at least every seven days. A PBM must maintain a procedure to eliminate products from the maximum allowable cost (MAC) list of drugs or modify maximum allowable cost pricing within seven days if the drugs do not meet the standards as provided in the bill.

A PBM must reimburse pharmacies for drugs subject to maximum allowable cost pricing based upon pricing information which has been updated within seven days. A drug must not be placed on a MAC list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from only one manufacturer and is generally available for purchase from national or regional wholesalers.

All contracts must include a process to internally appeal, investigate, and resolve disputes regarding MAC pricing as provided in the bill. Appeals must be upheld if the pharmacy being reimbursed for the drug on the MAC list was not reimbursed according to the provisions of the bill or the drug does not meet the requirements for being placed on the MAC list.

MISSOURI HEALTH INSURANCE RATE TRANSPARENCY ACT (Section 376.465)

The bill creates the "Missouri Health Insurance Rate Transparency Act" to apply to health benefit plans, excluding large group market, long-term care, and Medicare supplemental plans, delivered, issued for delivery, continued, or renewed on or after January 1, 2018. No health carrier shall deliver, issue for delivery, continue, or renew a health benefit plan until the rates for that plan have been filed with the Director of the Department of Insurance, Financial Institutions, and Professional Registration as specified in the bill. Rates shall be filed for excepted health benefits plans, as defined in the bill, and grandfathered health benefit plans 30 days prior to use for informational purposes only. For all other plans, a health carrier may use rates on the date the director determines such rates are reasonable, the date the health carrier notifies the director of its intent to use rates the director has determined are unreasonable, or 60 days after filing rates with the director.

The director shall determine by rule when rates filed by health carriers shall be made publicly available and shall provide a means by which the public can submit written comments concerning proposed rate increases. The director shall review the proposed rate and accompanying documentation and determine whether the rate is reasonable or unreasonable. Within 60 days of rate filing, the director shall provide the health carrier with written notice detailing whether the proposed rate is reasonable or unreasonable. If the director deems the rate is unreasonable, the written notice shall specify the deficiencies and detailed reasons why the rate is excessive, inadequate, unfairly discriminatory, or unjustified. Within 30 days of receiving written notice that the proposed rate is unreasonable, the health carrier may amend its rate, request reconsideration, or implement the proposed rate. The health carrier shall notify the director of its intention within 30 days of receipt of the written notice. If a health carrier implements a rate determined to be unreasonable, the department shall make such determination public.

The director shall publish final rates on the department's website no earlier than 30 days prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year.

PRESCRIPTION EYE DROP REFILLS (Section 376.1237)

The bill extends the termination date on provisions relating to the refilling of prescription eye drops to January 1, 2020.

SMALL EMPLOYER HEALTH BENEFIT PLANS (Sections 379.934, 379.936, 379.938, and 379.940)

The bill limits current law relating to small employer health benefit plans to only plans purchased on or before March 23, 2010.