House _____ **Amendment NO.**____

Offered By

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AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 198, Page 39, Section 302.181, Line 113, by inserting after all of said section and line the following:

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

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

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

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

(2) "Covered entity", an entity that is described in:

(a) Sections 340B(a)(4)(A) through (J) of the Public Health Service Act, 42 U.S.C. Section 256b(a)(4)(A) through (J);

(b) Sections 340B(a)(4)(N) of the Public Health Service Act, 42 U.S.C. Section 256b(a)(4)(N); and

(c) Sections 340B(a)(4)(O) of the Public Health Service Act, 42 U.S.C. Section 256b(a)(4)(O) that is not a rural referral centers as defined by section 1886(d)(5)(C)(i) of the Social Security Act;

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

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

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

(2) Imposing any terms or conditions on covered entities or specified pharmacies that differ from such terms or conditions applied to other similarly situated pharmacies that are not covered

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entities or specified pharmacies on the basis that the entity or pharmacy is a covered entity or specified 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 specified pharmacy, whether in person or via direct delivery, mail, or other form of shipment; or

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

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

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

3. The director of the department of commerce and insurance shall impose a civil penalty on any 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, 2022, shall be invalid and void.

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

(1) "Cost-sharing", any co-payment, coinsurance, deductible, amount paid by an enrollee for health care services in excess of a coverage limitation, or similar charge required by or on behalf of an enrollee in order to receive a specific health care service covered by a health benefit plan, whether covered under medical benefits or pharmacy benefits. The term "cost-sharing" shall include cost-sharing as defined in 42 U.S.C. Section 18022(c);

(2) "Enrollee", the same meaning given to the term in section 376.1350;

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

(4) "Health care service", the same meaning given to the term in section 376.1350;

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

(6) "Pharmacy benefits manager", the same meaning given to the term in section 376.388.

2. When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health benefit plan, a health carrier or pharmacy benefits manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee for any medication where a generic substitute for said medication is not available.

3. If, under federal law, application of the requirement under subsection 2 of this section would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, the requirement under subsection 2 of this section shall apply to health savings account-qualified high deductible health plans with respect to any cost-sharing of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except with respect to items or services that are preventive care under Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirement of subsection 2 of this section shall apply regardless of whether the minimum deductible under Section 223 has been satisfied.

4. Nothing in this section shall prohibit a health carrier or health benefit plan from utilizing step therapy pursuant to section 376.2034."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.