

COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5331H.03C
 Bill No.: HCS for HB Nos. 1850 & 1975
 Subject: Pharmacy; Drugs and Controlled Substances
 Type: Original
 Date: March 19, 2026

Bill Summary: This proposal modifies provisions relating to pharmacy benefits managers.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Total Estimated Net Effect on General Revenue	\$0	\$0	\$0

ESTIMATED NET EFFECT ON OTHER STATE FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Insurance Dedicated Fund (1566)*	(\$653,472 to \$903,472)	(\$719,152 to \$969,152)	(\$727,555 to \$977,555)
State Road Fund (1320)	\$0 or (\$21,400)	\$0 or (\$21,400)	\$0 or (\$21,400)
Total Estimated Net Effect on <u>Other</u> State Funds	(\$653,472 to \$924,872)	(\$719,152 to \$990,552)	(\$727,555 to \$998,955)

*Estimated costs include contracted consultations with a pharmacist for the completion of market conduct investigations or examinations and 3 FTE for DCI.

Numbers within parentheses: () indicate costs or losses.

ESTIMATED NET EFFECT ON FEDERAL FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Total Estimated Net Effect on <u>All</u> Federal Funds	\$0	\$0	\$0

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Insurance Dedicated Fund (1566)	3 FTE	3 FTE	3 FTE
Total Estimated Net Effect on FTE	3 FTE	3 FTE	3 FTE

- Estimated Net Effect (expenditures or reduced revenues) expected to exceed \$250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.
- Estimated Net Effect (savings or increased revenues) expected to exceed \$250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Local Government	\$0	\$0	\$0

FISCAL ANALYSIS

ASSUMPTION

§§338.600, 376.388, 376.394 and 376.399 – Pharmacy Benefit Managers

Officials from the **Department of Commerce and Insurance (DCI)** assume this proposal would amend the pharmacy practice act to address audits of pharmacy records by managed care companies, insurance companies, or pharmacy benefit managers.

The proposal also makes changes to insurance laws related to pharmacy benefit managers (PBMs). These changes include broadening the definition of a “covered person” and allowing the Department to audit information provided by a PBM. It outlines requirements for information that must be included in claims data submitted by a pharmacy for payment by a PBM. The proposal requires PBMs to provide the Department and plan sponsors with documentation of benefit designs that encourage or require enrollees to fill prescriptions at the PBM’s affiliates. It requires PBMs with affiliates to disclose specified information to the plan sponsor and to the Department. It specifies that PBMs owe a fiduciary duty to each plan sponsor. Finally, the proposal states that the Department may “audit” a PBM to ensure compliance.

This proposal does not include a new benefit mandate; however, it would impose additional regulatory requirements on the Department, which will likely require expertise that the Department currently lacks. Additionally, if implemented, this proposal may lead to increased consumer and provider complaints.

DCI will need to contract with firms with the necessary knowledge and expertise to determine compliance with the new provisions. In addition, DCI will need 1 FTE Examiner-in-charge and 2 FTE Insurance Examiners due to the number and complexity of investigations/examinations needed to ensure compliance. Contracted consultation with a pharmacist for the completion of market conduct investigations or examinations are assumed to be an annual cost of \$250,000 to \$500,000 using an assumed hourly rate of \$300-\$500.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the estimated cost as provided by the DCI to the Insurance Dedicated Fund (1566).

Officials from the **Missouri Department of Transportation (MoDOT)** assume the provisions in section 376.394 would impact the MoDOT-MSHP medical plan as increased appeals would increase claim costs for the plan. It is estimated that approximately a third of pharmacies would be impacted by this change, which could result in an increased cost of \$0.09 per member per month, or \$21,400 annually, dependent on the increased percentage of appeals.

Oversight notes cost to the plan would be conditional, as any increase in claim expenditures would depend on whether an increase in appeals leads to a higher number of approved services or prescriptions following review. Oversight assumes an increase in appeals could lead to higher

claim cost if a greater number of denied claims are overturned and paid. For fiscal note purposes, Oversight will range the fiscal impact as \$0 or the estimate provided by MoDOT to the State Road Fund (1320).

Officials from the **Department of Health and Senior Services, Department of Social Services, Missouri Department of Conservation, Missouri Consolidated Health Care Plan** and the **City of Kansas City** each assume the proposal will have no fiscal impact on their respective organizations. **Oversight** does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for these agencies.

Officials from the **Department of Public Safety - Missouri Highway Patrol** defer to the Missouri Department of Transportation for the potential fiscal impact of this proposal.

<u>FISCAL IMPACT – State Government</u>	FY 2027 (10 Mo.)	FY 2028	FY 2029
STATE ROAD FUND (1320)			
<u>Cost – MoDOT (§376.394) Increase in appeals p.4</u>	<u>\$0 or (\$21,400)</u>	<u>\$0 or (\$21,400)</u>	<u>\$0 or (\$21,400)</u>
ESTIMATED NET EFFECT ON THE STATE ROAD FUND (1320)	<u>\$0 or (\$21,400)</u>	<u>\$0 or (\$21,400)</u>	<u>\$0 or (\$21,400)</u>
INSURANCE DEDICATED FUND (1566)			
<u>Cost – DCI (§§338.600 - 376.394) p.3</u>			
Personal Service	(\$224,928)	(\$275,312)	(\$280,818)
Fringe Benefits	(\$131,306)	(\$159,738)	(\$161,953)
Equipment and Expense	(\$47,238)	(\$34,102)	(\$34,784)
<u>Total Costs – DCI</u>	<u>(\$403,472)</u>	<u>(\$469,152)</u>	<u>(\$477,555)</u>
FTE Change – DCI	3 FTE	3 FTE	3 FTE
<u>Cost – DCI (§§338.600 - 376.394) Contracted consultation p.3</u>	<u>(\$250,000 to \$500,000)</u>	<u>(\$250,000 to \$500,000)</u>	<u>(\$250,000 to \$500,000)</u>
ESTIMATED NET EFFECT ON THE INSURANCE DEDICATED FUND (1566)	<u>(\$653,472 to \$903,472)</u>	<u>(\$719,152 to \$969,152)</u>	<u>(\$727,555 to \$977,555)</u>
Estimated Net FTE Change on the Insurance Dedicated Fund (1566)	3 FTE	3 FTE	3 FTE

<u>FISCAL IMPACT – Local Government</u>	FY 2027 (10 Mo.)	FY 2028	FY 2029
	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

FISCAL IMPACT – Small Business

No direct fiscal impact on small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

Current law requires a one-week notice for an on-site audit. This bill changes that timeframe to 14 days and requires the notice to specify which prescriptions will be audited. The notice is required to be in writing and to be sent by means allowing tracking of delivery. The bill includes an exception to this notice requirement if certain conditions are met. Any audit involving clinical judgment will be conducted by a licensed pharmacist, who must be made available to the audited pharmacy to discuss clinical rationale and Missouri legal requirements.

Under this bill, a pharmacy has the right to submit amended claims within 30 days of the discovery of an error to correct such errors in lieu of recoupment if the prescription was dispensed in accordance with state or federal requirements.

This bill limits audits to 40 unique and randomly selected prescriptions, with a maximum of 200 separately adjudicated claims, and the bill specifies additional provisions applicable to audits, including that an entity is prohibited from initiating an audit of a pharmacy more than two times in a calendar year.

Recoupments will 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, and recoupment will only occur following the correction of a claim and is limited to amounts adjudicated by a pharmacy benefits manager.

Except for MO HealthNet claims, approval of drug, prescriber, or patient eligibility upon adjudication of a claim cannot be reversed unless the pharmacist or pharmacy obtained the adjudication by means of fraud, waste, or abuse, a misrepresentation of claim elements, or claims that were not properly rendered or billed by a pharmacy or pharmacist.

Currently, the period covered by the audit does not exceed a twoyear 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 there has been a previous finding of fraud. This bill changes that

provision to be the date the claim was submitted for payment, unless there has been a previous finding of fraud.

Currently, an audit cannot be initiated or scheduled during the first three business days of any month. This bill changes that timeframe to the first five business days of any month.

Currently, the preliminary audit report is delivered to the pharmacy within 120 days after conclusion of the audit. This bill provides that reports not delivered to the pharmacy in such timeframe will be deemed to have no discrepancies and no recoupment will be made.

The bill prohibits the limitation of days' supply for unit-of-use items beyond manufacturer recommendations and establishes provisions for situations when the only commercially available package size exceeds an entity's maximum days' supply.

This bill establishes provisions for any entity conducting a wholesale invoice audit to comply with, including what will be accepted as evidence and what may or may not form the basis for recoupment.

This bill requires PBMs to provide plan sponsors with the sponsor's pharmacy claims data as reasonably requested by the plan sponsor. It additionally requires PBMs to provide to each plan sponsor and the Department of Commerce and Insurance (DCI) with documentation of any benefit design that encourages or requires enrollees to fill prescriptions at the pharmacy benefits manager's affiliates. All required disclosures must be provided to the plan sponsor in a universally accessible manner.

If a pharmacy benefits manager has an affiliate, the pharmacy benefits manager is required to disclose to the plan sponsor and DCI:

- (1) The amount charged per dosage unit to the affiliate; and
- (2) The median amount charged per dosage unit at in-network pharmacies that are not affiliates.

The Department of Commerce and Insurance may audit a pharmacy benefits manager to ensure compliance with the provisions of this bill.

The bill prohibits PBMs from reimbursing a "critical-access care pharmacy", as defined in the bill, for a prescription drug or device in an amount that is less than the actual cost to that pharmacy for the drug or device, plus a professional dispensing fee of \$10.50 per claim. The bill requires a pharmacy benefits manager to establish a process by which a pharmacy can appeal a reimbursement. If a critical-access care pharmacy chooses to contest a reimbursement for failing to pay at least the actual cost that the pharmacy incurred for a drug, medical product, or device, the pharmacy has the right to designate a pharmacy services administrative organization or other agent to file and handle its appeal.

If a critical-access care pharmacy or agent acting on its behalf prevails in an appeal, the pharmacy benefits manager or covered entity must do the following within seven business days after notice of the appeal is received:

- (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 pharmacy or agent the National Drug Code number for the drug;
- (3) Permit the challenging 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 pharmacy at least in an amount equal to the pharmacy's actual cost for the drug or device; and
- (6) Apply the findings from the appeal as to the rate of reimbursement and actual cost for the drug or product or device to other similarly situated critical-access care pharmacies.

The bill establishes additional provisions for situations in which a critical-access care pharmacy or agent acting on its behalf loses or is denied an appeal. The bill requires health benefit plans beginning on or after January 1, 2027, to comply with the provisions of H.R. 7148, the Consolidated Appropriations Act, 2026.

For plan years beginning on or after January 1, 2027, no contract or arrangement, renewal, or extension thereof 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 insurance coverage, a third-party administrator, an entity providing pharmacy benefit management services, is reasonable within the meaning of this bill's provisions unless the entity providing pharmacy benefit management services:

- (1) Remits 100% of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to the utilization of drugs or drug spending under the health plan or health insurance coverage, to the group plan or 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 100% 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 the health insurance issuer on behalf of the plan by the entity providing pharmacy benefit management services.

With respect to 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 90 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 90 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 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.

The bill additionally repeals an existing section of law relating to limitations and restrictions on PBMs.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Commerce and Insurance
Department of Health and Senior Services
Department of Public Safety - Missouri Highway Patrol
Missouri Department of Conservation
Missouri Consolidated Health Care Plan
City of Kansas City



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March 19, 2026



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