HCS HBs 1850 & 1975 -- PHARMACY BENEFITS MANAGERS

SPONSOR: Hewkin

COMMITTEE ACTION: Voted "Do Pass with HCS" by the Standing Committee on Health and Mental Health by a vote of 16 to 0. Voted "Do Pass" by the Standing Committee on Rules-Administrative by a vote of 10 to 0.

The following is a summary of the House Committee Substitute for HBs 1850 & 1975.

This bill adds and modifies provisions relating to pharmacy benefits managers (PBMs).

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 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 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.

The following is a summary of the public testimony from the committee hearing. The testimony was based on the introduced version of the bill.

PROPONENTS: Supporters say that this bill is designed to allow the consumer to understand the cost of medication and for pharmacies to better negotiate costs. PBMs are generally responsible for the rise in prescription drug costs, and these provisions have passed in other states trying to rein PBMs in. The bill's intention is to allow pharmacies to continue serving their communities and improve patient outcomes as pharmacists are a critical part of the overall care team.

Testifying in person for the bill were Representative Hewkin; Brandon Gregory; Martin Hintelrong, The Medicine Shoppe #0961; Martin Hinterlong, The Medicine Shoppe; Brandon Gregory, Good Graces Pharmacy; Amy Mitchell, Mo PBC; Anthony Desha, Summit Pharmacy; Missouri Pharmacy Association; Arnie Dienoff; Missouri State Medical Association; Missouri Association of Osteopathic Physicians and Surgeons; Anthony Desha, Flow's Pharmacy; and Missouri Pharmacy Business Council.

OPPONENTS: Those who oppose the bill say that if a dispensing fee is imposed, such fee will be paid at the pharmacy counter and come directly out of the patient's pocket. PBMs just process claims, and are not payers. The bill could mandate minimum reimbursement, and should not pass down costs to consumers.

Testifying in person against the bill were PCMA; America's Health Insurance Plans, Missouri Insurance Coalition; and Mid-America Carpenters Regional Council.

Written testimony has been submitted for this bill. The full written testimony and witnesses testifying online can be found under Testimony on the bill page on the House website.