Missouri

Missouri - HB 1677

Sponsor: Representative Dale Wright (R)

Actions:
02/14/2022 Executive Session held; passed committee
02/08/2022 Referred to House Rules Administrative Oversight Committee
02/07/2022 Executive Session Held; Substituted; Passed Committee
01/31/2022 Hearing Held
01/24/2022 Hearing Held
01/06/2022 Introduced; Referred to House Health and Mental Health Policy Committee
12/01/2021 Pre-filed

Summary: Summary of 2/8/2022 Version

This measure requires Pharmacy Benefit Managers to issue a report to the Missouri Consolidated Health Care Plan and to implement procedures for the management of contracts with pharmacies as described in the measure.

This measure is applicable to pharmacy benefit managers, this measure also applies to drug pricing transparency.

This measure establishes that a pharmacy benefits manager utilized by the Missouri Consolidated Health Care Plan must file an annual report with the Plan before March 1, 2024. The report will contain information on the aggregate dollar amount of all rebates that the pharmacy benefits manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs and the aggregate dollar amount of all rebates, excluding any portion of the rebates received by the plan, concerning drug formularies that the pharmacy benefits manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs.

The Missouri consolidated health care plan will submit an annual report to the legislature before July 1, 2024, based on the information provided by pharmacy benefit managers. The Plan will prepare a report for the immediately preceding calendar year describing the rebate practices of the plan and its pharmacy benefits manager.

The plan may impose a penalty of no more than $7,500 dollars on its pharmacy benefits manager for each violation of the provisions listed above.

This measure provides that no pharmacy benefit manager may prohibit or redirect by contract, or otherwise penalize or restrict a covered person from obtaining prescription services, consultation, or advice from a contracted pharmacy.

This measure also provides that any entity that enters into a contract to sell, provide, pay, or reimburse a pharmacy in the state for prescription drugs on behalf of itself or another entity will define and apply the term "generic", with respect to prescription drugs, to mean any "authorized generic drug." A pharmacy benefits manager that has contracted with an entity

to provide pharmacy benefit management services for such an entity will owe a fiduciary duty to that entity and shall discharge that duty in accordance with federal and state law.

This measure also applies to contracts between pharmacies and pharmacy benefit managers by requiring that if reimbursement to a contracted pharmacy is below the pharmacy's cost to purchase the drug, the pharmacy benefits manager will sustain an appeal and increase reimbursement to the pharmacy and other contracted pharmacies to cover the cost of purchasing the drug. Additionally, a pharmacy benefits manager will not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services. This measure also establishes that pharmacy benefit managers must notify health carriers and pharmacies in writing of any potential conflict of interest, including common ownership or any other relationship between pharmacy benefit managers and any other health carrier or pharmacy with which the pharmacy benefit managers contract.

A health carrier or pharmacy benefit manager may not discriminate against any covered entity or pharmacy for reimbursing a pharmacy for a 340 B Drug in an amount less than such health carrier or pharmacy benefit manager would pay to any other pharmacy that is not a specified pharmacy that dispenses 340B drugs. They may not impose any covered entities or specified pharmacies that have different terms or conditions than other pharmacies. This includes fees, chargebacks, clawbacks, adjustments, other assessments, professional dispensing fees, or restrictions in preferred pharmacy networks. They may not interfere with an individual's choice to receive a 340 B drug from an entity via mail or in-person.

"Specified pharmacy", is 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.

"340B drug", a drug that is 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.

"Covered Person" means a policyholder, subscriber, enrollee, or another individual who is entitled to health care services from a health carrier.

"Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for prescription drugs and pharmacist services to those who reside in this state.

The director of the Department of Commerce and insurance will promulgate rules to implement these provisions.

If enacted, this measure takes effect on August 28, 2022. Pharmacy benefits manager reporting must be performed prior to March 1, 2024.

Bill Links 2/8/2022 Version
12/1/2021 Version

Missouri - HB 2850

Sponsor: Representative Tony Lovasco (R)

Actions:
03/21/2022 Hearing Scheduled
03/10/2022 Referred to House Health and Mental Health Policy Committee
03/01/2022 Introduced

Summary: Summary for 3/1/2022 Version

This measure relates to physicians, allowing physicians and caregivers to obtain and prescribe natural medicines to eligible patients.

This measure allows natural medicines to be obtained by caregivers and eligible patients and provided to eligible patients. Health insurers are not required to provide coverage for the cost of natural medicine. A health care insurer can provide coverage for natural medicine or for treatment or therapy that occurs in conjunction with the medical use of natural medicine.

The use and administration of natural medicine must be within a facility, hospice facility, or office that provides health-related services. A physician will not be subject to criminal or civil liability or sanction under the laws of this state for recommending natural medicine to an eligible patient, and no state agency or regulatory board cannot revoke, fail to renew, or take any other action against a physician's license issued under chapter 334 based solely on the physician's recommendation to an eligible patient regarding treatment with natural medicine unless it is done so through gross negligence. The same applies to providers and produces of natural medicines.

The measure provides exemptions for the possession of natural medicines from laws regarding controlled substances.

For this measure, "Caregiver" means a person twenty-one years of age or older who is designated by the eligible patient to assist in the eligible patient's medical use of natural medicine.

For this measure, "Department", the department of health and senior services.

For this measure, "Eligible patient", a person who: (a) Has been diagnosed by a physician with one or more of the following conditions: a. Treatment-resistant posttraumatic stress disorder; b. Treatment-resistant depression; c. Terminal illness; or d. Any other serious condition that has not responded positively or significantly to treatment and that is approved by the department as described in subsection of this section; and (b) Has documentation from the person's physician that the person has met the requirements of this subdivision.

For this measure, "Medical use" means the acquisition, use, production, possession, delivery, transfer, or administration of natural medicine, or paraphernalia used to administer natural medicine by a caregiver or an eligible patient, for the benefit of an eligible patient.

For this measure, "Natural medicine", dimethyltryptamine; ibogaine; mescaline other than Lophophora williamsii (peyote); psilocybin; or psilocyn, if derived from a plant or fungus.

Bill Links 3/1/2022 Version

Missouri - SB 1129

Sponsor: Senator Bill White (R)

Actions: 02/07/2022 Introduced

Summary: Summary of 2/7/2022 Version

This measure creates provisions relating to insurance coverage of pharmacy services. This measure prohibits a health carrier or pharmacy benefits manager from discriminating against an entity that is in contract with or participates in the 340B drug pricing program.

This measure is applicable to health care providers. This measure provides that a health carrier or pharmacy benefits manager must not impose any penalty, impediment, differentiation, or limitation on participating providers for providing medically necessary clinician-administered drugs, regardless of whether the participating provider obtains the drugs from an in-network provider, including but not limited to refusing to approve or pay, or reimbursing less than the contracted payment amount. These provisions will not apply if the clinician-administered drug is not otherwise covered by the carrier or pharmacy benefits manager.

This measure also prohibits a health carrier or pharmacy benefits manager to discriminate, lower the reimbursement, or impose any separate terms upon an entity in any contract based in whole or in part on the entity's participation in the 340B drug pricing program under federal law. The measure states that a health carrier or pharmacy benefits manager must not limit a patient's freedom to use an entity that participates in the 340B pricing program by any means, including but not limited to modifying a patient's payment limitations or cost-sharing obligations on the basis of participation in the 340B pricing program.

This measure requires a health carrier or pharmacy benefits manager providing coverage for a reference product or a biological product that is biosimilar to the reference product to 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 the required coverage must be the same, including but not limited to any payment limitations or cost-sharing obligations.

The measure will become effective on August 28 of the year in which it passes the Legislature.

Bill Links 2/7/2022 Version

Missouri - SB 1242

Sponsor: Senator Rick Brattin (R)

Actions: 03/01/2022 Introduced

Summary: Summary for 3/1/2022 Version

This measure relates to physicians, pharmacists, and COVD-19, prohibiting the denial, suspension, revocation, or other disciplinary action by the board on physicians or pharmacists for dispensing, prescribing, administering, or otherwise distributing ivermectin or hydroxychloroquine to treat COVID-19.

This measure prohibits the denial, suspension, revocation, or other disciplinary action by the board on physicians or pharmacists for dispensing, prescribing, administering, or otherwise distributing ivermectin or hydroxychloroquine for the prophylaxis or treatment of COVID-19. Licensed physicians and pharmacists who distribute or prescribe the use of such tablets are not liable for any damages incurred through the usage of such tablets unless it was an act of gross negligence provided that the patient provides written, informed consent.

For this measure, "written, informed consent" means a written document signed by the patient, the patient's legal guardian, or the patient's attorney-in-fact designated in a durable power of attorney for health care, or if the patient is a minor, the patient's parent or legal guardian, and that, at a minimum, includes the following: (1) An explanation of the currently approved products and treatments for COVID-19; (2) Clear identification of the specific proposed medication the patient is seeking to use; (3) A description of the potentially best and worst outcomes of using the medication and a realistic description of the most likely outcome; and (4) A release of liability relative to the treating physician or pharmacist.

Bill Links 3/1/2022 Version

Missouri - SB 727

Sponsor: Senator Robert Onder (R)

Actions:
02/23/2022 Hearing Held
01/13/2022 Referred to Senate Health and Pensions Committee
01/05/2022 Introduced
12/01/2021 Prefiled

Summary: Summary for 12/1/2021 Version

This measure modifies the certificate of need for certain medical facilities.

This measure is applicable to certificates of need.

This measure alters the certificate of need law relating to hospitals. This measure clarifies the definition of a long-term care facility as well as creates requirements surrounding the amount of beds in the facility. This measure repeals provisions related to the certificates of need for major medical equipment and expenditure minimums.

The measure also makes technical changes to the certificate of need statutes. This measure will take effect August 28, 2022.

Bill Links 12/1/2021 Version

Missouri - SB 947

Sponsor: Senator Bill White (R)

Actions: 02/16/2022 Referred to the Senate Insurance and Banking Committee
12/01/2021 Prefiled

Summary: Summary for 12/1/2021 Version

This measure creates provisions for health care providers seeking prior authorization for health care services.

This measure prohibits heath carriers or utilization review entities from requiring a health care provider to obtain prior authorization for a particular health care service if the review entity has approved no less than 90% of the prior authorization requests in the most recent 6 month evaluation period. They then must determine whether a provider qualifies for exemption once every 6 months.

This measure provides that exemptions remain in effect until the 30th day after the health carrier or utilization review entity notifies the provider of its decision to rescind the exemption, if the provider does not request a review of the decision or if on the 5th day after the independent review organization affirms the determination to rescind the exemption, if the provider requests a review of the decision as specified in the act. If they do not finalize a rescission determination in one of these manners, the provider must be considered to have met the criteria for an exemption, and the exemption remains in effect.

This measure requires health carriers or utilization review entities to rescind prior authorization provider exemptions only during January or July of each year, if they determine that less than 90% of a random sample of 5 to 20 claims for the particular health care service met the medical necessity criteria used for prior authorization review, if they notify the provider at least 25 days before the proposed rescission is to take effect, and if they provide along with this notice both the sample information used to make the determination and a plain language explanation of how the provider may request an independent review.

This measure requires a rescission determination of a licensed medical practitioner, and if made for a physician, have the same or similar specialty as that physician. A health carrier or utilization review entity must deny a prior authorization provider exemption only if the provider does not have an exemption at the time of the relevant evaluation period, and they provide the provider with data and information for the relevant evaluation period sufficient to demonstrate that the provider does not meet the criteria for the exemption.

This measure authorizes providers to review any adverse determination regarding a prior authorization provider exemption. A health carrier or utilization review entity must pay for any appeal or independent review of an adverse determination, and pay a reasonable fee for any copies of medical records or other documents requested from a provider. The review must be completed no later than 30 days after the provider files the request. A provider may request that the independent review organization consider another random sample of 5 to 20 claims submitted by the provider during the relevant evaluation period for the relevant health care service. If the provider makes this request, the organization can base its

determination on both the claims initially reviewed by the health carrier or utilization review entity and the claims included in the additional random sample requested by the provider.

This measure requires that a health carrier or utilization review entity be bound by an independent review determination that doesn't affirm the determination made by the carrier or entity to deny or rescind a prior authorization provider exemption. This measure prohibits denying coverage for a health care service on the basis of a rescission of a prior authorization provider exemption, even if the carrier's or entity's determination to rescind the exemption is affirmed by an independent review organization. If a health carrier's or utilization review entity's determination of a prior authorization provider exemption is overturned on review by an independent review organization, the carrier or utilization review entity can't attempt to rescind the exemption before the end of the next evaluation period that occurs.

This measure provides that a provider be eligible for consideration for an exemption for the same health care service after a final determination or review affirming the rescission or denial of a prior authorization provider exemption.

Bill Links 12/1/2021 Version

Missouri - SB 959

Sponsor: Senator Doug Beck (D)

Actions:
03/08/2022 Hearing scheduled
02/24/2022 Referred to the Senate Insurance and Banking Committee
12/02/2021 Prefiled

Summary: Summary for 12/2/2021 Version

This measure will add additional circumstances for when a patient will be granted an exception to a step therapy protocol required by a health carrier for coverage of a prescription drug.

This measure is applicable to health insurers.

In this measure, a step therapy overrides exception determination will be granted if:

(1) The patient has tried step therapy required for prescription drugs while on their previous health insurance or health benefit plan, and the drug was discontinued due to ineffectiveness.

(2)Delay of effective treatment would lead to severe or irreversible consequences.

(3) Any treatments otherwise required under the step therapy protocol are contraindicated for the patient or have caused, or are likely to cause, based on clinical, peer-reviewed evidence, harm to the patient.

(4) Any treatment otherwise required under the step therapy protocol has prevented, will prevent, or is likely to prevent a patient from achieving or maintaining reasonable and safe functional ability in performing occupational responsibilities.

(5)The patient is stable for his or her disease or condition on the prescription drug or drugs selected by the prescribing health care provider and has previously received approval for coverage of the relevant drug or drugs for the disease or condition under his or her current or previous health insurance or health benefit plan.

This measure will take effect on August 28, 2022.

Bill Links 12/2/2021 Version