Miss. Code Ann. § 73-21-151
MISSISSIPPI CODE of 1972
*** Current through the 2021 Regular Session ***
TITLE 73. PROFESSIONS AND VOCATIONS
CHAPTER 21. PHARMACISTS
PHARMACY BENEFIT PROMPT PAY ACT
Miss. Code Ann. § 73-21-151

[Effective from and after January 1, 2021, this section will read:]

§ 73-21-151. Short Title.

Sections 73-21-151 through 73-21-163 shall be known as the "Pharmacy Benefit Prompt Pay Act."

**History:** Laws, 2006, ch. 533, § 31, eff from and after June 30, 2006; Laws, 2020, ch. 395, § 1, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-153
MISSISSIPPI CODE of 1972
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Miss. Code Ann. § 73-21-153

§ 73-21-151. Definitions.

**[Effective from and after January 1, 2021, this section will read:]**

For purposes of Sections 73-21-151 through 73-21-163, the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

**(a)** "Board" means the State Board of Pharmacy.

**(b)** "Commissioner" means the Mississippi Commissioner of Insurance.

**(c)** "Day" means a calendar day, unless otherwise defined or limited.

**(d)** "Electronic claim" means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a pharmacy benefit manager and approved by the department.

**(e)** "Electronic adjudication" means the process of electronically receiving, reviewing and accepting or rejecting an electronic claim.

**(f)** "Enrollee" means an individual who has been enrolled in a pharmacy benefit management plan.

**(g)** "Health insurance plan" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

**(h)** "Pharmacy benefit manager" shall have the same definition as provided in Section 73-21-179. However, through June 30, 2014, the term "pharmacy benefit manager" shall not include an insurance company that provides an integrated health benefit plan and that does not separately contract for pharmacy benefit management services. From and after July 1, 2014, the term "pharmacy benefit manager" shall not include an insurance company unless the insurance company is providing services as a pharmacy benefit manager as defined in Section 73-21-179, in which case the insurance company shall be subject to Sections 73-21-151 through 73-21-159 only for those pharmacy benefit manager services. In addition, the term "pharmacy benefit manager" shall not include the pharmacy benefit manager of the Mississippi State and School Employees Health Insurance Plan or the Mississippi

Division of Medicaid or its contractors when performing pharmacy benefit manager services for the Division of Medicaid.

**(i)** "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager.
**(j)** "Pharmacy benefit management plan" shall have the same definition as provided in Section 73-21-179.

**(k)** "Pharmacist," "pharmacist services" and "pharmacy" or "pharmacies" shall have the same definitions as provided in Section 73-21-73.

***(l)*** "Uniform claim form" means a form prescribed by rule by the State Board of Pharmacy; however, for purposes of Sections 73-21-151 through 73-21-159, the board shall adopt the same definition or rule where the State Department of Insurance has adopted a rule covering the same type of claim. The board may modify the terminology of the rule and form when necessary to comply with the provisions of Sections 73-21-151 through 73-21-159.

**(m)** "Plan sponsors" means the employers, insurance companies, unions and health maintenance organizations that contract with a pharmacy benefit manager for delivery of prescription services.

**History:** Laws, 2006, ch. 533, § 32; Laws, 2013, ch. 541, § 3, eff from and after July 1, 2013; Laws, 2020, ch. 395, § 2, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-155
MISSISSIPPI CODE of 1972
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Miss. Code Ann. § 73-21-155

§ 73-21-155. Most current reference price to be used in calculation of reimbursement for prescription drugs and other products and supplies; updating of reference price; time period for payment of benefits; "clean claim" defined; compliance; penalties; retroactive denial or reduction of claim after adjudication prohibited [Effective January 1, 2021].
(This section has more than one version with varying effective dates.)

**(1)** Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses Medi-Span, Gold Standard or a nationally recognized reference that has been approved by the board in the pricing calculation shall use the most current reference price or amount in the actual or constructive possession of the pharmacy benefit manager, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of electronic adjudication or on the date of service shown on the nonelectronic claim.

**(2)** Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.

**(3)**

**(a)** All benefits payable under a pharmacy benefit management plan shall be paid within seven (7) days after receipt of due written proof of a clean claim where claims are submitted electronically, and shall be paid within thirty-five (35) days after receipt of due written proof of a clean claim where claims are submitted in paper format. Benefits due under the plan and claims are overdue if not paid within seven (7) days or thirty-five (35) days, whichever is applicable, after the pharmacy benefit manager receives a clean claim containing necessary information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits and subrogation provisions under the plan sponsor's health insurance plan. A "clean claim" means a claim received by any pharmacy benefit manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefit manager. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subsection. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

**(b)** A clean claim does not include any of the following:

**(i)** A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

**(ii)** Claims which are submitted fraudulently or that are based upon material misrepresentations;

**(iii)** Claims that require information essential for the pharmacy benefit manager to administer preexisting condition, coordination of benefits or subrogation provisions under the plan sponsor's health insurance plan; or

**(iv)** Claims submitted by a pharmacist or pharmacy more than thirty (30) days after the date of service; if the pharmacist or pharmacy does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the pharmacist or pharmacy to the insured.

**(c)** Not later than seven (7) days after the date the pharmacy benefit manager actually receives an electronic claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the pharmacy benefit manager actually receives a paper claim, the pharmacy benefit manager shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the pharmacist or pharmacy (where the claim is owed to the pharmacist or pharmacy) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the pharmacy benefit manager shall be paid within twenty (20) days after receipt.

**(4)** If the board finds that any pharmacy benefit manager, agent or other party responsible for reimbursement for prescription drugs and other products and supplies has not paid ninety-five percent (95%) of clean claims as defined in subsection (3) of this section received from all pharmacies in a calendar quarter, he shall be subject to administrative penalty of not more than Twenty-five Thousand Dollars ($25,000.00) to be assessed by the State Board of Pharmacy.

**(a)** Examinations to determine compliance with this subsection may be conducted by the board. The board may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the pharmacy benefit manager examined.

**(b)** Nothing in the provisions of this section shall require a pharmacy benefit manager to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance or prepaid coverage.

**(c)** If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the pharmacy benefit manager must pay the pharmacy (where the claim is owed to the pharmacy) or the patient (where the claim is owed to a patient) interest on accrued benefits at the rate of one and one-half percent (1-1/2%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

**(d)** Any pharmacy benefit manager and a pharmacy may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (3) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the pharmacy benefit manager to the pharmacy. If the express written agreement is silent as to any interest penalty where claims are not

paid in accordance with the agreement, the interest penalty provision of subsection (4)(c) of this section shall apply.

**(e)** The State Board of Pharmacy may adopt rules and regulations necessary to ensure compliance with this subsection.

**(5)**

**(a)** For purposes of this subsection (5), "network pharmacy" means a licensed pharmacy in this state that has a contract with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate. A network pharmacy or pharmacist may decline to provide a brand name drug, multisource generic drug, or service, if the network pharmacy or pharmacist is paid less than that network pharmacy's acquisition cost for the product. If the network pharmacy or pharmacist declines to provide such drug or service, the pharmacy or pharmacist shall provide the customer with adequate information as to where the prescription for the drug or service may be filled.

**(b)** The State Board of Pharmacy shall adopt rules and regulations necessary to implement and ensure compliance with this subsection, including, but not limited to, rules and regulations that address access to pharmacy services in rural or underserved areas in cases where a network pharmacy or pharmacist declines to provide a drug or service under paragraph (a) of this subsection. The board shall promulgate the rules and regulations required by this paragraph (b) not later than October 1, 2016.

**(6)** A pharmacy benefit manager shall not directly or indirectly retroactively deny or reduce a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated.

**History:** Laws, 2006, ch. 533, § 33; Laws, 2016, ch. 453, § 1, eff from and after July 1, 2016; Laws, 2020, ch. 395, § 3, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-156
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TITLE 73. PROFESSIONS AND VOCATIONS
CHAPTER 21. PHARMACISTS
PHARMACY BENEFIT PROMPT PAY ACT
Miss. Code Ann. § 73-21-156

§ 73-21-156. Placement of drug on maximum allowable cost list; access, update and notification of update to maximum allowable cost list; administrative appeal procedure for challenge to maximum allowable cost list and reimbursements; reimbursement by pharmacy benefit manager to pharmacy or pharmacist in amount less than reimbursement to pharmacy benefit manager affiliate for same pharmacist services prohibited.

**(1)** As used in this section, the following terms shall be defined as provided in this subsection:

**(a)** "Maximum allowable cost list" means a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product or other prescription drug. The term "maximum allowable cost list" includes without limitation:

**(i)** Average acquisition cost, including national average drug acquisition cost;
**(ii)** Average manufacturer price;
**(iii)** Average wholesale price;
**(iv)** Brand effective rate or generic effective rate;
**(v)** Discount indexing;
**(vi)** Federal upper limits;
**(vii)** Wholesale acquisition cost; and
**(viii)** Any other term that a pharmacy benefit manager or a health care insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.

**(b)** "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice.

**(2)** Before a pharmacy benefit manager places or continues a particular drug on a maximum allowable cost list, the drug:

**(a)** If the drug is a generic equivalent drug product as defined in 73-21-73, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference approved by the board;

**(b)** Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Mississippi; and

**(c)** Shall not be obsolete.

**(3)** A pharmacy benefit manager shall:

**(a)** Provide access to its maximum allowable cost list to each pharmacy subject to the maximum allowable cost list;

**(b)** Update its maximum allowable cost list on a timely basis, but in no event longer than three (3) calendar days; and

**(c)** Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list.

**(4)** A pharmacy benefit manager shall:

**(a)** Provide a reasonable administrative appeal procedure to allow pharmacies to challenge a maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

**(i)** Not meeting the requirements of this section; or
**(ii)** Being below the pharmacy acquisition cost.

**(b)** The reasonable administrative appeal procedure shall include the following:

**(i)** A dedicated telephone number, email address and website for the purpose of submitting administrative appeals;
**(ii)** The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefit management plan or through a pharmacy service administrative organization; and
**(iii)** A period of less than thirty (30) business days to file an administrative appeal.

**(c)** The pharmacy benefit manager shall respond to the challenge under paragraph (a) of this subsection (4) within thirty (30) business days after receipt of the challenge.

**(d)** If a challenge is made under paragraph (a) of this subsection (4), the pharmacy benefit manager shall within thirty (30) business days after receipt of the challenge either:

**(i)** If the appeal is upheld:

**1.** Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;
**2.** Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;
**3.** Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and
**4.** Make the change under item 1 of this subparagraph (i) effective for each similarly situated pharmacy as defined by the payor subject to the maximum allowable cost list; or

**(ii)** If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Mississippi that have the drug currently in stock at a price below the maximum allowable cost as listed on the maximum allowable cost list; or
**(iii)** If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit

manager shall adjust the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

**(5)**

**(a)** A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services.

**(b)** The amount shall be calculated on a per unit basis based on the same brand and generic product identifier or brand and generic code number.

**History:** Laws, 2020, ch. 395, § 4, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-157
MISSISSIPPI CODE of 1972
*** Current through the 2021 Regular Session ***
TITLE 73. PROFESSIONS AND VOCATIONS
CHAPTER 21. PHARMACISTS
PHARMACY BENEFIT PROMPT PAY ACT
Miss. Code Ann. § 73-21-157

[Effective from and after January 1, 2021, this section will read:]

§ 73-21-157. License required to do business as pharmacy benefit manager; pharmacy benefit managers to file certain financial statements with State Board of Pharmacy; proprietary information to be marked confidential when submitted to board; penalty for release of confidential information; criminal history records check for board employees with access to such information; time period for filing statements.

**(1)** Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license to do business from the board. To obtain a license, the applicant shall submit an application to the board on a form to be prescribed by the board.

**(2)** Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1 or within sixty (60) days of the end of its fiscal year if not a calendar year. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year or the immediately preceding fiscal year of the pharmacy benefit manager.

**(3)** The statement shall be on forms prescribed by the board and shall include:

**(a)** A financial statement of the organization, including its balance sheet and income statement for the preceding year; and
**(b)** Any other information relating to the operations of the pharmacy benefit manager required by the board under this section.

**(4)**

**(a)** Any information required to be submitted to the board pursuant to licensure application that is considered proprietary by a pharmacy benefit manager shall be marked as confidential when submitted to the board. All such information shall not be subject to the provisions of the federal Freedom of Information Act or the Mississippi Public Records Act and shall not be released by the board unless subject to an order from a court of competent jurisdiction. The board shall destroy or delete or cause to be destroyed or deleted all such information thirty (30) days after the board determines that the information is no longer necessary or useful.

**(b)** Any person who knowingly releases, causes to be released or assists in the release of any such information shall be subject to a monetary penalty imposed by the board in an amount not exceeding Fifty Thousand Dollars ($50,000.00) per violation. When the board is considering the imposition of any penalty under this paragraph (b), it shall follow the same policies and procedures provided for the imposition of other sanctions in the Pharmacy Practice Act. Any penalty collected under this paragraph (b) shall be deposited into the special fund of the board and used to support the operations of the board relating to the regulation of pharmacy benefit managers.

**(c)** All employees of the board who have access to the information described in paragraph (a) of this subsection shall be fingerprinted, and the board shall submit a set of fingerprints for each employee to the Department of Public Safety for the purpose of conducting a criminal history records check. If no disqualifying record is identified at the state level, the Department of Public Safety shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history records check.

**(5)** If the pharmacy benefit manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within thirty (30) days of the report being final.

**(6)** The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However, the board shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by subsection (1) of this section. The board may waive the requirements for filing financial information for the pharmacy benefit manager if an affiliate of the pharmacy benefit manager is already required to file such information under current law with the Commissioner of Insurance and allow the pharmacy benefit manager to file a copy of documents containing such information with the board in lieu of the statement required by this section.

**(7)** The expense of administering this section shall be assessed annually by the board against all pharmacy benefit managers operating in this state.

**(8)** A pharmacy benefit manager or third-party payor may not require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state.

**History:** Laws, 2006, ch. 533, § 34; Laws, 2011, ch. 546, § 31; Laws, 2013, ch. 541, § 4; Laws, 2016, ch. 453, § 2, eff from and after July 1, 2016; Laws, 2020, ch. 395, § 5, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-159
MISSISSIPPI CODE of 1972
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TITLE 73. PROFESSIONS AND VOCATIONS
CHAPTER 21. PHARMACISTS
PHARMACY BENEFIT PROMPT PAY ACT
Miss. Code Ann. § 73-21-159

[Effective from and after January 1, 2021, this section will read:]

§ 73-21-159. Financial examination of pharmacy benefit manager.

(1) In lieu of or in addition to making its own financial examination of a pharmacy benefit manager, the board may accept the report of a financial examination of other persons responsible for the pharmacy benefit manager under the laws of another state certified by the applicable official of such other state.

(2) The board shall coordinate financial examinations of a pharmacy benefit manager that provides pharmacy management benefit plans in this state to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation. The pharmacy benefit manager being examined shall pay the cost of the examination. The cost of the examination shall be deposited in a special fund that shall provide all expenses for the licensing, supervision and examination of all pharmacy benefit managers subject to regulation under Sections 73-21-71 through 73-21-129 and Sections 73-21-151 through 73-21-163.

(3) The board may provide a copy of the financial examination to the person or entity who provides or operates the health insurance plan or to a pharmacist or pharmacy.

(4) The board is authorized to hire independent financial consultants to conduct financial examinations of a pharmacy benefit manager and to expend funds collected under this section to pay the costs of such examinations.

**History:** Laws, 2006, ch. 533, § 35; Laws, 2011, ch. 546, § 32; Laws, 2013, ch. 541, § 5; Laws, 2016, ch. 453, § 3, eff from and after July 1, 2016; Laws, 2020, ch. 395, § 6, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-161
MISSISSIPPI CODE of 1972
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TITLE 73. PROFESSIONS AND VOCATIONS
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PHARMACY BENEFIT PROMPT PAY ACT
Miss. Code Ann. § 73-21-161

§ 73-21-161. Referral by pharmacy or pharmacy benefit manager or affiliate, or transfer or sharing records relative to certain prescription information, or presentation of claim for payment pursuant to referral from affiliate prohibited; pharmacy licensed or holding nonresident pharmacy permit to annually file disclosure statement identifying affiliates; violation of section [Effective January 1, 2021].

**(1)** As used in this section, the term "referral" means:

**(a)** Ordering of a patient to a pharmacy by a pharmacy benefit manager affiliate either orally or in writing, including online messaging;

**(b)** Offering or implementing plan designs that require patients to use affiliated pharmacies; or

**(c)** Patient or prospective patient specific advertising, marketing, or promotion of a pharmacy by an affiliate.

The term "referral" does not include a pharmacy's inclusion by a pharmacy benefit manager affiliate in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the affiliate includes information regarding eligible nonaffiliate pharmacies in those communications and the information provided is accurate.

**(2)** A pharmacy, pharmacy benefit manager, or pharmacy benefit manager affiliate licensed or operating in Mississippi shall be prohibited from:

**(a)** Making referrals;

**(b)** Transferring or sharing records relative to prescription information containing patient identifiable and prescriber identifiable data to or from a pharmacy benefit manager affiliate for any commercial purpose; however, nothing in this section shall be construed to prohibit the exchange of prescription information between a pharmacy and its affiliate for the limited purposes of pharmacy reimbursement; formulary compliance; pharmacy care; public health activities otherwise authorized by law; or utilization review by a health care provider; or

**(c)** Presenting a claim for payment to any individual, third-party payor, affiliate, or other entity for a service furnished pursuant to a referral from an affiliate.

**(3)** This section shall not be construed to prohibit a pharmacy from entering into an agreement with a pharmacy benefit manager affiliate to provide pharmacy care to patients, provided that the pharmacy does not receive referrals in violation of subsection (2) of this section and the pharmacy provides the disclosures required in subsection (1) of this section.

**(4)** If a pharmacy licensed or holding a nonresident pharmacy permit in this state has an affiliate, it shall annually file with the board a disclosure statement identifying all such affiliates.

**(5)** In addition to any other remedy provided by law, a violation of this section by a pharmacy shall be grounds for disciplinary action by the board under its authority granted in this chapter.

**(6)** A pharmacist who fills a prescription that violates subsection (2) of this section shall not be liable under this section.

**History:** Laws, 2020, ch. 395, § 7, eff from and after January 1, 2021.

Miss. Code Ann. § 73-21-163
MISSISSIPPI CODE of 1972
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Miss. Code Ann. § 73-21-163

§ 73-21-163. Action for temporary or permanent injunction against pharmacy benefit manager or affiliate to prohibit use of certain methods, acts or practices; monetary penalties for noncompliance with Sections 73-21-151 through 73-21-163; enforcement of payment of penalties; development of uniform penalty policy [Effective January 1, 2021].

Whenever the board has reason to believe that a pharmacy benefit manager or pharmacy benefit manager affiliate is using, has used, or is about to use any method, act or practice prohibited in Sections 73-21-151 through 73-21-163 and that proceedings would be in the public interest, it may bring an action in the name of the board against the pharmacy benefit manager or pharmacy benefit manager affiliate to restrain by temporary or permanent injunction the use of such method, act or practice. The action shall be brought in the Chancery Court of the First Judicial District of Hinds County, Mississippi. The court is authorized to issue temporary or permanent injunctions to restrain and prevent violations of Sections 73-21-151 through 73-21-163 and such injunctions shall be issued without bond.

**(2)** The board may impose a monetary penalty on a pharmacy benefit manager or a pharmacy benefit manager affiliate for noncompliance with the provisions of the Sections 73-21-151 through 73-21-163, in amounts of not less than One Thousand Dollars ($1,000.00) per violation and not more than Twenty-five Thousand Dollars ($25,000.00) per violation. Each day a violation continues for the same brand or generic product identifier or brand or generic code number is a separate violation. The board shall prepare a record entered upon its minutes that states the basic facts upon which the monetary penalty was imposed. Any penalty collected under this subsection (2) shall be deposited into the special fund of the board.

**(3)** The board may assess a monetary penalty for those reasonable costs that are expended by the board in the investigation and conduct of a proceeding if the board imposes a monetary penalty under subsection (2) of this section. A monetary penalty assessed and levied under this section shall be paid to the board by the licensee, registrant or permit holder upon the expiration of the period allowed for appeal of those penalties under Section 73-21-101, or may be paid sooner if the licensee, registrant or permit holder elects. Any penalty collected by the board under this subsection (3) shall be deposited into the special fund of the board.

**(4)** When payment of a monetary penalty assessed and levied by the board against a licensee, registrant or permit holder in accordance with this section is not paid by the licensee, registrant or permit holder when due under this section, the board shall have the power to institute and maintain proceedings in its name for enforcement of payment in the chancery court of the county and judicial district of residence of the licensee, registrant or permit holder, or if the licensee, registrant or permit holder is a nonresident of the State of Mississippi, in the Chancery Court of the First Judicial District of Hinds County, Mississippi. When those proceedings are instituted, the board shall certify the record of its proceedings, together with all documents and evidence, to the chancery court and the matter shall be heard in due course by the court, which shall review the record and make its determination thereon in accordance with the provisions

of Section 73-21-101. The hearing on the matter may, in the discretion of the chancellor, be tried in vacation.

**(5)** The board shall develop and implement a uniform penalty policy that sets the minimum and maximum penalty for any given violation of Sections 73-21-151 through 73-21-163. The board shall adhere to its uniform penalty policy except in those cases where the board specifically finds, by majority vote, that a penalty in excess of, or less than, the uniform penalty is appropriate. That vote shall be reflected in the minutes of the board and shall not be imposed unless it appears as having been adopted by the board.

**History:** Laws, 2020, ch. 395, § 8, eff from and after January 1, 2021.