SB 14

Senate Bill 14 amends the Pharmacy Benefit Manager Regulation Act as follows: Section 3 amends the appeals process by requiring a PBM to reimburse a pharmacy in an amount that is calculated on a per-unit basis using the same generic product identifier or the generic code number.

Section 4 amends the existing provisions on PBM contracts so as to prohibit a PBM from requiring an insured to use a specific pharmacy if the PBM or its corporate affiliate has an ownership interest in the pharmacy, and also prohibits a PBM from charging a different costsharing amount for drugs or services at a non-affiliated pharmacy. Other provisions prohibit a PBM from requiring or incentivizing the purchase of a medication in a quantity greater than that prescribed, and prohibits denial or reduction of a claim unless the claim was intentionally submitted fraudulently, the claim was a duplicate of claim previously paid, or the goods or services were not properly rendered by the pharmacy or pharmacist.

Section 7 creates a new section of the PBM Regulation Act entitled “Pharmacy Benefits Reimbursement Transparency” authorizing the Superintendent to review and approve the compensation program of a PBM to ensure that the reimbursement for pharmacist services is fair. In addition, PBMs are required to report to the Superintendent information that is based on the PBM requirements adopted by the Texas legislature in 2021. The provisions also prohibit a PBM from being paid on a percentage of the cost of a drug, and requires payment based on a fixed fee determined in advance.

Section 9 creates a new section of the act entitled “Patient Cost Sharing” which prohibits a PBM from requiring an insured to make a payment for a covered prescription drug in an amount greater than (1) the applicable cost-sharing amount for the drug, (2) the amount an insured would pay if the insured purchased the drug without using a health benefits plan, (3) the total amount the pharmacy would be reimbursed for the drug

from the PBM, or (4) the value of the rebate from a drug manufacturer provided to the PBM for the drug. When calculating an insured's cost sharing obligation for covered drugs, an insurer must credit the insured for the out-of-pocket cost for the full value of any discounts provided or made by third parties at the time of the drug claim. The new provisions further provide that any rebate amount is to be counted toward the insured's out-of-pocket prescription drug costs. Section 9 also provides that "if an insured or the insured's health care provider identifies a clinically appropriate, non-formulary, specialty prescription drug available at a lower cost than a drug covered on the PBM's formulary, the PBM must reimburse the insured, minus applicable cost sharing, for the non-formulary drug." Section 10 requires a PBM to develop a drug formulary that covers "all medically necessary drugs." Section 11 amends the act to include a provision that prohibits a PBM from restricting participation of a pharmacy in a pharmacy network if the pharmacy meets accreditation or certification requirements.

SB 51

The Cost-Sharing Contributions for Prescriptions would prohibit discrimination against entities participating in the federal 340B drug pricing program. It states that pharmacy benefit managers and third parties cannot discriminate against entities that participate in the 340B program by: Reimbursing a covered entity less than it would an entity not covered by the 340B program, Assessing covered entities fees or other assessments different from non-covered entities, preventing or interfering with a patient's right to use a 340B program drug from a covered entity, Imposing different requirements for covered vs. non-covered entities, including: o requiring

use of a pharmacy network, o requiring use of different audit procedures, o requiring claim procedures that would not be required of non-covered entities, or o charging additional fees or other provisions that would interfere with a patient’s right to receive a 340B drug from a covered entity.

SB 498

Senate Bill 498 would amend the Pharmacy Benefits Manager Regulation Act to expand the maximum-allowable-cost process from generic pharmaceuticals to all pharmaceuticals and to increase the amount of information provided on the maximum-allowable-cost list. Additionally, the bill would require pharmacy benefits managers to set reimbursement rates no lower than a pharmacy is able to purchase the drug from their wholesaler. Finally, the bill would require pharmacy benefits managers to allow any pharmacy access to its preferred pharmacy network and prohibits a manager from restricting an individual’s choice in pharmacy.

Health Care Service Corp. to expand Medicare Advantage coverage areas

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Midwest hospital M&A market heats up, but faces policy hurdles

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Cross-Market Health System Mergers to Pick Up Steam

HB 400

State-administered Health Coverage Plan. An Act relating to health care, requiring a study on the feasibility of creating and implementing a state-administered health coverage plan.

HB 385

Health Practitioner Nonsolicitation. A nonsolicitation provision in an agreement, which provision restricts the right of a health care practitioner to solicit patients or employees of the party seeking to enforce the agreement, shall be unenforceable upon the termination of:

(1) the agreement;

(2) a renewal or extension of the agreement; or

(3) a health care practitioner’s employment with a party seeking to enforce the agreement.”

Presbyterian-UnityPoint merger moves forward

State public option plans keep hitting obstacles