SB 513

requires each health benefit plan to provide coverage for biomarker testing and to provide evidence of such coverage. The document showing the plan covers biomarker testing shall include labeled indications for tests that are approved or cleared by the United States Food and Drug Administration (FDA), tests for a drug that is approved by the FDA, precautions on FDA approved drug labels, national coverage determinations or Medicare administrative contractor local coverage determinations, and nationally recognized clinical practice guidelines and consensus statements. The insured shall also have access to a clear, readily available, and convenient process to request an exception to a coverage policy of a health benefit plan under this subsection.

SB 242 (see companion bill HB 2330)

Long-term care; eliminating certificate of need requirements for long-term care facilities and psychiatric and chemical dependency facilities.

SB 143

provides that any high deductible health plan, as defined in current law, shall allow an insured member to set aside funds on a tax-free basis, up to the contribution limit provided in

Section 223 of the Internal Revenue Code, to pay for out-of-pocket medical expenses.

SB 549

requires the Patient’s Right to Pharmacy Choice Commission conduct hearings in accordance with the Administrative Procedures Act. Requires each health insurer payor that utilizes the services of a pharmacist benefits manager (PBM) and each PBM to electronically submit a network adequacy audit and any fees assessed to the Insurance Department on a semiannual basis. Each calendar day in a single 5-digit postal code where a PBM or insurer has failed to comply with these provisions shall be deemed an instance of violation. The measure also provides that a PBM contract shall not be amended or modified unilaterally by any party to the original or subsequent contract without providing proper notice and all parties agreeing to the changes. Additionally, no such contract may be unilaterally cancelled on or before the date of renewal without providing proper notice. The measure establishes a minimum fee of $100.00 for each PBM violation. The measure also provides that if the National Drug Code number provided by the PBM is not available below the provider’s acquisition cost from the pharmaceutical wholesaler from whom the provider purchases the majority of prescription drugs for resale, then the PBM shall adjust the Maximum Allowable Cost List above the challenging provider’s acquisition cost and permit the provider to reverse and rebill each claim affected.

SB 145

prohibits insurers from modifying an insured’s coverage of a prescription drug if drug had been previously preauthorized for coverage, the insured already received the drug, and a practitioner continues to prescribe the drug. If the Food and Drug Administration (FDA) has issued a statement calling into question the clinical safety of the drug or if the FDA has been notified of a manufacturing discontinuance or potential discontinuance of the drug, the measure does not prohibit modification of coverage. Any insurer that violates the provisions of this measure shall be subject to a civil penalty in an amount determined by the Insurance Commissioner.

SB 144

directs the Insurance Department to compile list of prescription drugs that the Department determines to be essential for treating diabetes. The list will include price increases for said drugs. Any manufacturer of a drug that appears on the list must provide information outlined in the measure to the Department, including the drug’s price, administrative expenditures associated with the drug, profit from the drug, financial assistance received relating to the drug, wholesale acquisition cost of the drug, a history of price increases relating to the drug, the aggregate amount of rebates received relating to the drug, and the cost associated with coupons provided directly to consumers relating to the drug no later than April 1 of each year. The measure directs a manufacturer of a drug that appears on the list to submit a report to the Department describing the reasoning for any increase to the wholesale acquisition cost of the drug. The

measure directs the Department to create and maintain a website showing the list and reports submitted by manufacturers.

SB 142

lowers the price cap on a 30-day supply of insulin from $30.00 to $25.00. The measure also provides that if the price of an FDA-approved diabetes equipment or supply product cost exceeds $35.00, the health benefit plan shall cap the total amount that an insured is required to pay for a 30-day supply at an amount not to exceed $35.00. The measure provides that, if the cost of the 30-day supply, ninety-day supply, or diabetes equipment or supply product is less than the applicable copayment cap, a health benefit plan shall reduce the cost-sharing amount to the lesser assigned copayment.

HB 1843

restores previously stricken language in Section 3, allowing the Insurance Commissioner to censure, suspend, revoke or refuse to issue or renew a license of or levy a civil penalty against any person licensed under the insurance laws of this state for any violation of the Patient’s Right to Pharmacy Choice Act. The amendment also allows for the Attorney General to recommend that a pharmacy benefits manager (PBM) be censured if they are found in violation of the measure, and requires that the Insurance Commissioner take the recommended action.

SB 879

provides that pharmacy benefits manager (PBM) contracts shall not prohibit from or penalize for a pharmacy or pharmacist disclosing to an individual information regarding the existence and clinical efficacy of a generic equivalent nor shall it prohibit or penalize a pharmacy or pharmacist selling a therapeutically equivalent drug that would be less expensive to the enrollee. Additionally, PBM's are required to publish on their website the health plan formulary and timely notification of formulary changes and product exclusions for each of their contracts. The measure directs every PBM to also provide the Insurance Department with a report containing information outlined in the measure. The Department shall publish this information, provided, no information that would disclose the identity of a specific health plan or financially compromise the information shall be published. The measure also provides that an enrollee's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to 100% of all rebates received. The measure provides that any PBM found to have violated this provision shall be subject to a $100.00-$5,000.00 fine for each occurrence. The measure also establishes new requirements for the P&T committee.

SB 768

requires any pharmacy benefits manager (PBM) to provide the Insurance Department with the minimum and maximum wholesale acquisition cost (WAC) of a drug, the minimum and maximum WAC

for each indicated drug and drug group for which the PBM has negotiated directly with the manufacturer, the number of WAC units that were negotiated in the current calendar year, the projected number of WAC units in the current calendar year, rebates and discounts negotiated, projected rebates and discounts, total discounts, projected total discounts, total net income, and projected total net income. Manufacturers shall be required to notify the Department of any increase in the WAC if such an increase 20% of the current cost. Additionally, manufacturers must disclose if they plan to introduce a drug exceeding $670.00 per WAC unit. Distributors shall provide the Department with information in a similar manner as PBM's. Insurers are directed to report spending on prescription drugs before enrollee cost sharing, in total and per prescription drug user, and spending on the top 25 prescription drugs. The report shall also contain information outlined in the measure. Each reporting entity outlined in the measure shall be required to register with the Department beginning January 1, 2024, no later than January 31 of each calendar year. Such entities shall annually pay a $100.00 fee to the Department to register. The Department may impose a maximum $30,000.00 civil penalty on any entity that fails to comply with registration requirements. The Department is directed to publish on its website an annual report on emerging trends in prescription drug prices as well as conduct public hearings based on the report findings beginning July 1, 2024.