SB 146

creates the Access to Lifesaving Medicines Act. The measure prohibits health insurers or pharmacy benefits managers from imposing an excess cost burden on an insured. Pharmacy benefits managers must offer the health benefit plan the option of extending point-of-sale rebates to enrollees of the plan when contracting with a health insurer or health benefit plan. The measure requires prescription drug cost sharing for an insured to be the lesser of applicable copayment for the prescription medication, maximum allowable cost, maximum allowable claims, the adjusted out-of-pocket amount, the amount an insured would pay for the prescription medication if the insured purchased it without using his or her health benefit plan, or amount the pharmacy will be reimbursed for the prescription medication.

SB 881

creates the Surprise Billing Protection Act of 2023. The measure requires health insurance carriers to directly reimburse a nonparticipating provider for emergency care necessary to evaluate and stabilize a covered person if a prudent layperson would reasonably believe that emergency care is necessary. No insurance carrier shall require prior authorization for emergency care, though such an entity may establish a cost-sharing or limitation of benefits requirement for emergency care performed by a nonparticipating provider to the same extent that the copayment, co-insurance or limitation of benefits requirement applies for participating providers and is documented in the policy. Additionally, the measure provides that carriers shall cover nonemergency treatment in

out-of-network facilities in certain conditions. The measure directs the State Department of Health to require each health facility licensed pursuant to the Public Health Act to post certain information outlined in the measure no later than December 31, 2023. The Insurance Commissioner shall review the reimbursement rate for surprise bills by July 1, 2024. If a covered person pays a nonparticipating provider more than the in-network costsharing amount for services provided under circumstances giving rise to a surprise bill, the nonparticipating provider shall refund to the covered person within 45 calendar days of receipt.

SB 850

creates the Task Force on Rural Health Care Reimbursement. The Task Force shall study the care provided by health care providers in rural areas and ensure that items and services provided by health care providers are appropriately reimbursed. The Task Force shall also examine whether insurers discriminate against such providers through intentional denial of payment, breach of fiduciary duty, reimbursement at an amount lower than the in-network costsharing amount, and the provision of lower rates for services. The Task Force shall be comprised of 5 members. The Task Force shall publish its findings and recommendations in a report to be delivered to the Governor, the President Pro Tempore of the Senate, the Speaker of the House, the Chairman of the House Insurance Committee, and the Chairman of the Senate Retirement and Insurance Committee no later than December 1, 2024.

SB 442

requires Any insurer of a health benefit plan to publish an electronic provider directory for each of its network plans, and update the directory every 30 days. The measure requires insurers to make certain that the public has access to the directory and that information surrounding the listed health care professionals, hospitals, and other health care facilities is accurate. Additionally, the measure requires each network plan to have a description of the criteria used to build its provider network in the publication. The insurer will audit its provider directories for accuracy on an annual basis and base it on 4 utilized specialties, with 1 of the specialties focused on mental health.

SB 441

provides that a health benefit plan utilizing a preauthorization process for health care services may exempt a health care provider from obtaining preauthorization for a particular health care service. The health benefit plan shall examine whether the provider meets such exemption requirements once every 6 months, though the plan may continue providing an exemption without examination. The health benefit plan must publish its criteria for obtaining such an exemption and may only deny a provider if the provider does not have the exemption at the time of the relevant evaluation period and if the health benefit plan provides the provider with sufficient data for the relevant preauthorization request period that demonstrates that the provider does not meet the criteria for the exemption. An exemption may only be rescinded in January or June using a retrospective review process for the most

recent evaluation period. Providers may review a determination regarding the recission of a preauthorization exemption using an independent review organization. A health benefit plan is bound by an appeal or independent review determination that does not affirm the determination made by the plan to rescind a preauthorization exemption.

HB 1655

authorizes pharmacists to test and administer treatment for minor, nonchronic health conditions and dispense self-administered hormonal contraceptives and nicotine replacement therapy products.

SB 931

expands the practice of pharmacy to include ordering, performing, and interpreting tests authorized by the Food and Drug Administration and waived under the federal Clinical Laboratory Improvement Amendments of 1988 as well as the initiation of drug therapy for minor, nonchronic health conditions. Minor, nonchronic health conditions are defined by the measure as a typically short-term health condition that is generally managed with noncontrolled drug therapies, minimal treatment, or self-care such as the flu. The measure also expands the practice to include the dispensing of self-administered hormonal contraceptives.

SB 827

authorizes pharmacists to prescribe nonprescription drugs for the purposes of extemporaneous compounding or compounding for a known patient need in the practice area.

SB 228

authorizes pharmacists to enter into a collaborative practice agreement with one or more practitioners. Such an agreement is defined by the measure as a formal agreement in which a licensed practitioner makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.

HB 2117

An Act relating to pharmacy practice agreements; defining terms; providing what health care services pharmacists can provide; providing requirements for health plans and pharmacists; establishing requirements for pharmacist; establishing requirements related to a collaborative agreement; requiring process for patient medical records; provided that employer-employee relationship not created; allowing pharmacists to prescribe contraceptives; providing

exception; requiring promulgation of rules; providing for codification; and providing an effective date.