Leaders in Oncology Legislative Town Hall March 22, 2022

Meeting Recording:

https://zoom.us/rec/share/gz7cHJssXRDK1EPwuPODdCxt1Ss58HwRejhwvkCc7yOTB6lS08_aSKI0G7j5_RS6.o8JdTZIkuvwa2LVW

Access Passcode: &57cySt.

Note - Include the period at the end of password

ONCOLOGY STATE SOCIETIES AT ACCC

ACCC Association of Community Cancer Centers

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Discussion Highlights are included in the Notes Section of each slide

Moderators

Debra Patt MD, PhD, MBA
President, Texas Society of Clinical Oncology

Stephen Schleicher, MD, MBA
President, Tennessee Oncology Practice Society

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Team-Based Approach

- Multi-disciplinary boards…
- Medical Oncology
- Radiation Oncology
- Advanced Practice Providers
- Pharmacy
- Administrators
- Surgical Oncology
- Gynecologic Oncology

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Key Issues

- PBM Reform in the Post-Rutledge era
- Steerage
- DIR Fees
- Prior Authorization control– Gold Carding
- White Bagging
- Access to Care
- Coverage of testing (NGS, mammography)

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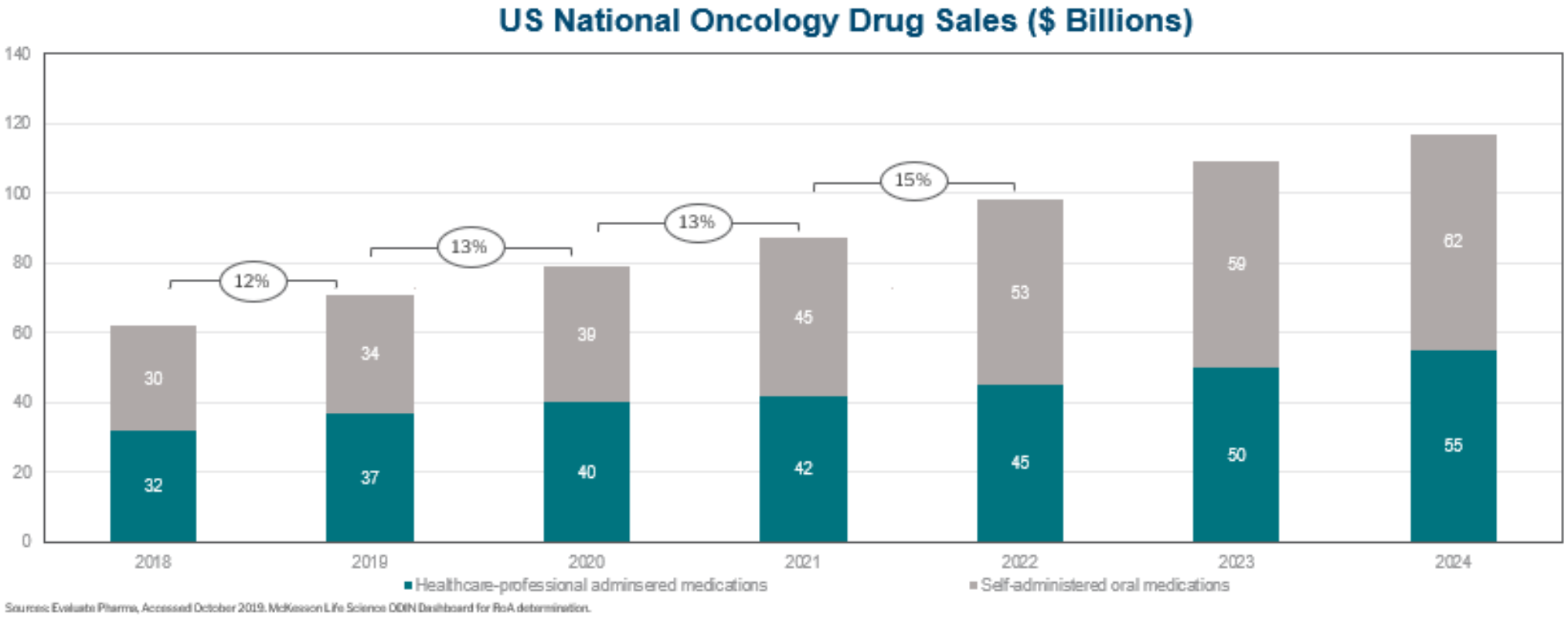
Let's Get Vertical: Insurer + PBM + Specialty Pharmacy + Provider

1. Cigna partners with providers via its Cigna Collaborative Care program. However, Cigna does not directly own healthcare providers.
2. AllianceRx Walgreens Prime is jointly owned by Prime Therapeutics and Walgreens Boots Alliance.

Source: Drug Channels Institute research; *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Chapter 5.

DRUG CHANNELS INSTITUTE

Oncology Landscape



Sources: Evaluate Pharma, Accessed October 2019. McKesson Life Science ODIN Dashboard for RoA determination.

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HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:
EMPLOYEE RETIREMENT INCOME SECURITY ACT | REGULATION | COSTS AND SPENDING | PHARMACY BENEFIT MANAGERS | HEALTH REFORM

The Implications Of *Rutledge v.* PCMA For State Health Care Cost Regulation

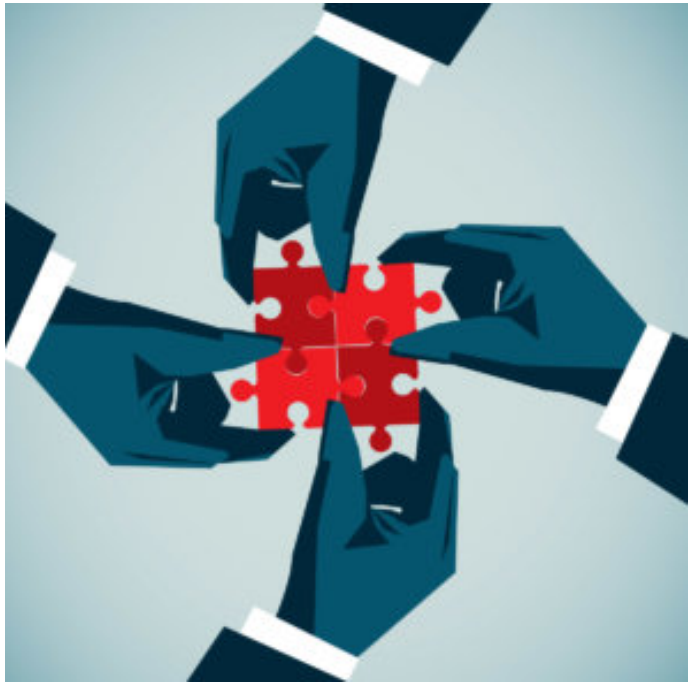
Erin C. Fuse Brown, Elizabeth Y. McCuskey

DECEMBER 17, 2020

10.1377/forefront.20201216.909942

Who are Your Partners?

- Genetic Testing and Next Generation Sequencing
  - ACS CAN
- White Bagging
  - Hospital Systems
- Pharmacy Solutions (Steerage, PBM)
  - Retail Pharmacy
- Professional Societies
  - ACCC, ASCO, COA
  - NCODA, COPA, CHOP
- Patient resources: CPAN, Komen, NPAF



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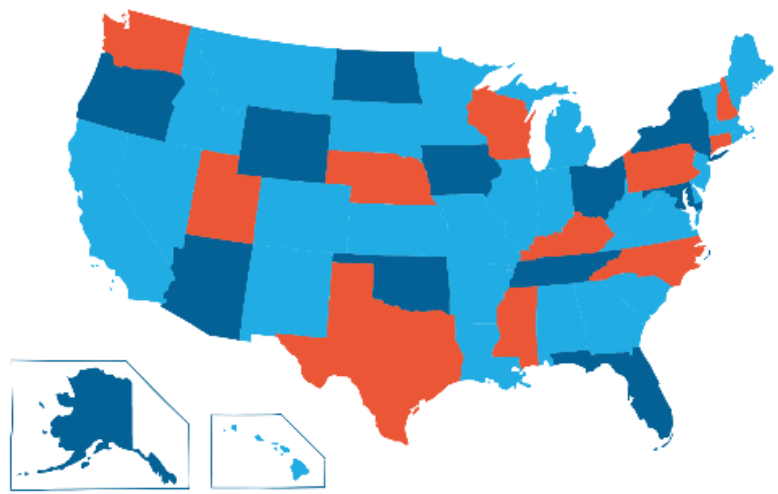
ONCOLOGY LEGISLATION TRACKER

COMPREHENSIVE ONCOLOGY STATE LEGISLATION TOOL

The NCODA Oncology State Legislation Tracking Tool provides comprehensive access to the most up-to-date information on state legislation interests related to oncology health policy. This NCODA member tool allows users to select individual states of interest and access relevant bill numbers, complete bill readings, a brief bill summary and a 'why it matters' section for each bill.

All NCODA Members Have Access To This Tool.



NCODA Legislative Tracker

Information on Texas, Tennessee and Ohio

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Texas

(Last updated 2/24/22)

		Summary	Why it Matters?
Co-pay Accumulator/Maximizer Information	Currently no active legislation against copay accumulators/maximizers	N/A	N/A
PBM Information	**Previous Bills:** From 2021: **HB 2658: Relating to the Medicaid program, including the administration and operation of the Medicaid managed care program** (Law passed 6/16/21) https://www.tahp.org/news/568604/Medicaid-Monday-Legislative https://legiscan.com/TX/text/HB2658/2021 https://legiscan.com/TX/supplement/HB2658/id/200954 **HB 18: Relating to establishment of the prescription drug savings program for certain uninsured individuals** (Law passed 6/15/21) https://legiscan.com/TX/text/HB18/2021 https://www.texaspharmacy.org/news/565515/Texas-Legislature-Passes-PBM-Reform-Bill-Headed-to-Governor.htm **HB 1763: Relating to the contractual relationship between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager** (Law passed 5/26/21) https://legiscan.com/TX/text/HB1763/2021 https://www.texaspharmacy.org/news/565515/Texas-Legislature-Passes-PBM-Reform-Bill-Headed-to-Governor.htm **HB 1919: Relating to prohibited practices for certain health benefit plan issuers and pharmacy benefit managers.** (Law passed on 6/18/21) https://legiscan.com/TX/text/HB1919/2021 https://www.texaspharmacy.org/news/565515/Texas-Legislature-Passes-PBM-Reform-Bill-Headed-to-Governor.htm	**HB 2658:** This law: (1) Makes sure that the Texas Health and Human Services Commission (HHSC) and Medicaid managed care organizations work together to make medication therapy management (MTM) services more affordable (2) Grants two back to back periods of eligibility (for 12 months back-to-back) for the Medicaid program for children (3) Makes sure that the HHSC grants at least one preventive dental care visit each year for an adult with a disability who is enrolled in the STAR+PLUS Medicaid managed care program. **HB 18:**This law establishes the Texas Cares Program and a trust fund, which will provide lower costs for prescription drugs to those who are uninsured. It also makes pharmacy benefit managers and other vendors to arrange drug rebates covered by this program. The rebate will count when the individual buys their prescription, however, they are still responsible for any remaining cost-share amounts. **HB 1763:** This law stops pharmacy benefit manager	**HB 2658:** By making sure the time a child is elibible for coverage with the Medicaid program is extended, parents will have more time to make sure they are able to get coverage for their child and prevent any medical problems that may arise from not having coverage. Also, having coverage for at least one dental prevental dental care visit per year for adults with disabilities will lead to less costs, less visits to the emergency room, and improve health overall. **HB 18:** If an individual does not have health insurance, this law, by allowing rebates to count towards a prescription's cost, will help reduce what the individual has to pay for their medication. This can be very helpful when it comes to expensive medications (including brand names) for those without health insurance, and help them to get the treatment they need. **HB 1763:** By preventing "claw backs" from pharmacy benefit managers, pharmacies will not be caught off guard with fees that come in weeks/months after a prescription was filled. This may help keep many pharmacies stay in business
Other legislative/advocacy news	**Previous Bills:** From 2021: **HB 428: Relating to health benefit plan coverage for ovarian cancer testing and screening** (Law Passed 6/7/21) https://legiscan.com/TX/text/HB428/2021 **SB 1028: Relating to health benefit plan coverage for colorectal cancer early detection** (Law Passed 6/4/21) https://legiscan.com/TX/text/SB1028/2021 https://legiscan.com/TX/supplement/SB1028/id/202111	**HB 428:** This law expands coverage for ovarian cancer testing and screening by including coverage for any other test or screening approved by the United States Food and Drug Administration (U.S FDA) for the detection of ovarian cancer. This is in addition to coverage for: (1) a CA 125 blood test, and (2) a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the U.S FDA, alone or in combination with a test approved by the U.S FDA for the detection of the human papilloma virus.	**HB 428:** Through this expansion in coverage, patients will have increased access to ovarian cancer testing and screening and will be able to obtain the necessary testing and screening, allowing them to seek treatment in a timely manner. This will allow patients to avoid harm from delays in treatment. **SB 1028:** Through these requirements, patients in Texas will have increased access to screening examinations for colorectal cancer, allowing them to

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Summary of PBM Steerage

HB 2658: This law: (1) Makes sure that the Texas Health and Human Services Commission (HHSC) and Medicaid managed care organizations work together to make medication therapy management (MTM) services more affordable (2) Grants two back to back periods of eligibility (for 12 months back-to-back) for the Medicaid program for children (3) Makes sure that the HHSC grants at least one preventive dental care visit each year for an adult with a disability who is enrolled in the STAR+PLUS Medicaid managed care program.

HB 18: This law establishes the Texas Cares Program and a trust fund, which will provide lower costs for prescription drugs to those who are uninsured. It also makes pharmacy benefit managers and other vendors to arrange drug rebates covered by this program. The rebate will count when the individual buys their prescription, however, they are still responsible for any remaining cost-share amounts.

HB 1763: This law stops pharmacy benefit manager clawbacks, which lower the amount paid to a pharmacy for a prescriptions that was filled weeks/months ago. Pharmacies are also protected against any retaliation by pharmacy benefit managers for lodging appeals/complaints against them. - It also makes sure patients have a choice in how they get their medication from their local pharmacy by allowing those pharmacies to mail/deliver the medication if the patient requests it. It will also stop pharmacy benefit managers (PBM) from directing patients to only use a PBM-owned specialty pharmacy.

HB 1919: This law makes sure that an individual's health plan or a pharmacy benefit manager does NOT direct the individual to only use the health plan or pharmacy benefit manager's affiliated provider in any way (not through online messaging, advertisements, marketing and promotions). This law also stops the health plan or pharmacy benefit manager from: • Using lower cost measures to direct an individual to use their affiliated provider • Using patient/provider specific information for commercial reasons - This bill also requires a patient's consent before the patient's health plan or a pharmacy benefit manager can transfer the patient's prescription to their affiliated provider

Why it matters?

HB 2658: By making sure the time a child is eligible for coverage with the Medicaid program is extended, parents will have more time to make sure they are able to get coverage for their child and prevent any medical problems that may arise from not having coverage. Also, having coverage for at least one dental care visit per year for adults with disabilities will lead to less costs, less visits to the emergency room, and improve health overall.

HB 18: If an individual does not have health insurance, this law, by allowing rebates to count towards a prescription's cost, will help reduce what the individual has to pay for their medication. This can be very helpful when it comes to expensive medications (including brand names) for those without health insurance, and help them to get the treatment they need.

HB 1763: By preventing "claw backs" from pharmacy benefit managers, pharmacies will not be caught off guard with fees that come in weeks/months after a prescription was filled. This may help keep many pharmacies stay in business and provide its services to patients within their community, which is especially important for pharmacies in rural areas. Also, stopping pharmacy benefit managers from leading patients to get their medication only from specialty pharmacies owned by these pharmacy benefit managers will allow patients the chance to get their medication from the most beneficial source. This is important when it comes to anti-cancer medications, for which there can be significant benefit from patients using medically integrated dispensing facilities.

HB 1919: With these restrictions on an individual's health plan and a pharmacy benefit manager, the individual's best interests and personal choice in whom they receive treatment from are protected. This helps to make sure that patients maintain their existing relationships with their provider/pharmacy and continue to receive lifesaving medication, which is especially important in cancer patients.

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Summary

HB 2090: This law makes sure that an individual's health insurance plan to provide information on prices for medical visits/procedures and the individual's cost-sharing requirements for specific preventive or non-preventive health care service when the individual requests it. The provided cost-sharing information must accurate and would have to explain, in plain language, balance billing, actual charges, cost-sharing liability of the individual, copayment assistance, and other information that is appropriate. Also, the information can be provided through an app or other internet-based self-services.

HB 3459: This law makes changes to prior authorizations and utilization review procedures for physicians and other healthcare providers for health insurance policies and health maintenance organizations. Also: • If the physician or provider submitted at least five prior authorization requests for a health care service in the previous year and at least 80 percent of those requests were approved by that health benefit plan, the physician/provider is exempt from the prior authorization requirements • If a physician has to undergo a utilization review, the utilization review agent would have to be a physician licensed to practice in Texas in the same or similar specialty as the physician who has to undergo a utilization review.

Why it matters?

HB 2090: By requiring health plans to reveal certain health care cost information to the individual under that plan, those individuals will be able to make more informed decisions about their health care before they receive health care services.

HB 3459: With these restrictions on prior authorization requirements for physicians and providers, they will be able to make sure that their patients are receiving reasonable and adequate treatment in a timely manner. Also, patients will benefit from avoiding potential delays caused by prior authorization requirements, allowing them to avoid potential harm that may arrive because of delays to obtaining their treatment/medication.

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Ohio

(Last updated 2/23/22)

		Summary	Why it Matters?
Co-pay Accumulator/Maximizer Information	**Previous Bills:** From 2021: **This bill has not left Health committee on health since 2021** **HB 135: Prohibit certain health insurance cost-sharing practices** (Chamber: House; Action: Reported: Health on 3/16/21; Introduced: 2/18/21) https://legiscan.com/OH/text/HB135/2021	**HB 135:** This bill makes sure that health insuring corporations (including sickness and accident insurers) do NOT exclude any amounts paid by a covered individual (or someone on his/her behalf) when calculating the individual's contribution to any cost-sharing requirement of their health plan (including any coverage limit,	**HB 135:** By including all amounts paid by covered individual (or on his/her behalf) for a prescription drug and counting them towards the individual's cost-sharing responsibility under his/her health plan, the covered individual will be able to get their prescription faster, easier, and stay healthy.
PBM Information	**Previous Bills:** From 2021: **HB 336: Regards health plan issuers, Medicaid, pharmacies, cancer drugs** (Chamber: House; Action: Refer to Committee: Insurance on 6/10/21; Introduced: 6/7/21) https://legiscan.com/OH/bill/HB336/2021 https://legiscan.com/OH/supplement/HB336/id/210070/Ohio-2021-HB336-As_Introduced.pdf **HB 451: Revise physician-administered drug law** (Chamber: House; Action: Refer to Committee: Insurance on 10/13/21; Introduced: 10/12/21) https://legiscan.com/OH/text/HB451/2021	**HB 336:** This bill enhances fair auditing practices including limiting penalties to pharmacies solely based on the fact that all materials requested by the auditing entity are not available during the audit, giving pharmacies the opportunity to provide supplemental material after completion of an audit, and limiting audits to 250 prescriptions or the number of prescriptions dispensed in the pharmacy in the last 2 years (whichever	**HB 336:** Through these requirements, pharmacies will experience fair auditing and reimbursement practices, allowing them to better manage their costs and continue providing services to patients in their communities. Patients will also have more freedom in which pharmacy they choose to use that is the most convenient and beneficial for them. Cancer patients will be able to obtain their medications faster and avoid delays in their cancer treatment. Also, dangerous drugs
Other legislative/advocacy news	**Previous Bills:** From 2021: **HB 371: Regards screening mammography and dense breast tissue** (Chamber: Senate; Action: Refer to Committee: Health on 11/30/21; Engrossed: 11/18/21) https://legiscan.com/OH/text/HB371/2021 _____ Article: https://insidehealthpolicy.com/inside-drug-pricing-daily-news/ohio-medicaid-demands-accounting-pbm-pharmacy-clawback-fees **- Ohio Medicaid Demands Accounting Of PBM Pharmacy Clawback Fees (By Gabrielle Wanneh / January 7, 2022 at 6:06 PM):** The buckeye state has requested an account of so-called clawback fees that pharmacy benefit managers charged pharmacies during 2020 and 2021 to crack down on the practice. In a Dec. 22 memo, the Ohio Medicaid department asked five managed care plans to report on the price concessions that their pharmacy benefit managers retroactively charge pharmacies. Ohio law requires PBMs to subtract those price concessions when they charge Medicaid, and state health officials want to know whether PBMs are abiding by that law. They want a list of all effective-rate contracts and the maximum time allowed under the contracts for payments to pharmacies to be finalized.	**HB 357:** This bill expands the definition of screening mammogram to include digital breast tomosynthesis and adds a new definition for supplemental breast cancer screening to be additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening including magnetic resonance imaging, ultrasound, or molecular breast imaging. The bill expands coverage to cover expenses for 1 screening mammogram every year, including breast tomosynthesis. The bill also requires coverage for supplemental breast cancer screening for adult women who: 1) has a screening mammogram that demonstrates dense breast tissue	**HB 357:** Through these expansions, women will be covered for breast cancer screenings, allowing them to seek treatment ahead of time. This will lead to patients avoiding delays in treatment and positive healthcare outcomes.

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Summary of Copay & PBM Bills

HB 135: This bill makes sure that health insuring corporations (including sickness and accident insurers) do NOT exclude any amounts paid by a covered individual (or someone on his/her behalf) when calculating the individual's contribution to any cost-sharing requirement of their health plan (including any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements). These requirements do not apply for brand name drugs with generic alternatives; unless the covered individual's prescriber determines that the brand prescription drug is medically necessary.

HB 336: This bill enhances fair auditing practices including limiting penalties to pharmacies solely based on the fact that all materials requested by the auditing entity are not available during the audit, giving pharmacies the opportunity to provide supplemental material after completion of an audit, and limiting audits to 250 prescriptions or the number of prescriptions dispensed in the pharmacy in the last 2 years (whichever is LESS). The bill also STOPS health plans and pharmacy benefit managers (PBMs) from directing covered individuals to fill a prescription from an affiliated pharmacy, limit their ability to select or use a pharmacy, and implement different cost-sharing requirements on them. Health plans and PBMs must allow pharmacies to join their network if they agree to terms and conditions.

- The bill also require health plans and PBMs to set forth proper a proper incentive payment and adjustment system for pharmacies (which analyzes performance payments, rebates, fees, etc.) based on ACTUAL data received and NOT from an extrapolation of a sample of data. This system must NOT favor affiliated pharmacies or discriminate against non-affiliated pharmacies. The bill also STOPs a pharmacy from mailing a dangerous drug to a patient when an in-person consultation is required, unless the patient waives the consultation and elects to receive the dangerous drug via mail order
- In this bill, a clean claim is a claim that can be processed without obtaining additional information from the prescribing provider, not for someone who receives financial assistance for the drug, and is not for a drug that has a national drug shortage. This bill requires health plans and PBMs to make sure that a covered individual can receive oral cancer drugs within 72 hours after submission of a clean claim or prior authorization request and, if this cannot be done, they must cover the drug even if it is purchased from an out-of-network pharmacy/physician.

HB 451: This bill STOPs health benefit plans from: 1) Requiring physician-administered drugs to be dispensed only by a pharmacy or affiliated pharmacy in order for the covered individual to obtain coverage 2) Limit or exclude coverage for physician-administered drugs when it is NOT dispensed by a pharmacy or affiliated pharmacy 3) Cover the clinician-administered drug administered at a physician's office, hospital outpatients infusion center, or other out-patient clinical setting at a DIFFERENT benefits tier or with MORE EXPENSIVE cost-sharing requirements than if the patient used a pharmacy.

- In this bill, a health benefit plan includes a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans.

Why it matters?

HB 135: By including all amounts paid by covered individual (or on his/her behalf) for a prescription drug and counting them towards the individual's cost-sharing responsibility under his/her health plan, the covered individual will be able to get their prescription faster, easier, and stay healthy.

HB 336: Through these requirements, pharmacies will experience fair auditing and reimbursement practices, allowing them to better manage their costs and continue providing services to patients in their communities. Patients will also have more freedom in which pharmacy they choose to use that is the most convenient and beneficial for them. Cancer patients will be able to obtain their medications faster and avoid delays in their cancer treatment. Also, dangerous drugs will not be mailed to a patient (unless requested by the patient) if an in-person consultation is required, allowing patients to remain safe with their treatment and avoid complications.

HB 451: This bill will allow patients greater access to drugs that need to be administered by a physician without the worry of additional cost-requirements or limitations on where they can have the drug administered.

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Tennessee

(Last updated 2/24/22)

		Summary	Why it Matters?
Co-pay Accumulator/Maximizer Information	**Previous Bills:** From 2021: **HB 619: AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, relative to pharmacy benefits.** (Law passed on 5/18/21; substituted for SB 1397) https://legiscan.com/TN/text/HB0619/2021	**HB 619:** This law makes sure that an individual's health plan (including Pharmacy Benefit Managers) counts everything (including coupons) the individual (or anyone on their behalf) has paid for their prescription toward their out of pocket expenses.	**HB 619:** By making sure an individual's discounts and other expenses made for their prescription count toward their health plan's cost requirements, the individual will be able to get their prescription faster, easier, and stay healthy.
PBM Information	**2022 Bills:** **SB 603: AN ACT to amend Tennessee Code Annotated, Title 4; Title 8; Title 33; Title 47; Title 56; Title 63; Title 68 and Title 71, relative to health care.** (Chamber: Senate; Action: Assigned to General Subcommittee of Senate Commerce & Labor Committee on 2/23/22; Introduced: 2/9/21) https://legiscan.com/TN/supplement/SB0603/id/186372 https://legiscan.com/TN/text/SB0603/2021 **SB 2456: AN ACT to amend Tennessee Code Annotated, Title 4; Title 56 and Title 71, relative to pharmacy benefits** (Chamber: Senate; Action: Passed on Second Consideration, refer to Senate Commerce and Labor Committee on 2/7/22; Introduced: 2/2/22) https://legiscan.com/TN/text/SB2456/2021 **Previous Bills:** From 2021: **HB 145: AN ACT to amend Tennessee Code Annotated, Title 4; Title 53; Title 56; Title 63; Title 68 and Title 71, relative to pharmacy benefits managers.** (Chamber: Senate; Action: Received from House, Passed on First Consideration on 4/15/21; Introduced: 1/12/21) & **SB 1403: AN ACT to amend Tennessee Code**	**SB 603:** This bill requires a health plan providing a network plan to maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve mostly low income, medically underserved individuals, to make sure that all covered services to covered individuals (including children and adults) will be accessible WITHOUT unreasonable travel or delay (including access to emergency services, without unreasonable travel or delay, 24 hours a day 7 days a week). This bill also requires a health plan to have a process that allows covered individuals to obtain covered benefits	**SB 603:** Through these requirements, patients (especially those residing in rural or underserved areas) will gain more access to healthcare services, allowing them to obtain treatment in a timely manner. Patients will also better afford medical services, even if it's provided by a prover that is not participating within the network of the patients' health plan(s). **SB 2456:** With this extension to 30 days, pharmacists will have more time to prepare for an audit, which will potentially reduce the number or errors and fines that may occur. This will allow pharmacies to better manage
Other legislative/advocacy news	**2022 Bills:** **HB 1719: AN ACT to amend Tennessee Code Annotated, Title 5; Title 7; Title 56; Title 68 and Title 71, relative to an assessment on ground ambulance service providers** (Chamber: Senate; Action: Received from House, Passed on First Consideration on 3/3/22; Engrosed 3/1/22) & **SB 1872: AN ACT to amend**	**HB 1719 & SB 1872:** These bills extend the "Ground Ambulance Service Provider Assessment Act" to June 30, 2023. They also enhance	**HB 1719 & SB 1872:** Through this extension, patients will have more access to enhanced emergency medical pre-hospital services, which

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Summary of Copay & PBM Bills

HB 619: This law makes sure that an individual's health plan (including Pharmacy Benefit Managers) counts everything (including coupons) the individual (or anyone on their behalf) has paid for their prescription toward their out of pocket expenses.
• This law is valid as long as the individual's prescription does NOT have a generic (unless the individual's brand name prescription was obtained through a prior authorization, a step therapy protocol, or exceptions and appeals process from their health insurance plan).

SB 603: This bill requires a health plan providing a network plan to maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve mostly low income, medically underserved individuals, to make sure that all covered services to covered individuals (including children and adults) will be accessible WITHOUT unreasonable travel or delay (including access to emergency services, without unreasonable travel or delay, 24 hours a day 7 days a week). This bill also requires a health plan to have a process that allows covered individuals to obtain covered benefits at an in-network level of benefits from a non-participating provider. This process must treat the healthcare services the covered person receives from a non-participating provider as if the services were provided by a participating provider, including applying the covered individual's cost-sharing for the services toward any maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

SB 2456: This bill extends from 2 weeks to 30 days the period of time a pharmacist or pharmacy must be provided written notice prior to a covered entity, pharmacy benefits manager, the state or a political subdivision of the state, or a party representing such entity begins an initial on-site audit for an audit cycle.

HB145 & SB 1403: These bills reduce the amount of time a pharmacy benefit manager (PBM) has to make any adjustments to the maximum allowable cost (MAC) of the drug or medical product/device after a pharmacy's appeal has been determined to be valid. More specifically, the amount of time decreases, from 3 business days to 2 business days. • A recent proposed amendment to these bills requires PBMs to show that they prioritize the best interests of the individuals under their health plan over the interests of the associated pharmacy, pharmacists, or health plan. The amendment also places more strict licensing requirements of PBMs and requires the development of a way to receive and process complaints against PBMs from individuals under the health plan, providers, pharmacists, and pharmacies.

HB 1349 & SB 1206: These bills increase the time period that an audit of a pharmacist or pharmacy can NOT be scheduled or started from the first 7 days of the month to the first 10 days of the month because of high number of prescriptions in that pharmacy.

Why it matters?

HB 619: By making sure an individual's discounts and other expenses made for their prescription count toward their health plan's cost requirements, the individual will be able to get their prescription faster, easier, and stay healthy.

B 603: Through these requirements, patients (especially those residing in rural or underserved areas) will gain more access to healthcare services, allowing them to obtain treatment in a timely manner. Patients will also better afford medical services, even if it's provided by a prover that is not participating within the network of the patients' health plan(s).

SB 2456: With this extension to 30 days, pharmacists will have more time to prepare for an audit, which will potentially reduce the number or errors and fines that may occur. This will allow pharmacies to better manage their cost and time, to continue providing services to patients in their communities.

HB 145 & SB 1403: Through these restrictions, there will be more oversight on pharmacy benefit manager practices and reduce abuses in power. More specifically with the amendment, PBMs will be forced to focus on the patient's needs over other entities involved and avoid violations.

HB 1349 & SB 1206: Through this extension, pharmacies will have more time to prepare for an audit, which can be a time consuming process with consequences for pharmacies with a high number of prescriptions every day. Pharmacists will have more time to focus on other tasks, such as making sure the patients they serve are able to get their medications in a timely manner.

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Summary

HB 1398 & SB 1617: This law stops pharmacy benefit managers (PBMs) and health plans from discriminating against 340B covered entities through unfair or lower reimbursements, additional fees, and exclusion from participating in the pharmacy network. The law also requires PBMs to allow a covered individual to obtain prescription drugs, including specialty drugs, from a physician's office, hospital outpatient infusion center providing and administering the prescription drug, or pharmacy and must not charge additional fees for this. PBMs are not to interfere with the patient's choice of pharmacy or provider in anyway (including steering or directing them to another pharmacy or using financial incentives).

• The law also stops a PBM from charging a covered entity an amount greater than the reimbursement paid by a PBM to a contracted pharmacy for the prescription drug or device. The law requires a covered entity to provide the cost, benefit and coverage data (which is accurate and in real-time) upon request of a covered individual (or a his/her representative or healthcare provider). The law stops health plans from hindering/penalizing/stopping a healthcare provider from talking about alternative and more affordable treatment options for their patients.

HB 1530 & SB 1249: This bill requires a health plan or pharmacy benefit manager (PBM) to provide data for each drug covered under an individual's health plan that includes list of covered clinically appropriate alternatives, cost-sharing information, and utilization management requirements (including prior authorization, step therapy, quantity limits, and site-of-service restrictions). If this information is requested by the covered individual or his/her doctor, the PBM must make sure that it is accurate and provided in real-time. PBMs also cannot delay providing this information nor can they PENALIZE or STOP a patient's healthcare provider from sharing this information with their patients.

Why it matters?

HB 1398 & SB 1617: With these requirements and restrictions, pharmacy benefit managers and health plans will not be able to discriminate against 340B covered entities (including pharmacies) in terms of reimbursements or opportunities to join the network. This will allow those pharmacies to better manage their costs and provide increased access to care for patients. Also, patients will be well aware of alternative and less expensive medication options available, allowing them to get the treatment that they need without delay.

HB 1530 & SB 1249: Through these requirements, healthcare providers will be more informed about their patients' cost sharing requirements as well as covered alternative drugs which may be more affordable for their patients. Patients will also be well aware of this information. As a result, healthcare providers will be able to better guide their treatment plans to make sure it is reasonable and appropriate for their patients, leading to greater access of care for patients in a timely manner.

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Thank you

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