The Texas Association of Health Plans

ALL REFERRED PBM BILLS

03-18-2023 - 09:11:59

Select All Deselect All

HB 25 Talarico, James Wholesale prescription drug importation

Remarks: SUMMARY: This bill would create a "wholesale prescription drug importation program," allowing contracts with wholesalers to seek importation of prescription drugs from Canadian suppliers. The bill would place guardrails on the program to ensure safety, and it would require annual reporting on participation, savings, and implementation. The program may be extended to other countries allowed by federal law to import drugs to the US.

TAHP POSITION: Support

EFFECTIVE DATE: 9/1/23

DATE UPDATED: 2/3 JB 2/21 JL

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 235 Howard, Donna Allow Pharmacists to Test/Treat

Companions:

HB 2049	Howard, Donna(D)	(Refiled from 87R Session)

Remarks: SUMMARY: This bill would allow pharmacists to furnish a prescription drug to a patient under a physician's written protocol. It would allow a pharmacist to perform rapid strep tests and rapid flu tests, and then furnish prescriptions to treat those acute conditions. The bill also provides that a pharmacist may not furnish a prescription drug under that section unless the pharmacist has completed a training program that is approved by the board and is relevant to the condition treated

by the drug.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: TAHP supports reducing barriers to care. Numerous states have safely expanded authority to pharmacists to allow testing and treatment for a small number of illnesses. Because of provider shortages Texans often lack easy access to primary care providers. Expanding pharmacist authority will allow patients to access treatments quickly and affordably for certain illnesses.

DATE UPDATED: 2/1 KS

Last Action: 2-23-23 H Introduced and referred to committee on House Public Health

HB 594 Shaheen, Matt Expands Telepharmacy

Remarks: SUMMARY: This bill would remove current restrictions on telepharmacy, such as restrictions on facilities it may be used in, the restrictions on locations eligible to be remote dispensing sites, and the requirement that pharmacists make at least monthly on-site visits to remote dispensing sites. The bill would also allow remote dispensing of CSIIs and remove the mileage limitations between remote sites and pharmacies.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: Since 2017, Texas has allowed limited access to telepharmacy services in certain rural and underserved communities. TAHP supports removing barriers to pharmacy care. This bill increases access to pharmacists, particularly in rural and underserved communities. Telemedicine has proven to be an effective and efficient way to provide quality care to patients, reducing costs and time associated with in-person visits. By allowing licensed pharmacists to offer telehealth services, patients will have greater access, regardless of their location, leading to improved patient outcomes and reduced healthcare costs. The demand for remote care is growing, making telemedicine and telehealth increasingly important in the future of healthcare. However, TAHP cautions against imposing any payment parity mandates that would undermine potential cost savings and innovation.

DATE UPDATED: 2/1 KS, 2/12 BH

Last Action: 2-28-23 H Rereferred to Committee on House Public Health

HB 595 Shaheen, Matt Physician Dispensing of Drugs

Companions:

HB 456	Shaheen, Matt(R)	(Refiled from 87R Session)

Remarks:

SUMMARY: This bill allows physicians to dispense prescription devices or drugs to their patients that are not controlled substances, including Schedules I through V or Penalty Groups 1 through 4 of Chapter 481 (Texas Controlled Substances Act). It also allows them to charge their patients for these drugs. The bill also removes important consumer protections. Section 5 of the bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with, including applicable labeling requirements and overseeing compliance with packaging and record-keeping. It also repeals the requirement that physicians who want to dispense dangerous drugs notify the Board of Pharmacy and the Medical Board of their intention to do so.

TAHP POSITION: Neutral/Monitor

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/12/23 BH

Last Action: 2-28-23 H Rereferred to Committee on House Public Health

HB 605 Shaheen, Matt MCO Negotiated Rate Disclosure lege

Remarks: SUMMARY: Requires MCOs and plans who contract with the state to provide to a legislator who requests it information regarding any negotiated rate for health care services included in a contract between the vendor and the state. Prohibits legislators and legislative staff from disclosing the information received to anyone not eligible to receive it. Provides that plans who provide confidential information or information that is otherwise excepted from disclosure do not waive their right to assert exceptions in the future or any right to confidentiality.

TAHP POSITION: Neutral as negotiated

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: TAHP worked with the author to ensure requests for information from legislative offices are directed to state agencies, first, to ensure a trackable chain of command. If the agency does not provide the information, legislators may request it directly from third party vendors. HB 605 will also be amended to strengthen the existing correlation between the appropriate standards of conduct and ethics policies with the requests. Finally, HB 605 will require disclosure of drug rebates to legislators.

DATE UPDATED: 2/24 by JL

Last Action: 2-23-23 H Introduced and referred to committee on House State Affairs

HB 638 Toth, Steve Right to Try Chronic Rx - Not coverage mandate

Remarks: SUMMARY: This bill would allow patients to access investigational drugs if they have severe chronic disease and the patient's physician has considered all treatment options approved by the FDA and determined that they are unlikely to provide relief. This bill does not create a new insurance mandate.

TAHP POSITION: Neutral as long as a coverage mandate is not added

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/3/23 JB

Last Action: 2-23-23 H Introduced and referred to committee on House Public Health

HB 755 Johnson, Julie Limits PAs to 1 to Year Autoimmune/Chronic

Companions:

SB 1150	Menendez, Jose(D)	(Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services		

Remarks:

SUMMARY: This bill would prohibit issuers that provide prescription drug benefits from requiring more than one preauthorization annually for a drug prescribed to treat a chronic or autoimmune disease.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers. Related legislation focusing on severely restricting PAs from the prior legislative session created a fiscal note of $169 million for TRS & ERS alone. Prior authorizations for prescription drugs are safety checks for appropriateness and patient risk based on FDA guidelines and medical guardrails. For example, in response to concerns about the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal — medications that can have serious side effects in children — in 2011, Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect those children. Accutane, a common medication for chronic acne, can cause birth defects and should never be used in pregnant women. Prior authorization safety checks can flag these issues and protect patients, however, moving to a single annual prior authorization for all chronic conditions would put patients at risk of missed drug interactions and other safety concerns. Prior authorizations for prescription

drugs protect patients from opioid abuse and severe drug interactions or reactions. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors. These adverse drug events (ADEs) account for more than 3.5 million physician office visits and 1 million emergency department visits each year.

Texas also has some of the strongest patient protections for PAs. Prior authorizations are required to be:

Evidence based: All prior authorization criteria must be based on evidence-based care developed and adopted by the medical community

Heavily regulated: Each step of the process is regulated, starting with TDI licensure or certification as a Utilization Review (UR) Agent

Reviewed quickly: Most prior authorizations are required to be processed in Texas within 3 calendar days—some of the shortest time frames in the country

Transparent: All prior authorization requirements are required to be transparent and posted on health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

LAST UPDATED: BH 2/20

Last Action: 2-28-23 H Introduced and referred to committee on House Insurance

T HB 756 Johnson, Julie — Mandates 24/7 Telephone Access for PAs/UR

Companions: SB 1149 Menendez, Jose(D) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill expands the hours during which issuers must have appropriate personnel available to receive requests for payment verification and requests for preauthorization to 24 hours a day and 365 days a year, including weekends and legal holidays. Currently, issuers must have personnel available 6am to 6pm, Monday through Friday, and 9am to 12pm on weekends and holidays, and outside of those hours be able to respond to requests within 24 hours.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 1/19/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and creates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours.

Moreover, there is no evidence to suggest that this requirement would improve patient outcomes or reduce healthcare costs, making it a potentially unnecessary burden on the healthcare system. Instead, a better solution would be to follow the federal government's recommended reforms to implement electronic prior authorizations, which could reduce costs and streamline the process, making it easier for providers to obtain necessary approvals. For pharmacy authorizations, around 60% of new prior authorizations are already received electronically, suggesting that there may be limited additional value in requiring health plans to have a 24/7 phone line for receiving new authorizations. By requiring the use of electronic prior authorizations, Texas could stay up to date with current best practices and provide a more effective and efficient prior authorization system for patients and providers. This approach could improve the overall quality and availability of healthcare in the state while reducing costs for both health plans and patients.

DATE UPDATED: 2/21 KS

Last Action: 2-28-23 H Introduced and referred to committee on House Insurance

HB 814 Thierry, Shawn Opioid Warning Label

Companions:	HB 849	Thierry, Shawn(D) (Refiled from 87R Session)

Remarks: SUMMARY: Prohibits pharmacists from dispensing an opioid without providing, receiving, and maintaining an acknowledgment form providing a warning about the risks of opioid addiction and overdose. Requires the Board to adopt by rules an acknowledgment form to be signed on receipt of an opioid that must include language substantially similar to "WARNING: THIS DRUG IS AN OPIOID. THE USE OF AN OPIOID MAY RESULT IN ADDICTION TO OPIOIDS AND DEATH," in all capital letters and printed in 14-point font.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED:2/3/23 JB

Last Action: 3- 1-23 H Introduced and referred to committee on House Public Health

HB 815 Thierry, Shawn Red Cap Opioid Safety Act

Remarks: SUMMARY: "Red Cap Opioid Safety Act" - Requires pharmacists to dispense opioids in "distinctive packaging" (a bottle with a distinctive red cap or a container with a conspicuous red label).

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

Last Action: 3- 1-23 H Introduced and referred to committee on House Public Health

HB 826 Lambert, Stan Permanent Formulary Freeze Mandate

Companions:	HB 1646	Lambert, Stan(R)	(Refiled from 87R Session)
	SB 1142	Zaffirini, Judith(D)	(Refiled from 87R Session)
	SB 1221	Zaffirini, Judith(D)	(Identical)
		3- 9-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: This bill would prohibit a health plan from ever making any change to a patient's benefits for a drug they are taking. This means a

health plan cannot even increase the copay amount by $5 or reduce the maximum drug coverage amount by $5, even at the annual renewal of the benefit plan, and even if the drug has been replaced on the health plan's formulary by a better or lower-priced drug. This mandate is referred to as a "permanent formulary freeze." This formulary freeze would apply to any enrollee taking a drug if: (1) the enrollee was covered by the benefit plan preceding the renewal date, (2) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness, and (3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment. The bill also expands notice requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

EFFECTIVE DATES: D, I, R 1/1/24

TAHP POSITION STATEMENT: TAHP is opposed to any new government mandate that permanently freezes health plan formularies and undermines important efforts by health plans to negotiate lower drug prices, ultimately driving up the cost of coverage for Texas employers, families, and taxpayers.

Texas already leads the nation with the strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That's the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can't be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable

mandate. Under a permanent “formulary freeze,” plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn’t make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a formulary freeze because once they have a patient on a drug, they’ll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

New mandates and overregulation hinder innovation, increase costs, and often provide no additional value for Texans and Texas employers. Employers and families bear the additional expense through increasingly unaffordable premiums. This is particularly true for small employers who have limited resources to absorb added costs. Moreover, families face increasingly unaffordable premiums as a result of overregulation.

Texas is already one of the most heavily regulated states when it comes to health care, ranking third in the nation for regulations that go beyond the federal requirements of the Affordable Care Act (ACA). As a result, small business owners in Texas consistently rank the cost of health insurance as their single biggest problem since 1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees.

Furthermore, TAHP opposes expensive mandates like this that raise costs for employers and families but do not apply to elected officials’ personal health insurance and their employees’ coverage through ERS. Texas legislators should not force costly regulations and mandates on employees and families when they are not willing to pay for it with their personal coverage.

DATE UPDATED: 2/3/23 BH

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

HB 839 Gonzalez, Jessica No PA mandate for infectious diseases

Remarks:

SUMMARY: This bill would prohibit plan issuers that provide prescription drug benefits from requiring an enrollee to receive a prior authorization for a drug prescribed to treat infectious disease.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS, Medicaid/CHIP

EFFECTIVE DATES: D, I, or R on or after 1/1/24

MANDATE: Plan Design

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers. Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary.

Texas also has some of the strongest patient protections for PAs. Prior authorizations are required to be:

Evidence based: All prior authorization criteria must be based on evidence-based care developed and adopted by the medical community

Heavily regulated: Each step of the process is regulated, starting with TDI licensure or certification as a Utilization Review (UR) Agent

Reviewed quickly: Most prior authorizations are required to be processed in Texas within 3

calendar days—some of the shortest time frames in the country

Transparent: All prior authorization requirements are required to be transparent and posted on health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/1 KS

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

HB 916 Ordaz, Claudia (F) 12 month contraceptive mandate

Companions:

HB 2651	Gonzalez, Jessica(D)	(Refiled from 87R Session)
SB 807	Paxton, Angela(R)	(Identical)

3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires a health plan with benefits for a prescription contraceptive drug to provide: (1) a three-month supply of the covered drug at one time the first time the enrollee obtains the drug; and (2) a 12-month supply of the covered drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health plan the first time she obtained the drug. An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

TAHP POSITION:Opposed. TAHP will propose an initial 3 month supply and subsequent 6 months supply. If the author accepts this amendment TAHP will be neutral.

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE:Benefit

TAHP POSITION STATEMENT: This bill creates an unfunded government mandate to cover a 12-month supply of contraceptive drugs at one time. The Insurance Code already mandates coverage for prescription contraceptives for any plan that covers prescription drugs. The Affordable Care Act also already requires most insurance plans to cover prescription contraceptives with no out-of-pocket costs. Additionally, health plans already offer 90-day supplies. TAHP believes there would

be a negative fiscal impact to the commercial market due to the expected waste of dispensed but unused drugs, and for coverage of drugs dispensed to participants who receive a 12-month supply but leave the plan and do not pay premiums for the full year. ERS previously estimated this mandate would cost more than $4 million. Based on these numbers, the private commercial market would see a similar impact with increased costs of more than $30 million. These types of unfunded government mandates significantly drive up the cost of coverage for Texas employers and families.

DATE UPDATED: 2/3 BH

Last Action: 3-14-23 H Committee action pending House Insurance

HB 999 Price, Four Co-Pay Accumulator Prohibition Mandate

Companions:

SB 1576 Schwertner, Charles(R) (Identical)
3-16-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: HB 999 creates a new contract mandate that prohibits plans from using co-pay accumulators. The bill requires health plans and PBMs to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's applicable deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum.

TAHP POSITION: Negotiating. TAHP will be neutral if bill author accepts addition of "therapeutic alternative"as an exception.

COVERAGE TYPES: Commercial

EFFECTIVE DATES: D, I, or R after 1/1/24

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300 billion per year. In order to control costs for employers and families, health plans steer patients to affordable generic options thro ugh lower out-of-pocket costs. That’s a problem for drug companies whose primary goal is to keep patients hooked on higher cost brand name drugs. Copay coupons are utilized by drug manufacturers to encourage the use of expensive brand name drugs over cheaper generics, biosimilars, or

therapeutic alternatives. Through coupons, a manufacturer aims to pay off the patient's out-of-pocket costs to encourage them to avoid lower cost alternatives and choose a brand name drug. Health insurers respond by only counting actual patient payments, not coupons, to the patient's out-of-pocket limits. The bill would allow health plans to continue this practice when a generic or biosimilar is available, however, the bill needs clarification to includ e "therapeutic alternatives" to high cost brand drugs.

DATE UPDATED: 1/19/23 (KS), 2/12/23

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 1050 Hinojosa, Gina — Authority pharmacists dispense some drugs

Remarks: SUMMARY: This bill would allow physicians to issue protocols allowing pharmacists to dispense self-administered hormonal contraceptives to patients over 18.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/4 KS

Last Action: 3- 2-23 H Introduced and referred to committee on House Public Health

HB 1105 Price, Four — Pharmacist Vaccination Authority

Companions: SB 749 Flores, Pete(R) (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would broaden pharmacists' vaccination authority in various ways, including by allowing them to provide immunizations and vaccinations to patients younger than three, but only if they are referred by a physician.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 2-23 H Introduced and referred to committee on House Public Health

HB 1190 Klick, Stephanie — APRN/PA Controlled Substances Rx

Companions:	HB 1524	Lucio III, Eddie(D)	(Refiled from 87R Session)

Remarks: SUMMARY: This bill would allow APRNs and PAs to prescribe Schedule II substances, regardless of the setting. Currently, they can only prescribe Schedule IIs in hospital and palliative care settings.

TAHP POSITION: Support TAHP dropped a cared in support 3/16

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/21 by JL

Last Action: 3-13-23 H Committee action pending House Public Health

HB 1240 Oliverson, Tom Physician Dispensing

Companions:	HB 1778	Oliverson, Tom(R)	(Refiled from 87R Session)
	SB 1503	Buckingham, Dawn(R)	(Refiled from 87R Session)

Remarks: SUMMARY: This bill adds that a physician may "dispense" and delegate "dispensing." Provides that a physician may: (1) provide or dispense dangerous drugs to the physician's patients; and (2) be reimbursed for the cost of providing or dispensing those drugs without obtaining a license as a pharmacist.

A physician may not provide or dispense controlled substance listed in Schedules II through V. A physician who provides or dispenses dangerous drugs must oversee compliance with state and federal law relating to those dangerous drugs. Before providing or dispensing dangerous drugs, a physician must notify the patient that the prescription may be filled at a pharmacy. The notification requirement may be satisfied by a written notice placed conspicuously in the office. Not later than the 30th day after the date a physician first provides or dispenses dangerous drugs, the physician must notify the TSBP and TMB that the physician is providing or dispensing dangerous drugs. A physician who notifies the board and who intends to continue to provide or dispense dangerous drugs must include notice of that intent in any subsequent registration permit renewal application. Amends the definition of "pharmacy" to include a location where a

physician provides or dispenses a dangerous drug or a person provides or dispenses a dangerous drug under a physician's supervision, but "retailing of prescription drugs" does not include a physician's collection of a reimbursement for cost.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/3 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Public Health

HB 1283 Oliverson, Tom PDL carve-out

Companions: SB 1113 Hughes, Bryan(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Permanently carves out the management of the PDL by MCOs. TAHP POSITION: Oppose

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: HB 1283 is inconsistent with Select House Committee on Health Care Reform's recommendation to "Ensure that Medicaid prescription drugs maintain continuity of care for members who move between managed care plans and minimizes administrative

burden for physicians." Under a permanent carve out, physicians and patients experience significant hurdles with non-medical switching and prior authorizations. While Texans in commercially insured products have step therapy protections, Medicaid enrollees do not.

TAHP opposes any further delays in the PDL carve-in. Pharmaceutical companies have already delayed this implementation for 10 years through heavy lobbying. It is crucial that Texas prioritize improving patient care and saving taxpayer dollars over protecting Pharma profits. Further delays will continue to harm health outcomes and timely access to prescription drugs, negatively impact efforts to modernize and improve patient outcomes, and substantially increase Medicaid costs for taxpayers.

It is worth noting that prior to 2011, Medicaid drug costs in Texas were out of control, almost doubling in a decade and growing more than 6.5% on average each year. In response, the legislature passed SB 7, which carved prescription drug coverage into managed care in order to slow the rapid growth in Medicaid drug spending. This measure was successful in reducing drug cost growth in Texas Medicaid by 50%.The second step in this process, allowing managed care organizations (MCOs) to develop formularies and PDLs, was originally scheduled for 2013 but has been repeatedly delayed due to pharmaceutical company lobbying. A Center for Public Integrity and NPR investigation found that these companies have a history of successfully lobbying state Medicaid drug boards in order to boost their profits and waste taxpayer dollars. Under the current system, the state chases rebate dollars from big drug companies, resulting in a formulary that is heavily reliant on brand name drugs rather than cheaper generics. This creates administrative burdens for physicians, pharmacists, and insurers, and leads to frustrations and delays in access to necessary prescription drugs for patients. It is clear that the current system is not working for Texas patients, doctors, or taxpayers. But patients really suffer. Medicaid families lack consumer protections that exist in the commercial market. Patients are routinely forced off of medications when they are stable and physicians are put through excessive administrative burdens. In testimony, physicians have called the state’s formulary “nonsensical”, “counterintuitive”, and “just nuts”. Allowing MCOs to fully manage the PDL will provide a more stable drug benefit that better reflects what physicians routinely prescribe and pharmacists stock. It will also give MCOs the tools they need to control costs and improve

health outcomes, as is done in the private market and in Medicare.

Texas patients deserve better access to prescription drugs, and it is crucial that we prioritize their needs and well-being. By supporting the planned implementation of full PDL management by MCOs, we can save taxpayer dollars, improve patient care, and modernize our Medicaid system.

DATE UPDATED:1/16 by JL, BH 2/23

Last Action: 3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 1293 Rose, Toni NADAC

Remarks: SUMMARY: Dictates the methodology and reimbursement rate Medicaid and CHIP MCOs and PBMs use to pay pharmacies. The reimbursement would be the lesser of: (1) the average of actual acquisition cost (AAC) which must be consistent with actual prices pharmacists pay to acquire a drug and may be based on NADAC plus a dispensing fee established by the Commission, or (2) the amount claimed by the pharmacy including the gross amount due or the usual and customary charge for the drug.

TAHP POSITION: Oppose - Seeking amendments

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: March 1, 2024

TAHP POSITION STATEMENT: Medicaid/CHIP MCO pharmacy reimbursement rates are currently based on negotiated contracts in the private market – not on government mandated rates. Government price-setting takes away the MCOs' ability to negotiate with pharmacies and negates opportunities for cost savings. When dispensing fees are set too high by the state, taxpayers pay pharmacies more than they would in a competitive market. NADAC is based on a national survey of pharmacies who voluntarily submit their drug invoices to CMS, making this an unreliable data source. NADAC does not reflect a pharmacy's actual net acquisition cost because the survey excludes off-invoice discounts, rebates and price concessions. Passage would result in additional costs to the Medicaid program. In 2015, HHSC estimated an average increase of $0.25 per prescription, or $4.6 million AF in FY16 and $9.6 million FY17 with additional increases in subsequent years as the number of prescriptions increases. CMS predicts from 2016-2025

prescription drug spending is projected to grow at an average rate of 6.7%.

DATE UPDATED: 1/17 by JL

Last Action: 3- 3-23 H Introduced and referred to committee on House Human Services

HB 1337 Hull, Lacey SMI Step Therapy Mandate

Companions: SB 452 Menendez, Jose(D) (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill limits step therapy for drugs prescribed to treat a serious mental illness to trying only one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug. For continued therapy of an SMI drug that someone is already taking, a health benefit plan issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only once in a plan year and only if the equivalent drug is added to the plan's drug formulary.

TAHP POSITION: Neutral (negotiated language) TAHP testified on the bill 3/14

COVERAGE TYPES: Commercial

EFFECTIVE DATES: D,I,R 1/1/24

MANDATE:Benefit

POSITION STATEMENT: TAHP negotiated language with the authors to add these new step therapy exceptions but ensure that lower cost generic and pharmaceutical equivalent drugs can still be used to lower costs. TAHP will be neutral on this bill as long as language is not added to freeze the formulary or go beyond the agreement with the authors as reflected in the filed bill. Health plans must continue to be able to update drug formularies to bring patients the most affordable prescription drug options including lower cost alternatives.

DATE UPDATED: 3/8 BH

Last Action: 3-14-23 H Committee action pending House Insurance

HB 1411 Rogers, Glenn Practitioner drug and device prescriptions

Remarks: SUMMARY: This bill would add persons authorized by the acupuncture, chiropractic, counseling, and psychology boards to prescribe or administer dangerous drugs to the definition of "practitioner."

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately or 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Public Health

HB 1647 Harris, Cody White Bagging Prohibition Mandate

Remarks: SUMMARY: This bill prohibits issuers, for an enrollee with a chronic, complex, rare, or life-threatening condition from: (1) requiring clinician-administered drugs to be dispensed by only by in-network pharmacies; (2) if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs when not dispensed by an in-netowork pharmacy; (3) reimburse at a lesser amount clinician-administered drugs based on the patient's choice of pharmacy; or (4) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other form of price increase for clinician-administered drugs when not dispensed by a network.

Nothing in the new section may be construed as: (1) authorizing a person to administer a drug when otherwise prohibited under law; or (2) modifying drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

POSITION STATEMENT: TAHP opposes HB 1647 without amendments that would ensure the bill does not reward price gouging and is aimed only at patient protections. The most expensive drugs are injectables and infusion drugs provided at a hospital, cancer center, or doctor’s office. These “specialty drugs” are typically covered under your medical benefits (not pharmacy benefits). New State and Federal transparency laws show that hospitals, cancer centers, and other clinics have been caught marking up drugs at excessive

amounts, on average 200% and up to 634% for cancer drugs. By comparison, Medicare allows a 6% markup or profit margin.Health plans are responding with competition by bringing in the same drug from lower cost specialty pharmacies but without the big markup. That's "white bagging" and it saves patients money. Massachusetts found the process saved 38% on average. The legislation would stop health plans from using lower cost drugs from outside pharmacies through a new mandate that prohibits a "white bagging" policy. The bill as filed also mandates that health plans and patients have to pay whatever prices are set by hospitals' and physicians' at in-house pharmacies. Importantly, patients pay for these markups through out-of-pocket costs and higher premiums. A white bagging prohibition would add over $300 million in Texas drug spending in the first year and over 3.7 billion in the next decade. No state has adopted a white bagging restriction with a payment mandate that rewards price gouging.

MANDATE: Contracting

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

HB 1754 Smithee, John RX Formulary API Mandate

Companions: SB 622 Parker, Tan (F)(R) (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would require issuers to provide information regarding prescription drugs to enrollees, including the drug formulary, eligibility, cost-sharing information, and utilization management requirements. The issuer must respond in real time to a request made through a standard API, allow the use of integrated technology as necessary, ensure information is current not later than one day after a change is made, and provide information if the request is made using the drug's unique billing code. The issuer may not deny or delay a response, restrict providers from communicating the information, or discourage access to the information.

TAHP POSITION: Neutral if amended

COVERAGE TYPES: EPO/PPO, HMO, CC, TRS/ERS.

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24.

DATE UPDATED: 2/13 KS

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

HB 2021 Oliverson, Tom ERISA Prescription Drug Mandate

Companions: SB 1137 Schwertner, Charles(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would require a PBM to comply with the provisions of Chapter 1369, Insurance Code, regardless of whether a provision of that chapter is specifically made applicable to the plan. It would create an exception for plans expressly excluded by the applicability of a provision or if the commissioner determines that the nature of third-party administrators renders the provision inapplicable to PBMs.

TAHP POSITION: Oppose

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24.

POSITION STATEMENT: HB 2021 applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees.

These mandates are expensive and cumbersome, that's why the bill exempts coverage for elected officials personal health insurance. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

DATE UPDATED: 2/13 KS, 2/22 BH

Last Action: 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

HB 2078 Jetton, Jacey Physician Dispensing of Drugs

Remarks: SUMMARY: This bill would allow physicians to dispense, and delegate the dispensing of, dangerous drugs to their patients. The physician could then bill for the cost of the drug and all other actual costs of dispensing. The physician must notify the patient that the prescription may be filled in a pharmacy. It would also require physicians to notify the Texas State Board of Pharmacy that the physician is dispensing dangerous drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

HB 2079 Jetton, Jacey Allow Pharmacists to Test/Treat

Remarks: SUMMARY: This bill would allow physicians to dispense, and delegate the dispensing of, dangerous drugs to their patients. The physician could then bill for the cost of the drug and all other actual costs of dispensing. The physician must notify the patient that the prescription may be filled in a pharmacy. It would also require physicians to

notify the Texas State Board of Pharmacy that the physician is dispensing dangerous drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

HB 2180 Harris, Cody Point of Sale Rebate mandate

Remarks: SUMMARY: This bill would require an enrollee's cost sharing amount for prescription drugs to be calculated at the point of sale, and that price would have to be reduced by any rebates that issuer or PBM receives for the prescription.

TAHP POSITION: Oppose unless amended. TAHP will be neutral is it is amended to match Select Committee's recommendation to ensure that 100% of rebates go to lowering the cost of coverage.

COVERAGE TYPES: EPO, HMO, MEWA, small employer, CC, ERS/TRS/UT

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: The bill as filed is inconsistent with the Select House Committee on Health Care Reform's interim recommendation to "consider opportunities to ensure rebates are used to lower the cost of coverage." The filed bill

prescribes how rebates must be used just for the small group of patients that take very expensive drugs and would prohibit an employer from using rebates to lower the costs of health care for all employees.

TAHP agrees something must be done to lower prescription drug prices. However, taking away employer choice is the wrong way and TAHP opposes the bill without an amendment that the full amount of the rebate go to reduce costs or premiums for the policyholder. This amendment would align the bill with the recommendation from the House Select Committee on Healthcare Reform's interim report to "Consider opportunities to ensure rebates are used to lower the cost of coverage".

We believe employers should have the choice of how to best use rebate savings including lowering premiums for all employees, adding more generous benefits, or further reducing employee costs at the pharmacy counter. Those choices have trade offs and a mandatory point-of-sale, one-size-fits-all policy would actually increase drug costs overall. Under this approach, only a few patients may see their costs go down at the pharmacy counter for one drug, but premiums and out-of-pocket costs go up for all. Moreover, this practice would reduce Pharma's incentive to lower the prices of their drugs by further masking the cost of high priced brand-name drugs.

An independent fiscal review found a similar bill in California was estimated to impact only 3.48% of prescriptions but would have increased health insurance premiums by $200 million annually. The review also found that a point of sale rebate mandate would only help 4% of enrollees but would increase premiums for 100% of enrollees. The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost.

The Congressional Budget Office (CBO) estimated that a Medicare point of sale rebate mandate would increase premiums by $43 billion (25%) over a decade and federal spending by $137 billion, so it was never implemented. Rebates reduce the cost of prescription drug coverage at the Teacher Retirement System by 30%. Without these savings, Texas would have to replace this cost with taxpayer dollars or by substantially increasing premiums to active and retired teachers. Employers cover the bulk of premiums for employees—more than 80%. They should be able to choose what to do with rebates. Everyone should be able to get the medications they need at a cost they can afford. But drug

prices are out of control, as Pharma continues to set very high prices for their prescription drugs and raise them year after year.

DATE UPDATED: 2/19 KS, BH 2/21

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 2529 Talarico, James Insulin VDP Reporting - Pay for Delay

Companions: SB 241 Perry, Charles(R) (Identical)
3-15-23 S Voted favorably from committee as substituted Senate Health and Human Services

Remarks: SUMMARY: This bill would require manufacturers of name-brand drugs, for which a generic is available and that is included on the Medicaid VDP, to submit to HHSC a written verification stating whether the unavailability of a generic is due to pay for delay, legal strategies to extend a patent, or manipulation of a patent.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/24

TAHP POSITION STATEMENT: Pharmaceutical manufacturers utilize numerous tactics to delay competition from generic competition. Patent games like pay-for-delay slow the advancement of more affordable generic drugs by slowing the entrance of lower cost generic options. In these co mplex schemes a generic manufacturer sues a patent holder who then countersues and the parties settle with a pay-for-delay deal and a financial reward to the generic manufacturer. Pay for Delay deals cost consumers and taxpayers $3.5 billion in higher drug costs every year.Using “evergreening” strategies to extend patent periods to either delay generic drug market entry or limit the number of patients who switch to a new generic. Drug companies exploit the patent system to delay competition. An analysis of the 10 best-selling drugs of 2019 found that on average these drugs held more than 69 patents with 37.5 years of patent protection, well past the 20 years of patent life intended by Congress. Furthermore, the prices for these drugs increased 71 percent over the previous five years. A federal ban saves $20 billion. The legislation simply requires these companies to disclose if these tactics have been used to delay the entrance of lower cost insulin medications.

DATE UPDATED: 2/1 KS, 2/16 BH

Last Action: 3-13-23 H Introduced and referred to committee on House Public Health

HB 2690 Toth, Steve — Civil Liability Abortion Drugs

Remarks: SUMMARY: This bill would prohibit manufacturing, possessing, distributing, or delivering abortion inducing drugs in this state. It would create civil liability for persons who cause a wrongful death of an unborn child or injury of an unborn child or pregnant person by taking those actions. It would also create civil liability for persons who host an interactive website that allows persons in Texas to access information that facilitates efforts to obtain elective abortions or abortions inducing drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3-13-23 H Introduced and referred to committee on House State Affairs

HB 2985 Jones, Venton (F) — Prior authorization prescription drug

Last Action: 3-14-23 H Introduced and referred to committee on House Insurance

HB 3026 Oliverson, Tom — Administration prescription drug manufacturer

Remarks: SUMMARY: HHSC is currently required to establish and administer a prescription drug savings program. This bill would make doing so permissive. HHSC would instead be required to create a prescription drug assistance program. HHSC would oversee implementation of the program, and would be allowed to contact with a third-party to administer it. HHSC would integrate assistance programs by drug manufacturers and other third parties into the program. HHSC would create a community outreach program to provide education to the public on eligibility. A person would be eligible if they meet criteria as determined by a drug manufacturer or another third-party prescription assistance program. The program would be funded by state and federal appropriations. The third-party administrator would be required to report to HHSC, and HHSC would provide annual reports to the legislature on implementation.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/5 KS

Last Action: 3-14-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 3082 Hayes, Richard (F) Pharmacist religious beliefs

Companions: HB 3083 Krause, Matt(R) (Refiled from 87R Session)

Last Action: 3-14-23 H Introduced and referred to committee on House Public Health

HB 3152 Price, Four Identification the country of origin of drug

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3227 Allison, Steve Authority physician to supervise

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3229 Allison, Steve Authority physician to supervise

Companions: SB 1959 Flores, Pete(R) (Identical)
3- 8-23 S Filed

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3230 Allison, Steve Prescribing ordering controlled substance

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3413 Frank, James PBM and Health Plan Relationships

Remarks: SUMMARY: This bill would prohibit health benefit plans that have an ownership or investment interest in a pharmacy benefit manager (PBM) from requiring the use of that PBM for the administration of pharmacy benefit.

TAHP POSITION:

COVERAGE TYPES: EPO/PPO, HMO, MEWA, CC, ERS/TRS/University.

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3414 Oliverson, Tom APCD Reforms

Companions: SB 2045 Hancock, Kelly(R) (Identical)
3- 9-23 S Filed

Remarks: SUMMARY: This bill would create "qualified market consultant entities" and "qualified market participant entities" that could access APCD data, in addition to the existing "qualified research entity." An entity that wants to access data would be required to submit an application that includes the sources of all funding, the names of all individuals who will have access to the data, the proposed project and how it will improve access or reduce costs of care, and a statement of what type of entity they are. The Center would review the application, and if it is rejected, would have to state the specific deficiency. If it is not granted in 31 days, the application is considered approved. Qualified research entities would be prohibited from selling or sharing the data, but they could report or publish data that identifies providers and payors.

A qualified market participant would only be allowed to access data of their own patients or enrollees. They would be prohibited from selling or sharing data, and would not be allowed to publicly report or publish any data that identifies a provider or payor.

A qualified market consultant would be able to access all data, but they would not be allowed to sell or share the data, and would not be allowed to publish data that identifies a provider or payor.

The bill would also give appointment power of the APCD advisory committee to the governor rather than the Center and clarify that the Center may not require the submission of data that is not included in a standard claim form.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3460 Price, Four Mental Health Parity ERS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

SB 160 Perry, Charles Pharmacist Test/Treat & Physician Dispensing

Remarks:

SUMMARY: This bill would allow a pharmacist, under a physician's written protocol, to treat an acute condition identified through a strep test, influenza test, or COVID-19 test. The bill would also allow physicians to dispense medications to treat conditions identified by one of those tests.

TAHP POSITION: Support

TAHP POSITION STATEMENT: Strep and influenza commonly afflict Texans every year. TAHP believes there is a need to make access to treatments for these illnesses more efficient, especially for low-income Texans, who often visit pharmacies rather than physicians' clinics to seek treatment. SB 160 seeks to address this issue by authorizing pharmacists to administer treatment for strep and influenza under an appropriate physician-approved protocol if a patient tests positive for those diseases at the pharmacy location. TAHP and its member health plans are not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required.

EFFECTIVE DATES: 1/1/23

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

SB 241 Perry, Charles Insulin VDP Reporting - Pay for Delay

Companions:

HB 2529	Talarico, James(D)	(Identical)
	3-13-23 H Introduced and referred to committee on House Public Health	
HB 5050	Button, Angie Chen(R)	(Identical)
	3-10-23 H Filed	

Remarks: SUMMARY: This bill would require manufacturers of name-brand drugs, for which a generic is available and that is included on the Medicaid VDP, to submit to HHSC a written verification stating whether the unavailability of a generic is due to pay for delay, legal strategies to extend a patent, or manipulation of a patent.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/24

TAHP POSITION STATEMENT: Pharmaceutical manufacturers utilize numerous tactics to delay competition from generic competition. Patent games like pay-for-delay slow the advancement of more affordable generic drugs by slowing the entrance of lower cost generic options. In these co mplex schemes a generic manufacturer sues a patent holder who then countersues and the parties settle with a pay-for-delay deal and a financial reward to the generic manufacturer. Pay for Delay deals cost consumers and taxpayers $3.5 billion in higher drug costs every year.Using “evergreening” strategies to extend patent periods to either delay generic drug market entry or limit the number of patients who switch to a new generic. Drug companies exploit the patent system to delay competition. An analysis of the 10 best-selling drugs of 2019 found that on average these drugs held more than 69 patents with 37.5 years of patent protection, well past the 20 years of patent life intended by Congress. Furthermore, the prices for these drugs increased 71 percent over the previous five years. A federal ban saves $20 billion. The legislation simply requires these companies to disclose if these tactics have been used to delay the entrance of lower cost insulin medications.

DATE UPDATED: 2/1 KS, 2/16 BH

Last Action: 3-15-23 S Voted favorably from committee as substituted Senate Health and Human Services

SB 452 Menendez, Jose SMI Step Therapy Mandate

Companions: HB 1337 Hull, Lacey(R) (Identical)
3-14-23 H Committee action pending House Insurance

Remarks: SUMMARY: This bill limits step therapy for drugs prescribed to treat a serious mental illness to trying only one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug. For continued therapy of an SMI drug that someone is already taking, a health benefit plan

issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only once in a plan year and only if the equivalent drug is added to the plan's drug formulary.

TAHP POSITION: Neutral (negotiated language)

COVERAGE TYPES: Commercial

EFFECTIVE DATES: D,I,R 1/1/24

MANDATE:Benefit

POSITION STATEMENT: TAHP negotiated language with the authors to add these new step therapy exceptions but ensure that lower cost generic and pharmaceutical equivalent drugs can still be used to lower costs. TAHP will be neutral on this bill as long as language is not added to freeze the formulary or go beyond the agreement with the authors as reflected in the filed bill. Health plans must continue to be able to update drug formularies to bring patients the most affordable prescription drug options including lower cost alternatives.

DATE UPDATED: 3/8 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 534 Paxton, Angela Allows Midwifes to Administer L&D Drugs

Remarks:

SUMMARY: This bill would allow midwives to administer drugs commonly used in labor or postpartum care and prophylactic drugs for newborns. In order for a midwife to do so, they would need to complete continuing education in pharmacology.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 622 Parker, Tan (F) RX Formulary API Mandate

Companions: HB 1754 Smithee, John(R) (Identical)
3- 7-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill would require issuers to provide information regarding prescription drugs to enrollees, including the drug formulary, eligibility, cost-sharing information, and utilization management requirements. The issuer must respond in real time to a request made through a standard API, allow the use of integrated technology as necessary, ensure information is current not later than one day after a change is made, and provide information if the request is made using the drug's unique billing code. The issuer may not deny or delay a response, restrict providers from communicating the information, or discourage access to the information.

TAHP POSITION: Neutral if amended

COVERAGE TYPES: EPO/PPO, HMO, CC, TRS/ERS.

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24.

DATE UPDATED: 2/13 KS

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 634 Menendez, Jose Prohibits PAs for Autoimmune/Chronic Drugs

Remarks: SUMMARY: Prohibits prior authorizations for prescription drugs for chronic or autoimmune disease

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care.

Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers.

Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary. Previous estimates show that eliminating prior authorizations for prescription drugs could cost ERS and TRS a combined $169 million over the next biennium, while Medicaid MCOs estimate an annual cost of over $100 million.

Most importantly, prior authorizations for prescription drugs are safety checks for appropriateness and patient risk based on FDA guidelines and medical guardrails. For example, in response to the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal, in 2011 Texas Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect these children from drugs with serious side effects.

Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. Medical errors, including adverse drug events, are now the third leading cause of death in the United States, leading to more than 3.5 million physician office visits and 1 million emergency department visits each year. Prior authorizations for prescription drugs are an important tool in preventing unnecessary medical care and ensuring patient safety.

DATE UPDATED: 2/17 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 749 Flores, Pete Pharmacist Vaccination Authority

Companions: HB 1105 Price, Four(R) (Identical)
3- 2-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill would broaden pharmacists' vaccination authority in various ways, including by allowing them to provide immunizations and vaccinations to patients younger than three, but only if they are referred by a physician.

TAHP Position: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

SB 773 Parker, Tan (F) Right to Try Chronic Rx - Not coverage mandate

Remarks: SUMMARY: This bill would allow the HHSC Commissioner to designate severe chronic diseases, for which a patient could take an investigational drug upon recommendation by a physician. Use of the drug would require informed consent, the provider would be immune from liability, and the state would be prohibited from interfering with the treatment. This bill would not affect the coverage of enrollees in clinical trials. This bill does not create a new insurance mandate.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

SB 807 Paxton, Angela 12 month contraception mandate

Companions:

HB 2651	Gonzalez, Jessica(D)	(Refiled from 87R Session)
HB 916	Ordaz, Claudia (F)(D)	(Identical)
	3-14-23 H Committee action pending House Insurance	

Remarks: SUMMARY: This bill would requires a health plan that provides benefits for a prescription contraceptive drug to provide: (1) a three-month supply of the covered drug at one time the first time the enrollee obtains the drug; and (2) a 12-month supply of the covered drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health plan the first time she obtained the drug. An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

TAHP POSITION: Opposed. TAHP will propose an initial 3 month supply and subsequent 6 months supply. If the author accepts this amendment TAHP will be neutral.

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Benefit

TAHP POSITION STATEMENT: Creates mandate to cover a 12-month supply of contraceptive drugs at one time. The Insurance Code already mandates coverage for prescription contraceptives for any plan that covers prescription drugs. The Affordable Care Act also already requires most insurance plans to cover prescription contraceptives with no out-of-pocket costs. Additionally, health plans already offer 90-day supplies. TAHP believes there would be a negative fiscal impact to the commercial market due to the expected waste of dispensed but unused drugs, and for coverage of drugs dispensed to participants who receive a 12-month supply but leave the plan and do not pay premiums for the full year. ERS previously estimated this mandate would cost more than $4 million. Based on these numbers, the private commercial market would see a similar impact with increased costs of more than $30 million. These types of mandates significantly drive up the cost of coverage for Texas employers and families.

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1113 Hughes, Bryan PDL carve-out

Companions: HB 1283 Oliverson, Tom(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: Permanently carves out the management of the PDL by MCOs. TAHP POSITION: Oppose

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: SB 1113 is inconsistent with Select House Committee on Health Care Reform's recommendation to "Ensure that Medicaid prescription drugs maintain continuity of care for members who move between managed care plans and minimizes administrative burden for physicians." Under a permanent carve out, physicians and patients experience significant hurdles with non-medical switching and prior authorizations. While Texans in commercially insured products have step therapy protections, Medicaid enrollees do not.

TAHP opposes any further delays in the PDL carve-in. Pharmaceutical companies have already delayed this implementation for 10 years through heavy lobbying. It is crucial that Texas prioritize improving patient care and saving taxpayer dollars over protecting Pharma profits. Further delays will continue to harm health outcomes and timely access to prescription drugs, negatively impact efforts to modernize and improve patient outcomes, and substantially increase Medicaid costs for taxpayers.

It is worth noting that prior to 2011, Medicaid drug costs in Texas were out of control, almost doubling in a decade and growing more than 6.5% on average each year. In response, the legislature passed SB 7, which carved prescription drug coverage into managed care in order to slow the rapid growth in Medicaid drug spending. This measure was successful in reducing drug cost growth in Texas Medicaid by 50%.The second step in this process, allowing managed care organizations (MCOs) to develop formularies and PDLs, was originally scheduled for 2013 but has been repeatedly delayed due to pharmaceutical company lobbying. A Center for Public Integrity and NPR investigation found that these companies have a history of successfully lobbying state Medicaid drug boards in order to boost their profits and waste taxpayer dollars. Under the current system, the state chases rebate dollars from big drug companies, resulting in a formulary that is heavily reliant on brand name drugs rather than cheaper generics. This creates administrative burdens for physicians, pharmacists, and insurers, and leads to frustrations and delays in access to necessary prescription drugs for patients. It is clear that the current system is not working for Texas patients, doctors, or taxpayers. But patients really suffer. Medicaid families lack consumer protections that exist in the commercial market. Patients are routinely forced off of medications when they are stable and physicians are put through excessive administrative burdens. In testimony, physicians have called the state's formulary "nonsensical", "counterintuitive", and "just nuts". Allowing MCOs to fully manage the PDL will provide a more stable drug benefit that better reflects what physicians routinely prescribe and pharmacists stock. It will also give MCOs the tools they need to control costs and improve health outcomes, as is done in the private market and in Medicare.

Texas patients deserve better access to prescription drugs, and it is crucial that we prioritize their needs and well-being. By supporting the planned implementation of full PDL management by MCOs, we can save taxpayer

dollars, improve patient care, and modernize our Medicaid system.

DATE UPDATED: BH 2/26

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1137 Schwertner, Charles ERISA Prescription Drug Mandate

Companions: HB 2021 Oliverson, Tom(R) (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill would require a PBM to comply with the provisions of Chapter 1369, Insurance Code, regardless of whether a provision of that chapter is specifically made applicable to the plan. It would create an exception for plans expressly excluded by the applicability of a provision or if the commissioner determines that the nature of third-party administrators renders the provision inapplicable to PBMs.

TAHP POSITION: Oppose

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24.

POSITION STATEMENT: This bill applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees. These mandates are expensive and cumbersome, that's why the bill exempts coverage for our elected officials personal health insurance and their employee's coverage. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

DATE UPDATED: 2/13 KS, 2/22 BH

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1138 Schwertner, Charles White Bagging Prohibition Mandate

Remarks: SUMMARY: This bill prohibits issuers, for an enrollee with a chronic, complex, rare, or life-threatening condition from: (1) requiring clinician-administered drugs to be dispensed by only by in-network pharmacies; (2) if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs when not dispensed by an in-netowork pharmacy; (3) reimburse at a lesser amount clinician-administered drugs based on the patient's choice of pharmacy; or (4) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other form of price increase for clinician-administered drugs when not

dispensed by a network.

Nothing in the new section may be construed as: (1) authorizing a person to administer a drug when otherwise prohibited under law; or (2) modifying drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

TAHP POSITION: Opposed unless amended to not mandate excessive prescription drug mark ups by doctors and hospitals

COVERAGE TYPES: Commercial, CC

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24 1/1/24

MANDATE: Contracting

POSITION STATEMENT: TAHP opposes HB 1647 without amendments that would ensure the bill does not reward price gouging and is aimed only at patient protections. The most expensive drugs are injectables and infusion drugs provided at a hospital, cancer center, or doctor's office. These "specialty drugs" are typically covered under your medical benefits (not pharmacy benefits). New State and Federal transparency laws show that hospitals, cancer centers, and other clinics have been caught marking up drugs at excessive amounts, on average 200% and up to 634% for cancer drugs. By comparison, Medicare allows a 6% markup or profit margin.Health plans are responding with competition by bringing in the same drug from lower cost specialty pharmacies but without the big markup. That's "white bagging" and it saves patients money. Massachusetts found the process saved 38% on average.

The legislation would stop health plans from using lower cost drugs from outside pharmacies through a new mandate that prohibits a "white bagging" policy. The bill as filed also mandates that health plans and patients have to pay whatever prices are set by hospitals' and physicians' at in-house pharmacies. Importantly, patients pay for these markups through out-of-pocket costs and higher premiums. A white bagging prohibition would add over $300 million in Texas drug spending in the first year and over 3.7 billion in the next decade. No state has adopted a white bagging restriction with a payment mandate that rewards price gouging.

LAST UPDATED: BH 2/21

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1149 Menendez, Jose Mandates 24/7 Telephone Access for PAs/UR

Companions: HB 756 Johnson, Julie(D) (Identical)
2-28-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill expands the hours during which issuers must have appropriate personnel available to receive requests for payment verification and requests for preauthorization to 24 hours a day and 365 days a year, including weekends and legal holidays. Currently, issuers must have personnel available 6am to 6pm, Monday through Friday, and 9am to 12pm on weekends and holidays, and outside of those hours be able to respond to requests within 24 hours.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and cr eates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours. Moreover, there is no evidence to suggest that this requirement would improve patient outcomes or reduce healthcare costs, making it a potentially unnecessary burden on the healthcare system. Instead, a better solution would be to follow the federal government's recommended reforms to implement electronic prior authorizations, which could reduce costs and streamline the process, making it easier for providers to obtain necessary approvals. For pharmacy authorizations, around 60% of new prior authorizations are already received electronically, suggesting that there may be limited additional

value in requiring health plans to have a 24/7 phone line for receiving new authorizations. By requiring the use of electronic prior authorizations, Texas could stay up to date with current best practices and provide a more effective and efficient prior authorization system for patients and providers. This approach could improve the overall quality and availability of healthcare in the state while reducing costs for both health plans and patients.

New mandates and overregulation hinder innovation, increase costs, and often provide no additional value for Texans and Texas employers. Employers and families bear the additional expense through increasingly unaffordable premiums. This is particularly true for small employers who have limited resources to absorb added costs. Moreover, families face increasingly unaffordable premiums as a result of overregulation.

Texas is already one of the most heavily regulated states when it comes to health care, ranking third in the nation for regulations that go beyond the federal requirements of the Affordable Care Act (ACA). As a result, small business owners in Texas consistently rank the cost of health insurance as their single biggest problem since 1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees. Furthermore, TAHP opposes expensive mandates like this that raise costs for employers and families but do not apply to elected officials' personal health insurance and their employees' coverage through ERS. Texas legislators should not force costly regulations and mandates on employees and families when they are not willing to pay for it with their personal coverage.

DATE UPDATED: 2/27 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1150 Menendez, Jose Limits PAs to 1 to Year Autoimmune/Chronic

Companions: HB 755 Johnson, Julie(D) (Identical)
2-28-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill would prohibit issuers that provide prescription drug benefits from requiring more than one preauthorization annually for a

drug prescribed to treat a chronic or autoimmune disease.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers. Related legislation focusing on severely restricting PAs from the prior legislative session created a fiscal note of $169 million for TRS & ERS alone. Prior authorizations for prescription drugs are safety checks for appropriateness and patient risk based on FDA guidelines and medical guardrails. For example, in response to concerns about the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal — medications that can have serious side effects in children — in 2011, Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect those children. Accutane, a common medication for chronic acne, can cause birth defects and should never be used in pregnant women. Prior authorization safety checks can flag these issues and protect patients, however, moving to a single annual prior authorization for all chronic conditions would put patients at risk of missed drug interactions and other safety concerns. Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors. These adverse drug events (ADEs) account for more than 3.5 million physician office visits and 1 million emergency department visits each year.

LAST UPDATED: BH 2/20

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1221 Zaffirini, Judith Permanent Formulary Freeze Mandate

Companions:

HB 1646	Lambert, Stan(R)	(Refiled from 87R Session)
SB 1142	Zaffirini, Judith(D)	(Refiled from 87R Session)
HB 826	Lambert, Stan(R)	(Identical)
	3- 1-23 H Introduced and referred to committee on House Insurance	

Remarks:

SUMMARY: This bill would prohibit a health plan from ever making any change to a patient's benefits for a drug they are taking. This means a health plan cannot even increase the copay amount by $5 or reduce the maximum drug coverage amount by $5, even at the annual renewal of the benefit plan, and even if the drug has been replaced on the health plan's formulary by a better or lower-priced drug. This mandate is referred to as a "permanent formulary freeze." This formulary freeze would apply to any enrollee taking a drug if: (1) the enrollee was covered by the benefit plan preceding the renewal date, (2) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness, and (3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment. The bill also expands notice requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

TAHP POSITION STATEMENT: TAHP is opposed to any new government mandate that permanently freezes health plan formularies and undermines important efforts by health plans to negotiate lower drug prices, ultimately driving up the cost of coverage for Texas employers, families, and taxpayers. Texas already leads the nation with the

strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That's the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can't be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable mandate. Under a permanent "formulary freeze," plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn't make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a formulary freeze because once they have a patient on a drug, they'll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

New mandates and overregulation hinder innovation, increase costs, and often provide no additional value for Texans and Texas employers. Employers and families bear the additional expense through increasingly unaffordable premiums. This is particularly true for small employers who have limited resources to absorb added costs. Moreover, families face increasingly unaffordable premiums as a result of overregulation.

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1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees.

Furthermore, TAHP opposes expensive mandates like this that raise costs for employers and families but do not apply to elected officials' personal health insurance and their employees' coverage through ERS. Texas legislators should not force costly regulations and mandates on employees and families when they are not willing to pay for it with their personal coverage.

DATE UPDATED: 2/3/23 BH

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1576 Schwertner, Charles Co-Pay Accumulator Prohibition Mandate

Companions: HB 999 Price, Four(R) (Identical)
3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

Remarks: SUMMARY: HB 999 creates a new contract mandate that prohibits plans from using co-pay accumulators. The bill requires health plans and PBMs to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's applicable deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum.

TAHP POSITION: Negotiating. TAHP will be neutral if bill author accepts addition of "therapeutic alternative"as an exception.

COVERAGE TYPES: Commercial

EFFECTIVE DATES: D, I, or R after 1/1/24

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300 billion per year. In order to control costs for employers and families, health plans steer patients to affordable generic options through lower out-of-pocket costs. That's a problem for drug companies whose primary goal is to keep patients hooked on higher cost brand name drugs. Copay coupons are utilized by drug manufacturers to encourage the use of expensive brand name

drugs over cheaper generics, biosimilars, or therapeutic alternatives. Through coupons, a manufacturer aims to pay off the patient's out-of-pocket costs to encourage them to avoid lower cost alternatives and choose a brand name drug. Health insurers respond by only counting actual patient payments, not coupons, to the patient's out-of-pocket limits. The bill would allow health plans to continue this practice when a generic or biosimilar is available, however, the bill needs clarification to include "therapeutic alternatives" to high cost brand drugs.

DATE UPDATED: 1/19/23 (KS), 2/12/23

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

	All	Track
Total Bills:	56	56

Track(s): (Master List Only)

Position: (None)

Add to Track