HB 474 -- PAYMENTS FOR PRESCRIPTION DRUGS

SPONSOR: Wright

The bill specifies that certain provisions of law pertaining to pharmacists and pharmacies must not be construed to prohibit patients' ability to obtain prescription services from any licensed pharmacist or pharmacy, and repeals language specifying that the provisions do not remove patients' ability to waive their freedom of choice under a contract with regard to payment or coverage of prescription expenses. Additionally, no pharmacy benefits manager (PBM) can prohibit, penalize, or restrict a health carrier or enrollees from obtaining services from a contracted pharmacy.

This bill prohibits PBMs from requiring a covered person to make a payment for a prescription drug in an amount that exceeds the lesser of either the copay, the amount that would be paid if cash were used, or the amount equal to the difference of the final reimbursement amount paid to the pharmacy minus any rebate paid as well as any amount paid or owed by the health benefit plan.

The bill extends to pharmacies or pharmacists the rights to provide any information, including pharmacy claims data, relating to a health benefit plan sponsor to such sponsor. It also prohibits PBMs from reducing the amount of a claim at the time of its adjudication or after it has been adjudicated, and prohibits PBMs from charging fees related to the adjudication of a claim.

Additionally, this bill repeals a provision of law specifying that certain PBM regulations will not apply with regard to Medicare Part D, or other health plans regulated partly or wholly under federal law. It also requires PBMs entering into a contract to provide standardized definitions for the terms "generic" and "rebate" applicable to PBMs and health carriers, and specifies that a PBM must owe a fiduciary duty to the state or any health carrier, health benefit plan, or political subdivision with which it contracts.

The bill adds that PBMs have a duty to disclose to a health benefit plan sponsor any material facts and actions taken by the PBM relating to the administration of benefits on behalf of the sponsor that may increase costs to the sponsor or its covered persons or that present a conflict of interest between the interests of the sponsor and the interests of the PBM. Any entity that enters into a contract to sell, provide, pay, or reimburse a pharmacy for prescription drugs on behalf of itself or another entity is prohibited from prohibiting a health benefit plan sponsor and a participating pharmacy from discussing any health benefit plan information.

This bill makes it unlawful for any PBM or any person acting on its behalf to charge a health benefit plan or payer a different amount for a drug's ingredient cost or dispensing fee than the amount reimbursed to the pharmacy by a PBM for the drug's ingredient cost or dispensing fee if the PBM retains any amount of any such difference.

The bill repeals a portion of a definition to specify that certain provisions relating to the maximum allowable cost of a prescription drug are applicable to all pharmacies, rather than only to contracted pharmacies.

If the reimbursement for a drug to a contracted pharmacy is below the pharmacy's cost to purchase the drug, the pharmacy may decline to dispense the prescription, and a PBM cannot prohibit a pharmacy from doing so or retaliate after it has done so.

This bill prohibits PBMs from:

(1) Paying or reimbursing a pharmacy in this state an amount that is less than the amount that a PBM reimburses to a PBM affiliate, as that term is defined in the bill, for providing the same costs and pharmacist services;

(2) Paying or reimbursing a pharmacy in the state for the ingredient drug product component of pharmacist services less than the national or, as specified, the wholesale acquisition cost;

(3) Making or permitting any reduction of payment for pharmacist services by a PBM or health care payer to a pharmacy under a reconciliation process; and

(4) Removing from any pharmacy its legal right to civil recourse.

The bill provides that when calculating an enrollee's overall contribution to an out-of-pocket max or any cost-sharing requirement under a health benefit plan, a health carrier or pharmacy benefits manager must include any amounts paid by the enrollee or paid on behalf of the enrollee only for medication where a generic substitute is not available. PBMs and health carriers are prohibited from varying an enrollee's out-of-pocket maximum, or any cost-sharing requirement, that is based on or designed to take into account the availability of any cost-sharing assistance program for any medication where a generic substitute is not available.

This bill is the same as HB 840 (2025) and similar to HB 1627 (2024) and HCS HB 442 (2023).