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State Prescription Drug Legislative Tracker 2019

State	Bill	Status	Category	Summary
AL	SB 73	Signed by Governor	Pharmacy Benefit Manager	This measure prohibits pharmacy benefit managers (PBMs) from restricting pharmacies and pharmacists from disclosing cost information to patients about alternative drugs or other services and costs. This measure also requires PBMs to register with the Department of Insurance.
AZ	HB 2166	Signed by Governor (Chapter 75)	Coupons	This measure requires that when calculating an insured's contribution to any applicable cost-sharing requirement, an insurer or pharmacy benefit manager must include any cost-sharing amount paid by either the enrollee or another person on behalf of the enrollee for a drug that is without a generic equivalent.
AZ	HB 2285	Signed by Governor	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to update their maximum allowable cost (MAC) lists in a timely manner. This measure also requires PBMs to share with pharmacies the sources used to determine MAC pricing. This measure also requires PBMs to establish an appeals process by which pharmacies can appeal MAC pricing reimbursement.
AR	HB 1269	Signed by governor (Act 637)	Other	This measure allows pharmacists to make biological product substitutions when there will be cost savings for the patient. The pharmacist must disclose the amount of the savings at the request of the patient.
AR	SB 520	Signed by governor (Act 994)	Pharmacy Benefit Manager	This measure requires a pharmacy benefit manager (PBM) to report rebate information to the Insurance Commissioner on a quarterly basis. This bill also prohibits a PBM from conducting "spread pricing" in the state. Under this bill, spread pricing applies to prescription drug pricing in which the PBM charges a plan a contracted price for prescription drugs, and the contracted price for the drugs differs from the amount the PBM directly or indirectly pays the pharmacist. This measure also requires a PBM to provide an appeal procedure to allow pharmacies to challenge maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drug as being an amount less than the current approved fee for the fee-for-service Arkansas Medicaid program-covered outpatient prescription drug reimbursement that includes an ingredient cost for the drug.
CA	ACR 105	Adopted in Assembly; referred to Senate Health Committee	Volume Purchasing	This is a resolution that encourages the governor to engage with Washington and Oregon and others who wish to partner with California to lower prescription drug prices across the country.
CA	AB 824	Signed by Governor	Other	This bill provides that an agreement resolving or settling a patent infringement claim, in connection with the sale of a pharmaceutical product, is to be presumed to have anticompetitive effects if a non-reference drug filer receives anything of value from another company asserting patent infringement, and if the non-reference drug filer agrees to limit or forego research, development, manufacturing, marketing or sales of the non-reference drug filer's product for any period of time.
CO	SB 5	Signed by Governor	Importation	This measure directs the Department of Health Care Policy and Financing to design a program to allow for the wholesale importation of prescription pharmaceutical products from Canada for sale to Colorado consumers.
CO	HB 1131	Signed by Governor	Transparency	This measure requires a drug manufacturer or a representative of a manufacturer to provide the wholesale acquisition cost of a prescription drug to an entity or individual with whom the manufacturer or wholesale is sharing information about the drug.
CO	HB 1216	Signed by Governor	Other	This measure caps the cost sharing a covered person is required to pay for prescription insulin drugs to $100 per one-month supply of insulin. The bill requires the Department of Law to investigate the pricing of prescription insulin drugs and submit a report of its finding.

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CO	HB 1296	Laid over in House Appropriations Committee	Transparency	This measure requires health insurers to submit information to the Insurance Commissioner about prescription drugs covered under their health insurance plan and paid for in the preceding calendar year, including information about rebates from manufacturers. This bill also requires reporting from manufacturers for drugs that cost $100 for a course of therapy and have increased in price by 10% over the course of a year or 16% over two years, or a drug that is considered essential and has increased by the same amounts. Under this bill, pharmacy benefit managers (PBMs) will also have to report information regarding rebates. This bill also requires an insurance carrier to reduce the cost sharing an enrollee is required to pay for a prescription drug by an amount equal to the greater of 51% of the average aggregate rebates received by the carrier for all prescription drugs, or an amount that ensures cost sharing will not exceed 125% of the carrier's cost for the drug. Finally, this bill prohibits PBMs from retroactively reducing payments on a clean claim submitted by a pharmacy.
CT	HB 6862	Failed upon adjournment	Importation	This measure allows the Department of Consumer Protection to import prescription drugs on a wholesale basis from Canada to provide consumers with a cost-saving alternative for prescription drugs.
CT	HB 7174	Failed upon adjournment	Volume Purchasing	This measure establishes the Connecticut Prescription Drug Program, which will purchase outpatient drugs, make them available at the lowest possible cost to participating individuals, maintain a list of the most cost-effective and therapeutically effective drugs available, purchase and provide discounted drugs, and coordinate a comprehensive pharmacy benefit for participating individuals. The comptroller will establish eligibility criteria and will negotiate with pharmaceutical manufacturers to secure discounts/rebates. Under the bill, the comptroller can cooperate with other states or regional consortia to purchase drugs. This bill also requires manufacturers to send notice to the Insurance Commissioner regarding "pay-for-delay" agreements. Within 30 days of receiving notice, the commissioner must send notice to each health carrier and disclose the name of the drug subject to the notice. If a carrier includes that drug on its formulary, the carrier must immediately reduce the cost of the drug by 50% of the wholesale list price for the drug. This measure also allows qualified private employers to purchase prescription drugs for their employees under the purchasing authority of the state or through the State Employees' Bargaining Agent Coalition's collective bargaining agreement. Additionally, this bill establishes a task force to study drug importation.
CT	HB 7267	Failed upon adjournment	Importation	This measure extends the period of time a child can retain dental insurance coverage under a parent's health insurance policy. An amendment to the bill requires the Commissioner of Consumer Protection to establish a wholesale Canadian prescription drug importation program.
CT	SB 27	Failed upon adjournment	Cost Review (Rate Setting)	This measure authorizes the Commissioner of Social Services to reduce prescription drug costs in the Medicaid program by establishing a price cap that requires additional negotiation for rebates with manufacturers and review when the cap is exceeded. This measure also requires the commissioner to develop a transparent reimbursement model for pharmacy benefit managers (PBM) that allows the Medicaid program to pay the discounted cost for drugs negotiated by the PBMs.
CT	SB 84	Failed upon adjournment	Importation	This measure allows for the wholesale importation of prescription drugs from Canada.
CT	SB 142	Failed upon adjournment	Importation	This measure establishes a wholesale Canadian drug importation program.
CT	SB 332	Failed upon adjournment	Pharmacy Benefit Managers	This measure requires that each pharmacy benefits manager (PBM) establish a uniform rate of compensation for each prescription drug covered by a drug benefit administered by the PBM.
CT	SB 370	Failed upon adjournment	Cost Review (Rate Setting)	This measure establishes a prescription drug review board to investigate spikes in prescription drug pricing.
DE	HCR 35	Passed House and Senate	Purchasing	This measure establishes the Interagency Pharmaceuticals Purchasing Study Group to review and made recommendations on how to leverage the bulk purchasing power of the state to negotiate lower prices.
DE	HCR 57	Passed Senate	Study	This measure establishes a task force to study pharmacy reimbursement practices in the state and the best practices and laws of other states to develop recommendations for action by the General Assembly or others. The task force must focus on reimbursement practices of pharmacy benefit managers.

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DE	HB 24	Signed by Governor	Pharmacy Benefit Managers	This measure prohibits insurers and pharmacy benefit managers from engaging in the practice of clawbacks. Under this measure, a carrier may not impose a copayment or coinsurance requirement for a covered drug that exceeds the lesser of the applicable cost-sharing amount or the amount an individual would pay for the drug if the individual were paying the usual and customary price.
DE	HB 194	Signed by Governor	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to register with the Insurance Commissioner and empowers the commissioner to issue cease and desist orders based on fraudulent acts or violations committed by PBMs. Under this bill, a PBM engaging in maximum allowable cost (MAC) pricing must make available to each network provider the sources utilized to determine the MAC pricing, provide a way for providers to readily access the most recently-updated MAC list, review and update MAC information at least once every week, and ensure that dispensing fees are not included in MAC calculations.
DE	HB 2166	Passed House Economic Development/Banking/Insurance and Commerce Committee	Pharmacy Benefit Manager	This measure authorizes a pharmacist or pharmacy to decline to dispense a prescription drug or provide pharmacy service to an "insured" if the amount reimbursed is less than the pharmacy acquisition cost. This bill also prohibits a pharmacy benefit manager (PBM) from reimbursing a pharmacist or pharmacy for a drug in an amount less than the PBM reimburses itself or an affiliate for the same drug.
FL	HB 19/SB 1452	Signed by Governor	Importation	This measure establishes a wholesale Canadian drug importation program. The state will contract with a vendor to provide services under the program, and the vendor will develop a wholesale prescription drug importation list identifying the prescription drugs that have the highest potential for savings to the state.
FL	SB 1528	Substituted by HB 19	Importation	This measure establishes the wholesale Canadian Prescription Drug Importation Program within the Agency for Health Care Administration. The agency will contract with a vendor to provide services under the program, and the vendor will develop a wholesale prescription drug importation list identifying the prescription drugs that have the highest potential for savings to the state.
GA	HB 233	Signed by Governor	Pharmacy Benefit Manager	This measure prohibits pharmacies from sharing or transferring records relative to prescription information for any commercial purpose with an affiliate. It also prohibits pharmacies from presenting a claim for a service furnished pursuant to a referral from an affiliate.
GA	HB 323	Signed by Governor	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to report annually to each client the aggregate amount of all rebates that the PBM received from pharmaceutical manufacturers in connection with claims and the aggregate amount of such rebates the PBM received from pharmaceutical manufacturers that it did not pass through to the client.
HI	HB 267/SB 1328	Conference committee appointed	Transparency	This measure requires drug manufacturers that produce a drug with a wholesale acquisition cost (WAC) of more than $40 to notify each benefit plan and pharmacy benefit manager of any planned price increase that will result in a 16% or more increase in the WAC over a two-year period. Notice of planned increases must be provided at least 60 days before the increase.
HI	HB 1442/SB 1521	Referred to House Finance Committee	Pharmacy Benefit Managers	This measure establishes requirements for pharmacy benefit managers (PBMs) and maximum allowable cost. This bill requires PBMs to disclose where an equivalent drug can be obtained at or below the maximum allowable cost.
HI	SB 507	Referred to Senate Commerce, Consumer Protection and Health Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBM) to notify contracting pharmacies of changes to maximum allowable costs (MAC) for any drug 15 days before the change. This measure also requires PBMs to disclose where an equivalent drug can be obtained at or below the maximum allowable cost when a MAC appeal is upheld on appeal. This measure also allows a pharmacy to decline to dispense a drug if the reimbursement is less than the acquisition cost
HI	SB 1401/HB 1361	Conference committee appointed	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBM) to obtain a license and prohibits a PBM from providing financial incentives to covered persons as incentives to use a retail pharmacies. This measure also requires PBMs to submit annually a transparency report regarding rebates received from manufacturers.
ID	S 1068	Passed Senate; referred to House Health and Welfare Committee	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers to register annually with the Department of Insurance. This bill also prohibits a PBM from withholding cost information to consumers. Under this bill, a pharmacy cannot charge a copayment that exceeds the total submitted charges by the network pharmacy.

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IL	HB 53	Referred to House Prescription Drug Affordability and Accessibility Committee	Transparency	This measure requires manufacturers of brand name or generic prescription drugs to notify state purchasers, health insurers, pharmacy benefit managers and the general assembly about specified increases in drug prices at least 60 days before an increase, and the cost of new prescription drugs within three days of US Food and Drug Administration approval. Notice must be provided if the brand manufacturer is increasing the wholesale price of the brand name drug by more than 10% or $10,000 during a 12-month period or if the generic manufacturer is increasing the wholesale price by 25% during a 12-month period. Price increases must be justified by manufacturers.
IL	HB 156	Referred to Senate Assignments Committee	Transparency	This measure requires health insurers to disclose certain rate and spending information concerning prescription drug pricing information to the Department of Public Health, which in turn must create a list annually of the state's high-spend drugs. This measure also requires drug manufacturers to notify the attorney general when they plan to introduce a new drug at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. This measure also requires a health insurer to apply the same cost-sharing requirements to interchangeable biological products as apply to generic drugs under the policy. Additionally, this measure instructs pharmacists to select the lowest-priced interchangeable biological product in place of a biologic drug, rather than allowing a pharmacist to substitute only if certain requirements are met. Finally, this bill requires that when a pharmacist receives a prescription from a Medicaid enrollee, the pharmacist must select the preferred drug or biologic from the state's preferred drug list.
IL	HB 204	Referred to House Appropriations - Human Services Subcommittee on Medicaid and Managed Care	Other	This measure reinstitutes the pharmaceutical assistance program for seniors that was eliminated by Public Act 97-689. The program will execute contracts with pharmacies to dispense covered prescription drugs and establish maximum limits on the size of prescriptions.
IL	HB 465	Signed by Governor	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to update their Maximum Allowable Cost (MAC) lists in a timely manner and to provide a process by which a pharmacy can appeal a MAC price. This measure also permits a plan sponsor contracting with a PBM to disclose the actual amounts paid by the PBM to pharmacies. Additionally, this measure prohibits PBMs from prohibiting pharmacies from disclosing cost information to enrollees. This bill also limits patient cost-sharing. This measure requires PBMs to register with the Insurance Director before operating in the state. This measure also requires health plans to apply any third-party payments, financial assistance, or discounts made on behalf of an enrollee toward the enrollee's cost-sharing responsibility or out-of-pocket maximum.
IL	HB 891	Referred to House Rules Committee	Pharmacy Benefit Managers	This measure allows a pharmacy or pharmacist to provide an insured consumer with information about the amount of the insured's cost-share for a prescription drug. Under this bill, neither a pharmacy nor a pharmacist will be penalized by a pharmacy benefit manager (PBM) for discussing cost information with a consumer or for selling a lower-priced drug if one is available.
IL	HB 1441	Referred to House Rules Committee	Importation	This measure establishes a wholesale Canadian drug importation program that allows the state to be a licensed wholesaler of imported drugs.
IL	HB 2174	Referred to Senate Insurance Committee	Other	This bill requires that every health insurance carrier that provides coverage for prescription drugs shall ensure that no fewer than 25% of certain individual and group plans offered shall apply a pre-deductible, flat-dollar copayment structure to the entire drug benefit.
IL	HB 2880	Referred to House Rules Committee	Other	This measure imposes a tax on each establishment that makes the first sale of a covered outpatient drug within the state. Under this bill, "first sale" means an initial sale of a covered outpatient drug from a manufacturer to a wholesaler or from a wholesaler to a pharmacy. This bill provides that the tax shall be charged against and paid by the establishment making the first sale and shall not be added as a separate charge or line item or otherwise passed down on any invoice to the customer.
IL	HB 3187	Referred to House Rules Committee	Pharmacy Benefit Manager	This measure provides that upon request by a party contracting with a pharmacy benefit manager (PBM), a PBM must disclose the actual amounts paid by the PBM to the pharmacy. Under this bill, a PBM will provide notice to the party contracting with the PBM about any consideration that the PBM receives from the manufacturer for dispense as written prescriptions once a generic or biologically similar product becomes available.

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IL	HB 3493	Failed House Prescription Drug Affordability and Accessibility Committee	Cost Review (Rate Setting)	This measure creates the Prescription Drug Affordability Board. The board must identify brand drugs and biologics that have a launch wholesale acquisition cost (WAC) of $30,000 or more or an increase of $3,000 in a year. The board must also identify biosimilar drugs that have a launch WAC that is not at least 15% lower than the reference biologic, as well as generic drug with a WAC of $100 or more, or that increased by 200% or more in a year. For drugs identified, the board will conduct a cost review. If the board determines the cost of a drug will lead to an affordability challenge for the state or patients, the board can establish an upper payment limit that applies to all purchases and payer reimbursements.
IL	SB 667	Sent to Governor	Other	This measure requires the attorney general to investigate the pricing of prescription insulin drugs to ensure adequate consumer protections for consumers and to determine whether additional consumer protections are necessary. This measure also provides that insurers must limit the total amount an enrollee is required to pay for insulin to $100 per 30-day supply, regardless of the type and amount needed. On January 1 of each year, the limit on the amount that an enrollee is required to pay will increase by a percentage equal to the change from the preceding year of the Consumer Price Index.
IN	HB 1029	Signed by Governor (Public Law 22)	Study	This measure urges the legislative council to assign to the Interim Study Committee on Public Health, Behavioral Health and Human Services the task of studying issues related to prescription drug price transparency by drug manufacturers in Indiana.
IN	HB 1180	Amended; passed Senate; conference committee appointed	Pharmacy Benefit Managers	This measure urges the legislative council to assign to an appropriate interim study committee the topic of regulation and practices of pharmacy benefit managers, including licensure and the ability of pharmacists to inform patients of pricing information.
IN	HB 1228	Referred to House Public Health Committee	Importation	This measure requires the Department of Health to conduct a study and report to the legislative council concerning a state wholesale prescription drug importation program.
IN	HB 1249	Referred to House Public Health Committee	Other	This measure requires the Office of the Secretary of Family and Social Services to provide a prescription drug benefit for a Medicaid recipient under the risk based managed care program and the Healthy Indiana Plan. Current law allows the office or the managed care organization to provide the benefit.
IN	HB 1252	Referred to House Insurance Committee	Pharmacy Benefit Managers	This measure requires a pharmacy benefit manager (PBM) that is not licensed as an administrator to be registered with the Board of Pharmacy. This measure also requires PBMs to submit annually a report containing information on the aggregate amount of all rebates the PBM received from pharmaceutical manufacturers, the aggregate amount of administrative fees that the PBM received from manufactures, and the aggregate amount of retained rebates the PBM received from manufacturers that were not passed through to the insurers.
IN	HB 1588	Signed by Governor (Public Law 286)	Study	This measure urges the legislative council to assign to an appropriate interim study committee the topic of regulating pharmacy benefit managers (PBMs) and their practices. If the topic is studied, the committee must provide any recommendations concerning licensure of PBMs and contracts that limit the disclosure of pricing information to consumers and other practices.
IN	SB 40	Referred to Senate Health and Provider Services Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBM) to obtain a certificate of registration. This measure also requires PBMs to submit annually a report with information about aggregate rebates received from all pharmaceutical manufacturers.
IN	SB 415	Referred to Senate Health and Provider Services Committee	Price Gouging	This bill prohibits a manufacturer or a wholesale distributor from engaging in price gouging in the sale of an essential off-patent or generic drug. The Office of the Secretary of Family and Social Services may provide a written notice of a price increase to the attorney general if the price increase represents an increase of at least 50% in the wholesale acquisition cost of the drug during a 12-month period and a 30-day supply of the drug costs $80 or more. Manufacturers must submit to the attorney general a statement that explains the price increase. The attorney general may bring action against a manufacturer under this bill.
IA	HF 489/SF 347/SF 563	Withdrawn/Reported out of Senate Human Resources Committee as SF 563/Signed by Governor	Pharmacy Benefit Manager	This measure requires each pharmacy benefit manager (PBM) to annually submit a report to the Insurance Commissioner. The report must contain rebate information.

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KY	HB 374	Introduced	Coupons	This measure prohibits a pharmacy benefit manager (PBM) from prohibiting financial assistance received by an insured from applying toward any cost sharing owed by the insured under the health benefit plan. Under this bill, amounts paid on an insured's behalf must apply towards any out-of-pocket maximums.
KY	HB 502	Referred to House Banking and Insurance Committee	Transparency	This measure requires the Cabinet for Health and Family Services to annually compile a list of essential diabetes medications that have been subject to at least a 10% price increase over the course of the year. Under the bill, manufacturers will be required to submit information to the cabinet related to the cost of manufacturing and marketing the drugs on the list. Pharmacy benefit managers will also be required to submit information related to rebates for essential diabetes medications on the list.
LA	HR 254	Adopted	Pharmacy Benefit Manager	This measure requests that the Department of Insurance study and make recommendations regarding the regulation of pharmacy services administrative organizations.
LA	HB 432	Referred to House Insurance Committee	Pharmacy Benefit Manager	This measure requires pharmacy service administrative organizations (PSAO) to be registered and licensed with the Department of Insurance. This measure also requires a PSAO to provide copies of contacts, payment schedules, and reimbursement rates to independent pharmacies. This bill also requires that a PSAO that provides, accepts, or processes a discount must provide to the Insurance Department an aggregated total of all transactions by independent pharmacy and an aggregated total of any payments received by the PSAO for providing, processing or accepting any discount.
LA	HB 433	Signed by Governor	Pharmacy Benefit Manager	This measure authorizes a pharmacist to decline to dispense a covered prescription drug if the coverage provider reimburses the pharmacy in an amount less than the drug's acquisition cost. If a pharmacy declines to provide a drug, the pharmacy must provide the consumer with information as to where the prescription may be filled.
LA	SB 41	Signed by Governor	Pharmacy Benefit Manager	This measure requires a pharmacy benefit manager (PBM) to obtain licensure from the state and authorizes the State Board of Medical Examiners to regulate PBMs. This measure additionally prohibits PBMs from participating in spread pricing in most circumstances. This measure also prohibits a PBM from reimbursing a local pharmacy less than a chain pharmacy. Additionally, this measure creates the PBM Monitoring Advisory Council. This measure requires PBMs to use good faith, honesty, trust, confidence and candor to beneficiaries of any PBM plans.
LA	SB 48	Substituted; passed Senate Health and Welfare Committee	Other	This measure requires the Department of Health and Human Services to establish a single preferred drug list that utilizes a prior approval process or any other process that proves to be cost-effective to the medical assistance program.
LA	SB 164	Deferred in House Health and Welfare Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from withholding cost information from a consumer. This measure also requires PBMs to obtain licensure from the Insurance Commissioner.
LA	SB 239	Signed by Governor	Pharmacy Benefit Manager	This measure allows the Louisiana Department of Health to remove pharmacy services from Medicaid managed care organization contracts and assume direct responsibility for all Medicaid pharmacy services. If the department does not carve in pharmacy services, the pharmacy benefit manager (PBM) administering benefits must be reimbursed a transaction fee only and will not be allowed to retain any portion of spread pricing or state supplemental rebates.
ME	LD 1162	Signed by Governor	Transparency	This measure requires manufacturers to report annually to the Maine Health Data Organization (MHDO) about drug prices when the manufacturer has, during the prior calendar year, increased the wholesale acquisition cost (WAC) of a brand-name drug by more than 20% per pricing unit, increased the WAC of a generic that costs at least $10 per pricing unit by more than 20% per pricing unit, or introduced a new drug for distribution when the WAC is greater than the Medicare Part D threshold. The bill also requires manufacturers, wholesale drug distributors, and pharmacy benefit managers to provide pricing component data per pricing unit of a drug within 60 days of a request by the MHD.
ME	LD 1272	Signed by Governor	Importation	This measure establishes a Canadian wholesale prescription drug importation program. Maine's Department of Health and Human Services must submit a request for approval and certification of the program to the US Department of Health and Human Services no later than May 1, 2020. This bill allows Maine to consider whether the program may be developed on a multistate basis through collaboration with other states.
ME	LD 1387	Carry over to next session	Importation	This measure allows an individual to import a prescription drug from a pharmacy in Canada that is allowed to export drugs under Canadian regulations for personal use. This measure prohibits the personal importation of controlled substances.

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ME	LD 1389	Failed Health Coverage, Insurance and Financial Services Committee	Pharmacy Benefit Manager	This bill requires that the Department of Health and Human Services register pharmacy benefit managers (PBMs) . This bill places a fiduciary duty on PBMs with respect to insurer clients and prohibits PBMs from entering into a contract that prohibits a pharmacy from recommending a lower cost alternative to a consumer. This measure also limits the amount of payment required by a covered person for a prescription drug at the point of sale and requires an annual report from PBMs that details rebates received from manufacturers.
ME	LB 1409	Failed Health Coverage, Insurance and Financial Services Committee	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to report annually information related to rebates. This measure also requires that a carrier or PBM certify on an annual basis that each health plan offered in the state will pass at least 50% of any drug rebates to consumers. Finally, this bill also requires the Maine Health Data Organization to report annually information related to drug costs and price increases.
ME	LD 1499	Signed by Governor	Cost Review (Rate Setting)	This bill establishes the Maine Prescription Drug Affordability Review Board. The board is made up of five members and has a 12-member advisory council. The board may recommend that a public payer pay an annual assessment to support the administrative costs of the board. Beginning in 2021, the board will determine annual spending targets for prescription drugs purchased by public payers based on a 10-year rolling average of the medical care services component of the Consumer Price Index plus a reasonable percentage for inflation and minus a spending target determined by the board for pharmacy savings. The board will also have the authority to determine spending targets on specific drugs that may cause affordability challenges to enrollees in a public plan. The board will determine methods for a public payer to meet spending targets established by the board and must determine if the following methods would reduce costs to individuals purchasing drugs through a public payer: negotiating specific rebate amounts on drugs that contribute most to spending that exceeds the targets; changing a formulary when sufficient rebates cannot be secured; changing a formulary with respect to all of the prescription drugs of a manufacturer within a formulary when sufficient rebates cannot be secured; establishing a common formulary for all public payers; prohibiting health insurance carriers from offering on their formularies a drug by a manufacturer when methods to change a formulary are implemented; bulk purchasing through a single purchasing agreement; collaborating with other states and consortia to purchasing in bulk or to jointly negotiate rebates; allowing insurance carriers providing coverage to small businesses and individuals to participate in the public payer prescription drug benefit for a fee; and procuring common expert services for public payers, including PBM services. The board must report its recommendations, including spending targets, by Oct. 1, 2020.
ME	LD 1504	Signed by Governor	Pharmacy Benefit Manager	This measure ensures that a pharmacy benefits manager (PBM) has a fiduciary duty to a carrier client. This measure prohibits PBMs from penalizing pharmacies or pharmacists for disclosing cost information to consumers. This bill also prohibits a carrier or PBM from requiring a consumer to make an excessive payment at the point of sale for a covered prescription drug. Under this bill, any compensation remitted by a manufacturer and retained by the PBM must be used by the carrier to lower premium costs or remitted directly to the covered person at the point of sale to reduce out-of-pocket costs. Additionally, if a carrier uses any PBM to administer or manage drug benefits, this bill provides that any PBM compensation constitutes an administrative cost incurred by a carrier for purposes of calculating anticipated loss ratio.
ME	LD 1591	Carry over to next session	Importation	This measure instructs the Department of Health and Human Services to design a wholesale prescription drug importation program.
MD	HB 1120/SB 946	Passed House/Passed House	Other	This measure requires the establishment of the Maryland State Retiree Prescription Drug Coverage Program. This measure authorizes retirees who participate in a prescription drug benefit plan with a spouse or dependent child to elect to have the spouse or dependent child covered under a state prescription drug benefit plan. It also authorizes survivors to enroll in a state prescription drug benefit plan.
MD	HB 1324/SB 1039	Failed upon adjournment/Failed upon adjournment	Pharmacy Benefit Manager	This measure requires the Maryland Medical Assistance Program to establish reimbursement levels, rather than maximum reimbursement levels for certain drugs. Under this bill, a pharmacy benefit manager (PBM) that contracts with a pharmacy must reimburse the pharmacy an amount that is at least equal to the National Average Drug Acquisition Cost plus the dispensing fee.

MD	SB 759/HB 768	Became law without Governor's signature	Cost Review (Rate Setting)	This measure establishes a Prescription Drug Affordability Board, which will be required to study the entire pharmaceutical distribution and payment system, as well as policy options used by other states and countries to lower the list price of pharmaceuticals, including setting upper payment limits, using a reverse auction marketplace, and implementing a bulk purchasing process. This study must be conducted before Dec. 31, 2020. Under this bill, the board must identify circumstances under which the cost of a prescription drug product may create or has created affordability challenges. If the board finds that it is in the best interest of the state to establish a process for setting upper payment limits for drugs that cause affordability challenges, the board must draft a plan of action for implementing the process that includes the criteria the board will use to set upper payment limits. The plan must either be approved by the Legislative Policy Committee or the Governor and Attorney General. The board will use information collected from the pharmaceutical supply chain to identify brand-name drugs that have a launch wholesale acquisition cost (WAC) of $30,000 or more per year, or that have had a WAC increase of $3,000 or more in a year. The board will also identify biosimilar drugs that have a launch WAC that is not priced more than 15% lower than the referenced brand biologic. For generics, the board will identify drugs that have a WAC of $100 or more for a course of treatment or that increased by 200% or more during the immediately preceding 12-month period.
MD	SB 819/HB 920	Failed upon adjournment	Transparency	This measure requires the Secretary of Health to identify up to 10 prescription drugs on which the state spends significant health care dollars, and for which the wholesale acquisition cost has increased by a total of 50% or more during the immediately preceding calendar year. Manufacturers of drugs on the list will be required to submit pricing information. This measure also requires pharmacy benefit managers (PBM) to provision the commissioner with a report on aggregate rebates from manufacturers.
MA	H 931	Referred to Joint Financial Services Committee	Transparency	This measure requires three representatives from the pharmaceutical industry to attend the Health Policy Commission's annual public hearing based on information submitted to the Center for Health Information and Analysis. They will be required to share information concerning factors underlying drug costs and price increases, the impact of manufacturer rebates, and the availability of alternative drugs. This bill also requires pharmaceutical manufacturers to provide early notice to the commission for a pipeline drug, an abbreviated new drug application or a biosimilar biologic license. This bill requires manufacturers to report drug pricing information to the commission.
MA	H 1013/S 652	Referred to Joint Financial Services Committee/Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from prohibiting a pharmacy from disclosing to an individual the cost of the prescription medication and the availability of any equivalent medication or alternative methods of purchasing the drug, including cash price. Additionally, under this bill, no PBM can require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the amount an individual would pay for the medication without insurance.
MA	H 1055/S 640	Referred to Joint Financial Services Committee/Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from prohibiting a pharmacy or pharmacist from providing information to a consumer regarding cost sharing or lower-cost alternatives. This measure also contains language regarding maximum allowable cost lists.
MA	H 1104	Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from prohibiting a pharmacy or pharmacist from providing information to a consumer regarding cost sharing or lower-cost alternatives. This measure also contains language regarding maximum allowable cost lists.

MA	H 1133/S 706	Referred to Joint Health Care Financing Committee/Referred to Joint Health Care Financing Committee	Cost Review (Rate Setting)	This measure requires the Health Policy Commission to decide whether to review a prescription if, based on information submitted by manufacturers, a drug could lead to an entity increase expenditures above the health care cost growth benchmark or if it would could create challenges to the affordability of health care in the state. A brand name drug or biologic can be reviewed if the product has a launch cost of $30,000 or more or a wholesale acquisition cost (WAC) of $3,000 or more. A biosimilar can be reviewed if the launch WAC is not at least 15% lower than the referenced brand biologic. Generic drugs can be reviewed if there is a price increase that results in an increase in the WAC that is equal to 200% or more over a year and the WAC is at least $100. The review will determine if the commission will set an upper payment limit on the drug. This measure also requires manufacturers to give 60 days' notice prior to a WAC increase of 10% or more for a drug that costs over $40. This measure also requires a study of the impact of pharmaceutical manufacturing company pricing factors and methodologies and the pharmacy benefit manager (PBM) business model. The top 20 selling drugs in the state will be studied. The Center for Health Information and Analysis will also require PBMs to submit information regarding rebates. This measure also requires the Secretary of Health and Human Services to set a pharmaceutical spending target pursuant to supplemental rebate cost containment. Under this bill, the secretary may directly negotiate supplemental rebate agreements with manufacturers. If a manufacturer and the secretary cannot establish a supplemental rebate agreement, the secretary can require the manufacturer to disclose records relating to the pricing of the drug under consideration. If the secretary deems the manufacturer's price excessive, the secretary can impose a penalty on the manufacturer. This measure requires PBMs to obtain a license and establishes a fiduciary duty to health benefit plans.
MA	H 1154	Referred to Joint Health Care Financing Committee	Transparency	This measure requires the Center for Health Information and Analysis to annually prepare a list of at least 10 outpatient drugs that the center determines account for a significant share of state health care spending. The manufacturer of a drug on the list must provide an explanation of the increase and aggregate, company-level research and development costs. This measure also requires pharmacies to post notices informing consumers that they can request the current pharmacy retail price for prescription drugs at the point of sale. If the consumer's cost-sharing amount for the drug exceeds the retail price, the pharmacist will charge the consumer the applicable cost-sharing amount or the current retail price. Additionally, this bill prohibits a pharmacy benefit manager (PBM) from preventing pharmacists from disclosing cost information to a consumer.
MA	H 1162/S 552	Referred to Joint Health Care Financing Committee/Referred to Joint Financial Services Committee	Transparency	This measure requires the Health Policy Commission to annually identify up to 15 prescription drugs on which the state spends significant health care dollars and for which the wholesale acquisition cost has increased by 50% or more over the past five years or by 15% or more over the past 12 months. For each drug on the list, the Attorney General will require manufacturers to submit pricing information. This measure also requires manufacturers to submit a report to the Health Policy Commission for each price increase of a prescription drug that will result in an increase in the average manufacturer price of that drug that is at least 10% over a year. Each year, the commission will hold public hearings based on the reports submitted by manufacturers.

MA	H 1167	Referred to Joint Health Care Financing Committee	Transparency	This measure requires the Health Policy Commission and the Center for Health Information and Analysis to create annually a list of 10 drugs on which the MassHealth program spends significant health care dollars and for which the WAC has increased by 50% or more over the past five years or by 15% during the previous year. This bill also requires carriers to create annually a list of 10 prescription drugs on which its plans spend significant amounts of their premium dollars, and for which the cost to the plans, net of rebates, has increased by 50 % or more over the past five years or 15% during the previous year. Using both sets of information, the Attorney General will create a list of up to 15 drugs on which the greatest amount of money was spent. Manufacturers of those drugs must submit pricing information to justify the increase in the net cost of the drug..
MA	H 1178	Referred to Joint Health Care Financing Committee	Transparency	This measure requires the Center for Health Information and Analysis to annually prepare a list of at least 10 outpatient drugs that the center determines account for a significant share of state health care spending. The manufacturer of a drug on the list must provide an explanation of the increase and aggregate, company-level research and development costs. This measure also requires pharmacies to post notices informing consumers that they can request the current pharmacy retail price for prescription drugs at the point of sale. If the consumer's cost-sharing amount for the drug exceeds the retail price, the pharmacist will charge the consumer the applicable cost-sharing amount or the current retail price. Additionally, this bill prohibits a pharmacy benefit manager (PBM) from preventing pharmacists from disclosing cost information to a consumer.
MA	H 1193	Referred to Joint Health Care Financing Committee	Cost Review (Rate Setting)	This measure creates the Drug Cost Review Commission. The commission will be notified by a manufacturer of a patent-protected, brand-name drug or biologic if the wholesale acquisition cost (WAC) increases by more than 10% or by $10,000 during any 12-month period or if the manufacturer intends to introduce to market a brand-name drug that has a WAC of $30,000 or more. A manufacturer of a generic or off-patent, sole-source brand product must notify the commission if the manufacturer is increasing the WAC by more than 25% or more $300 during a year. The commission will use a variety of economic factor to determine whether a drug has an excessive cost. If the commission determines a drug has an excessive cost, it will establish the level of reimbursement that will be paid among payers and pharmacies and wholesalers/distributors.
MA	H 1972	Referred to Joint Public Health Committee	Importation	This measure establishes a wholesale prescription drug importation program.

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MA	HB 4000	Signed by Governor	Cost Review (Rate Setting)	This is the conference committee version of the governor's budget proposal. Under this bill, the Executive Office of Health and Human services may directly negotiate supplemental rebate agreements (SRAs) with manufacturers for drugs covered by MassHealth. Negotiations may be based on value, efficacy, or outcomes of a drug. Before seeking an SRA with a manufacturer, the executive office must consider a drug's actual cost to the state and whether the manufacturer is providing significant discounts relative to other drugs covered by MassHealth. If the executive office and the manufacturer cannot conclude negotiations for an SRA and the drug is projected to exceed a cost of $25,000 per person per year or an aggregate annual cost to MassHealth of $10 million, the executive office may identify a proposed value of the drug. The executive office must consider a variety of factors when determining the proposed SRA or proposed value. There will be a public hearing in which the manufacturer can provide testimony. After the hearing, the executive office can make any updates to the proposed value or can engage in additional negotiations with the manufacturer. If, after this process, the manufacturer and executive office are unable to conclude negotiations, the Secretary of Health and Human Services will refer to manufacturer to the Health Policy Commission for review. The Health Policy Commission can then require a manufacturer of a specific drug to disclose drug pricing information, including a schedule of the drug's wholesale acquisition cost (WAC) over the past five years. Based on the information submitted, the commission may identify a proposed supplemental rebate for that drug. The proposed supplemental rebate may be based on a proposed value of the drug. If, after review of any records furnished to the commission, the commission determines that the manufacturer's pricing of the drug is potentially unreasonable or excessive in relation to the commission's proposed value, the commission must request the manufacturer provide additional drug pricing information and the manufacturer's justification for that pricing. This measure requires the commission to base its determination solely on the analysis or research of an outside third party. Each year, the executive office will report on the amount of supplemental rebates received under this law, the number of drugs receiving a supplemental rebate under this law, and a breakdown of the duration of the supplemental rebates received. Unlike previous versions of this bill, this version does not require manufacturers to negotiate or attend public hearings, and companies accused of charging excessive prices will not be referred to the attorney general.
MA	HB 4134	Governor's Health Care Bill	Cost Review (Rate Setting)	This measure subjects manufacturers of drugs that cost more than $50,000 per year to the Health Policy Commission accountability process. This measure also imposes a penalty on manufacturers that increase the price of a drug by more than 2% above the rate of inflation in a given year. This bill requires representatives from the pharmaceutical industry to participate in cost trend hearings and requires pharmacy benefit managers to obtain certification from the Department of Insurance.
MA	S 601	Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from charging a health carrier or health benefit plan more than what was paid to the pharmacy for those services. This measure also requires PBMs to submit aggregate rebate information to the Division of Insurance.
MA	S 646	Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure requires the Insurance Commissioner to promulgate regulations for the licensing of pharmacy benefit managers.
MA	S 653	Referred to Joint Financial Services Committee	Transparency	This measure requires insurance issuers that charge enrollees a cost-sharing amount that may result in an excessive consumer cost burden for covered prescription drugs to disclose to enrollees the fact that enrollees may be subject to an excessive cost burden. Under this bill, "excess consumer cost burden" means a cost burden amount charged to an enrollee for a covered drug that is greater than the amount that an enrollee's health insurance issuer pays, or would pay absent enrollee cost sharing.
MA	S 654	Referred to Joint Financial Services Committee	Pharmacy Benefit Manager	This measure requires the Insurance Commissioner to promulgate regulations for the licensing of pharmacy benefit managers.
MA	S 659	Became S 2364 (amended out of scope)	Pharmacy Benefit Manager	This measure requires pharmacies to post a notice informing consumers that a consumer may request current pharmacy retail prices at the point of sale. If a consumer's cost-sharing amount exceeds the retail price, the pharmacist must notify the consumer and charge the consumer the applicable cost-sharing amount or the current retail price.

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MA	S 695	Referred to Joint Health Care Financing Committee	Volume Purchasing	This measure establishes a special commission to examine the prospect of establishing a system for bulk purchasing and distribution of pharmaceutical products with a significant public health benefit and the potential for significant health care cost savings through overall increased purchase capacity.
MA	S 696/H 3551	Referred to Joint Health Care Financing Committee; Referred to Joint Elder Affairs Committee	Transparency	This measure requires the Health Policy Commission to develop a list of critical prescription drugs for which there is substantial public interest in understanding the development of pricing. The commission will examine multiple cost factors, including the total cost of production per dose, research and development costs and marketing costs. The commission will annually identify the drugs that due to their cost, jeopardize the state's ability to meet the statewide health care cost growth benchmark.
MA	S 712	Referred to Joint Health Care Financing Committee	Transparency	This measure requires the Health Policy Commission to conduct an annual study of pharmaceutical manufacturing companies with pipeline drugs, generic drugs, or biosimilar drug products that may have a significant impact on statewide health care expenditures. The Center for Health Information and Analysis will obtain cost information from manufacturer information. This measure also requires pharmaceutical manufacturers to provide early notice to the commission for a pipeline, an abbreviated new drug application for generic drugs, or a biosimilar biologics license application. This measure also requires the attorney general to monitor trends in the health care market and gives the attorney general to investigate manufacturers or pharmacy benefit managers.
MA	S 733	Substituted by S 2397	Pharmacy Benefit Manager	This measure requires a pharmacy to notify consumers that at the point of sale, they may request the current pharmacy retail price. If a pharmacist determines that the cost sharing for a prescription exceeds the current retail price, they shall notify the customer of the pharmacy retail price and the difference between it and the consumer's cost-sharing amount. A pharmacist will charge a customer the applicable cost-sharing or the current pharmacy retail price for that prescription, whichever is less.

MA	S 2397	Substituted for S. 733; passed Senate Ways and Means Committee; amended; substituted by S. 2409	Other	This measure authorizes the Health Policy Commission (HPC) to review drug costs that could have a significant impact on consumers. Drugs eligible for review are brand-name drugs or biologics that have a launch WAC of $50,000 or more for a one-year supply or biosimilar drugs that have a launch WAC that is not at least 15 percent lower than the referenced brand biologic. Public health essential drugs with a WAC of more than $25,000 for a+E100 one-year supply are also eligible for HPC review. The HPC can require a manufacturer to disclose pricing information in order to review a drug's cost. If, after reviewing a drug, the HPC determines the pricing of the drug does not exceed the proposed value, the HPC must evaluate other ways to mitigate the drug's cost in order to improve access. The HPC can issue recommendations on ways to reduce the cost of the drug, including an alternative payment plan or methodology, a bulk purchasing program, cost-sharing restrictions, and a reinsurance program to subsidize the cost of the drug. If the HPC determines the pricing of a drug exceeds the proposed value, the HPC must request that the manufacturer provide additional information related to the pricing of the drug. The HPC will then determine whether the pricing exceeds the HPC's proposed value. If it does, the HPC will notify the manufacturer and requires the manufacturer enter into access improvement plan. The plan must be generated by the manufacturer, identify the reasons for the drug's price and include specific strategies, adjustments and action steps the manufacturer proposes to address the cost of the drug in order to improve access. The timetable for an access improvement plan cannot exceed 18 months. The HPC will approve any plan that is likely to address the cost so that patient access improves and has a reasonable expectation for successful implementation. After the conclusion of the implementation timetable, a manufacturer must report outcomes to the HPC. If the HPC deems the outcomes insufficient, the HPC will extend the timetable and approve any amendments to the plan. If a manufacturer declines to enter into an improvement plan, the HPC can publicly post the proposed value of the drug, hold a public hearing on the proposed value and solicit public comment. The manufacturer will be required to appear and testify at any hearing held on a drug's proposed value. This measure establishes a four-year program to assess the public health utilization and cost impacts of capping copays and eliminating deductibles and co-insurance requirements for insulin. Under this bill, coverage for insulin cannot be subject to any deductible or coinsurance and copays cannot exceed $25 per month per insulin prescription. This measure requires PBMs to obtain a license from the Department of Insurance and requires PBMs to report rebate information to the Center for Health Information and Analysis.

MA	S 2409	Substituted for S. 2397; referred to House Committee on Ways and Means	Other	This measure authorizes the Health Policy Commission (HPC) to review drug costs that could have a significant impact on consumers. Drugs eligible for review are brand-name drugs or biologics that have a launch wholesale acquisition cost (WAC) of $50,000 or more for a one-year supply or biosimilar drugs that have a launch WAC that is not at least 15% lower than the referenced brand biologic. Public health essential drugs with a WAC of more than $25,000 for a one-year supply are also eligible for HPC review. The HPC can require a manufacturer to disclose pricing information in order to review a drug's cost. If, after reviewing a drug, the HPC determines the pricing of the drug does not exceed the proposed value, the HPC must evaluate other ways to mitigate the drug's cost in order to improve access. The HPC can issue recommendations on ways to reduce the cost of the drug, including an alternative payment plan or methodology, a bulk purchasing program, cost-sharing restrictions, and a reinsurance program to subsidize the cost of the drug. If the HPC determines the pricing of a drug exceeds the proposed value, the HPC must request that the manufacturer provide additional information related to the pricing of the drug. The HPC will then determine whether the pricing exceeds the HPC's proposed value. If it does, the HPC will notify the manufacturer and requires the manufacturer enter into access improvement plan. The plan must be generated by the manufacturer, identify the reasons for the drug's price and include specific strategies, adjustments and action steps the manufacturer proposes to address the cost of the drug in order to improve access. The timetable for an access improvement plan cannot exceed 18 months. The HPC will approve any plan that is likely to address the cost so that patient access improves and has a reasonable expectation for successful implementation. After the conclusion of the implementation timetable, a manufacturer must report outcomes to the HPC. If the HPC deems the outcomes insufficient, the HPC will extend the timetable and approve any amendments to the plan. If a manufacturer declines to enter into an improvement plan, the HPC can publicly post the proposed value of the drug, hold a public hearing on the proposed value, and solicit public comment. The manufacturer will be required to appear and testify at any hearing held on a drug's proposed value. This measure establishes a four-year program to assess the public health utilization and cost impacts of capping copays and eliminating deductibles and co-insurance requirements for insulin. Under this bill, coverage for insulin cannot be subject to any deductible or coinsurance and copays cannot exceed $25 per month per insulin prescription. This measure requires pharmacy benefit managers (PBMs) to obtain a license from the Department of Insurance and requires PBMs to report rebate information to the Center for Health Information and Analysis. The measure also creates a special commission to examine the feasibility of establishing a system for the bulk purchasing and distribution of pharmaceutical products with a significant public health benefit and the potential for significant health care cost savings for consumers through overall increased purchase capacity and for making bulk purchasing pricing information available to purchasers in other states.
MI	HB 4154	Introduced	Transparency	This measure requires a manufacturer to submit an annual report with the Department of Health and Human Services on costs associated with a prescription drug for the preceding calendar year if the drug has a wholesale acquisition cost (WAC) of $10,000 or more per course of treatment or if the WAC has increased by a total of 25% of more during the last 5 years or by 5% in the last year. Manufacturers will be required to submit pricing information with the report.
MI	HB 4155	Introduced	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to register with the Department of Insurance. This measure also requires PBMs to submit an annual report with rebate information.

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MI	HB 4235	Referred to Senate Appropriations Committee	Pharmacy Benefit Manager	This is a budget bill. This measure includes a requirement that any contract with a Medicaid managed care organization that relies on a pharmacy benefits manager use a transparent pass-through pricing model, in which the PBM discloses the administrative fee as a percentage of the professional dispensing costs.
MI	HB 4702	Referred to House Government Operations Committee	Other	This measure requires the attorney general to investigate pricing of insulin to ensure adequate consumer protections in pricing and whether additional protections are needed. If necessary, the attorney general may issue an administrative subpoena that could require a PBM, carrier or manufacturer to furnish material. By November 1, 2020, the attorney general must submit a report that includes a summary of insulin pricing practices and any public policy recommendations to control and prevent overpricing of insulin.
MI	HB 4978	Referred to House Health Policy Committee	Importation	This measure requires the Department of Health and Human Services to establish a wholesale prescription drug importation program from Canada. This measure requires the department to submit a request to the federal government by Jan. 1, 2021.
MI	HB 4979	Referred to House Health Policy Committee	Importation	This measure requires the Department of Health and Human Services to establish an international wholesale prescription drug importation program. This measure requires the department to submit a request to the federal government by Jan. 1, 2021.
MI	HB 5107	Referred to House Health Policy Committee	Importation	This measure requires the Department of Health and Human Services to establish a wholesale prescription drug importation program from Canada. This measure requires the department to submit a request to the federal government by Oct. 1, 2020.
MI	HB 5108	Referred to Assembly Health Policy Committee	Transparency	This measure requires manufacturers of drugs that have a wholesale acquisition cost (WAC) that is more than $40 to notify qualified purchasers if the manufacturer is increasing the WAC by 12% or more during any 24-month period. Notification must be provided at least 60 days before the increase, and the manufacturer must include a justification for the WAC increase. Notification must also include pricing information. Manufacturers must also provide notice if they plan to introduce a drug that exceeds the Medicare specialty drug threshold. This bill also establishes the drug consumer protection commission, which will review manufacturer reports to determine whether a manufacturer's price is excessive or if a price increase is excessive. If the commission determines that a manufacturer has charged an excessive price, the commission will submit a summary of finding to the Attorney General's office with a request that the Attorney General investigate the manufacturer.
MI	HB 5109	Referred to House Health Policy Committee	Price Gouging	This measure prohibits manufacturers from charging excessive prices or unconscionable increases in wholesale acquisition costs (WAC). Under this bill, the Attorney General must investigate any allegation she receives from the drug consumer protection commission.
MI	SB 139	PBM provisions vetoed by Governor	Pharmacy Benefit Manager	This measure prohibits the Department of Health and Human Services from entering into contracts with Medicaid managed care organizations that rely on PBMs that do not agree to move to a transparent pass-through pricing model or create new pharmacy administration fees. This measure also contains guidelines detailing which pricing methodologies pharmacies with a certain number of outlets should use.
MI	SB 525	Referred to Senate Health Policy and Human Services Committee	Importation	This measure allows for the establishment of a wholesale prescription drug importation program from Canada.
MN	HF 704	Referred to House Health and Human Services Policy Committee	Transparency	This measure requires each manufacturer of a prescription drug that has a wholesale acquisition cost (WAC) of $10,000 or more annually or per course of treatment to file a report with the Commissioner of Health. The report must include information about the total cost for production of the drug, total research and development costs, total costs for clinical trials, and total costs for marketing and advertising. The manufacturer must also give a cumulative annual history of average wholesale price and WAC increases.
MN	HF 743	Referred to House Commerce Committee	Pharmacy Benefit Manager	This measure prohibits a health plan from requiring an enrollee to pay a copayment for a prescription drug at the point of sale that is greater than the lesser of the allowable claim amount the pharmacy will receive from the plan or pharmacy benefit manager, or the amount an individual would pay at the pharmacy without using insurance.

MN	HF 1523/SF 1734	Amended, passed House Health and Human Services Committee; referred to House Ways and Means Health and Human Services Finance Division/Referred to Senate Health and Human Services Finance and Policy Committee	Volume Purchasing	This measure authorizes the Commissioner of Human Services to establish a prescription drug purchasing program that will: -Make drugs available at the lowest possible cost to participants; -Promote health; -Maintain a list of drugs recommended as the most effective prescription drugs at the best prices; -Administer drug benefits for medical assistance and MinnesotaCare; and -Adjudicate pharmacy claims. The commissioner will set the terms and conditions for pharmacies to participate in the program.
MN	HF 2414/SF 2452	Became special session SF 12	Transparency	This measure requires an annual report that details the state's effectiveness in promoting transparency in pharmaceutical pricing for the state and other payers, enhancing the understanding of pharmaceutical spending trends, and assisting the state in the management of pharmaceutical costs. This measure also limits cost-sharing requirements for prescription insulin drugs once the deductible is met. This measure requires the Human Services Commissioner to implement an insulin assistance program. The program will pay participating pharmacies for insulin that is dispensed by a participating pharmacy and maintain an up-to-date list of eligible individuals and make the list available to participating pharmacies. Eligible individuals must have a family income that is equal to or less than 400% of the federal poverty guidelines and be uninsured or have no prescription drug coverage.
MN	HF 2518	Referred to House Commerce Committee	Transparency	This measure requires that each manufacturer of a prescription drug that has a wholesale acquisition cost of $10,000 or more annually must file a report with the Commissioner of Health. The report must include information will include cost information, including marketing and advertising costs.
MN	HF 2819	Referred to House Taxes Committee	Other	This measure imposes an excess prices tax on prescription drugs. The amount of the tax has not yet been established. Under this bill, manufacturers and wholesalers will annually submit the number of units of each drug sold in the state during the year to the revenue commissioner. "Excess price amount" means the difference between the manufacturer's adjusted average manufacturer price of a prescription drug and the indexed average manufacturer's price of a drug for a certain year.
MN	SF 12	Signed by Governor	Other	This measure is the omnibus health and human services appropriation bill. Under this bill, a health plan that imposes a cost-sharing requirement on the coverage of a prescription insulin drug must limit the total amount of cost-sharing that an enrollee is required to pay at the point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met, at an amount that does not exceed the net price of the prescription insulin drug.
MN	SF 67/HF 723	Referred to Senate Health and Human Services Finance and Policy Committee/Referred to House Health and Human Services Policy Committee	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist for informing the covered person about the cost of the prescription or about any therapeutically equivalent alternative medications.
MN	SF 237/HF 149	Referred to Senate Health and Human Services Finance and Policy Committee/Amended, passed House Commerce Committee	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist from informing a patient about the out-of-pocket price for a drug. This measure also requires a pharmacist, when dispensing a prescription, to disclose the net amount the pharmacy will receive from all sources for dispensing the drug.

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MN	SF 278/HF 728	Signed by Governor (Chapter 39)	Pharmacy Benefit Managers	This measure requires a pharmacy benefit manager (PBM) to obtain a license. This measure also requires PBMs to disclose rebate and pricing information to plan sponsors and the state's Commissioner of Commerce. Under this bill, PBMs would be required to provide pharmacies with a maximum allowable cost (MAC) list, which must be updated every seven business days. PBMs must also provide the sources used to determine the MAC pricing. This measure also prohibits a PBM from prohibiting a pharmacist from disclosing information about the cost of the drug or the availability of alternative therapies. This bill imposes cost-sharing limits for consumers at the point of sale and allows a pharmacist to substitute a therapeutically equivalent and interchangeable drug in place of a prescribed drug. Under this bill, a PBM cannot retroactively adjust a claim for reimbursement submitted by a pharmacy.
MN	SF 353/HF 1668	Referred to Senate Health and Human Services Finance and Policy Committee/Referred to House Commerce Committee	Cost Review (Rate Setting)	This measure creates the Prescription Drug Affordability Commission. Under this bill, drug manufacturers must notify the commission if they increase the wholesale acquisition cost (WAC) of a brand-name drug or biologic by more than 10% or by more than $10,000 during any 12-month period, or if they intend to introduce a brand name drug to market with a WAC of $30,000 per calendar year. For generic drugs, a manufacturer must notify the commission if the WAC increases by more than 25% or $300 in an 12-month period. All manufactures must notify the commission of increases at least 30 days before an increase takes effect, along with a justification for the increase. The chair of the commission may initiate a review of the cost of a drug, and the commission will determine whether the drug will lead to excess costs on the health care system. If the commission finds that spending on the drug creates excessive costs for consumers, the commission will establish a maximum level of reimbursement.
MN	SF 364/HF 284	Referred to Senate Health and Human Services Finance and Policy Committee/Amended, passed House Health and Human Services Policy; referred to House Judiciary, Finance and Civil Law Division	Cost Review (Rate Setting)	This measure authorizes the Commissioner of Health to review costs for insulin products sold in Minnesota to determine if the cost is excessive. Under this bill, each manufacturer of an insulin product must report the wholesale acquisition cost for each insulin product offered for sale in the state. If the commissioner finds that spending on an insulin product is excessive, the commissioner will establish a maximum level of reimbursement that must not create more than 50% net profit for the manufacturer.
MN	SF 366/HF 289	Referred to Senate Health and Human Services Finance and Policy Committee/Amended; passed House Commerce Committee; passed House Health and Human Services Policy; referred to House Ways and Means Committee Health and Human Services Finance Division	Transparency	This measure requires the Commissioner of Health to compile a list of essential diabetes medications. From the list, the commissioner must also compile a list of diabetes medications that have been subject to an increase in the wholesale acquisition cost of a percentage equal to or great than the percentage increase in the Consumer Price Index Medical Care Component during the previous year or twice the percentage increase in the previous two years. Under this bill, manufacturers of drugs included on the commissioner's list must disclose pricing information, including the aggregate amount of all rebates the manufacturer provided to pharmacy benefit managers (PBM), as well as a justification for the price increase. This measure also requires PBMs to submit a report to the commissioner regarding rebates.
MN	SF 495	Referred to Senate State Government Finance and Policy and Elections Committee	Importation	This measure establishes a wholesale Canadian drug importation program. State and local government employee health care programs, as well as state health care programs and health plan companies, will be able to enter into an agreement with a pharmacy benefit manager to negotiate prices and administer contracts with Canadian pharmacies.
MN	SF 841	Referred to Senate Health and Human Services Finance and Policy Committee	Pharmacy Benefit Manager	This bill requires licensure for pharmacy benefit managers (PBMs). This measure also requires that each PBM provide to a covered entity all financial and utilization information requested by the covered entity relating to the provision of benefits to covered individuals through that covered entity and, including all rebates and discounts from drug manufacturers. This measure also requires PBMs to disclose pricing information to consumers.

MN	SF 1006/HF 1257	Referred to Senate Health and Human Services Finance and Policy Committee/Passed House Health and Human Services Policy Committee; referred to House Ways and Means Committee Health and Human Services Finance Division	Pharmacy Benefit Manager	This bill allows health plans to change their formularies midyear to remove a brand drug from its formulary or move a brand drug to a new cost-sharing tier if a generic equivalent is approved.
MN	SF 1098/HF 1246	Passed Senate Health and Human Services Finance and Policy Committee, referred to Senate Judiciary and Public Safety Finance and Policy Committee/passed House Judiciary, Finance and Civil Law Division, referred to House Health and Human Services Finance Division	Transparency	This measure requires drug manufacturers to submit a report to the Commissioner of Health for every prescription drug priced more than $40 for a course of therapy, whose price increases by more than 10% in a 12-month period or more than 16% in a 24-month period. Notice must be given to the commissioner at least 60 days before the planned increase. For every new brand-name drug priced over $5,000 for a 30-day supply or a generic that is price over $200 for a 30-day supply, the manufacturer must notify the commissioner within 60 days of introduction.
MN	SF 1184	Referred to Senate Health and Human Services Finance and Policy Committee	Importation	This measure instructs the Commissioner of Human Services to develop a wholesale drug importation program to make discounted prescription drugs imported from Canada available to Minnesotans.
MN	SF 1640	Referred to Senate Health and Human Services Finance and Policy	Transparency	This measure creates the Prescription Drug Price Transparency Act. This bill requires that for every drug priced more than $40 for a course of therapy, whose price increases by more than 10% in a 12-month period or more than 16% in a 24-month period, the manufacturer must report to the Health Commissioner at least 60 days in advance of the increase certain pricing information. For every new brand-name drug priced over $500 for a 30-day supply or for a generic drug priced over $200, manufacturers must provide pricing information as well.
MN	SF 1907/HF 743	Referred to Senate Commerce and Consumer Protection Finance and Policy Committee/amended, passed House Commerce Committee, referred to House Health and Human Services Finance Division	Other	This measure stipulates that a health plan that provides drug coverage shall not require an enrollee to pay a copayment for a prescription drug at the point of sale that is greater than the lesser of the allowable claim amount the pharmacy dispensing the drug will receive from the health plan company or pharmacy benefit manager or the amount an individual would pay at the pharmacy for the drug if the individual did not have insurance.
MN	SF 2302/HF 2184	Became special session SF 12	Other	This measure establishes the outpatient prescription drug program for MinnesotaCare. The human services commissioner will establish an outpatient prescription drug formulary for MinnesotaCare, which must contain at least one drug in every category and class or the same number of prescription drugs in each category and class as the essential health benefit benchmark plan. The outpatient pharmacy benefit will not be administered through a contract with a public or private entity.

MS	HB 482	Died in Committee	Transparency	This measure requires the attorney general to compile a list of essential diabetes medications, along with the wholesale acquisition cost (WAC) of each drug on the list. If the WAC of any drug on that list has increase in a percentage equal to the percentage increase in the Consumer Price Index in the previous year or twice that in the previous two years, it will be added to a separate list. Manufacturers of drugs on the second list must submit a justification for the price increase along with other cost information. This measure also requires pharmacy benefit managers to submit information regarding rebates.
MS	HB 976/SB 2365	Died in Committee/Signed by Governor	Other	This measure allows pharmacists to make a product selection for an interchangeable biological product in the same manner as a generic drug.
MS	HB 1215	Died in Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBM) to annually certify to the state's Board of Pharmacy that the insurer made available to enrollees at least a majority of rebates at the point of sale.
MO	HB 667	Passed House Professional Registration and Licensing Committee; referred to House Rules Committee	Importation	This measure prohibits a state official or law enforcement officer from impeding or inhibiting the importation of a prescription drug for personal use.
MO	SB 127	Referred to Senate Seniors, Families and Children Committee	Importation	This measure requires the Department of Health and Senior Services to conduct a study into the wholesale importation of prescription drugs by the state.
MO	SB 310/HB 1186	Referred to Senate Seniors, Families and Children Committee/Introduced	Cost Review (Rate Setting)	This measure creates the Prescription Drug Affordability Commission. Under this bill, drug manufacturers must notify the commission if the manufacturer increases the wholesale acquisition cost (WAC) of a brand-name drug or biologic by more than 10% or by more than $10,000 during any 12-month period, or if the manufacturer intends to introduce a brand name drug to market with a WAC of $30,000 per calendar year. For generic drugs, a manufacturer must notify the commission if the WAC increases by more than 25% or $300 in an 12-month period. All manufactures must notify the commission of increases at least 30 days before an increase takes effect, along with a justification for the increase. The chair of the commission may initiate a review of the cost of a drug, and the commission will determine whether the drug will lead to excess costs of the health care system. If the commission finds that spending on the drug creates excess costs for consumers, the commission will establish a maximum level of reimbursement. This measure also requires health carriers to report the top 25 most frequently prescribed drugs, the 25 costliest drugs, and the top 25 drugs that experienced the largest year-over-year increase in wholesale acquisition cost (WAC). Insurers must report on how drug prices impact premium costs. Additionally, this measure allows the commission to conduct studies on pipeline drugs that may have a significant impact on state spending. Any manufacturer involved in the study will be required to submit information regarding the cost of the pipeline drug. Pharmacy benefit managers also must report information regarding rebate amounts.
MO	SB 413/HB 1165	Referred to Senate Insurance and Banking Committee/Introduced	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to submit an annual report that contains information regarding rebates.
MT	HB 344	Referred to House Business and Labor Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBM) to submit a transparency report annually. The report must contain information on the aggregate amount of all rebates received from pharmaceutical manufacturers as well as the aggregate amount of administrative fees received from manufacturers.
MT	HB 710	Died in Committee	Transparency	This measure requires annual reports from pharmaceutical manufacturers for drugs with a price of $100 or more that had a price increase of more than 10% in the previous year. For each drug that fits that criteria, the manufacturer must report cost information. This bill also requires that when a manufacturer introduces a new drug for sale at a price that exceeds the threshold established by the US Centers for Medicare & Medicaid Services for specialty drugs in the Medicare Part D program, the manufacturer must provide the methodology used for establishing the drug price and a description of the marketing tools used, along with additional information. This measure additionally requires insurers to report the 25 most frequently prescribed drugs under the issuer's benefit plans and the 25 drugs that caused the greatest increase in total plan spending over the previous calendar year.

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MT	HB 729	Died in Committee	Other	This measure requires the Department of Public Health and Human Services to use a subscription model as an alternative payment method for high-cost or specialty drugs whenever possible.
MT	SB 71	Vetoed by Governor	Pharmacy Benefit Managers	This measure regulates health insurers' administration of pharmacy benefits for consumers. This bill prohibits the practice of spread pricing and requires all compensation remitted by the manufacturer or distributor to be retained by the health plan for the purpose of lowering premiums.
MT	SB 83	Referred to Senate Business, Labor and Economic Affairs Committee	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from preventing a pharmacy from disclosing information about the adjudicated reimbursement paid to the pharmacy to either the plan sponsor or to the patient as long as the pharmacist complies with HIPAA.
MT	SB 270	Signed by Governor	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from penalizing a pharmacy or pharmacist for disclosing reimbursement criteria to an enrollee or for selling a more affordable alternative to a covered person. This bill also prohibits a PBM from requiring a pharmacy to charge or collect a copayment from an enrollee that exceeds the total charges submitted by the network pharmacy.
NE	LB 316	Signed by Governor	Pharmacy Benefit Managers	This bill prohibits a pharmacy benefit manager (PBM) from collecting from a covered person a copayment for a prescription that exceeds the lesser of the individual's applicable cost-sharing or the amount retained by the network pharmacy for filling the prescription. This measure also prohibits a PBM from penalizing a pharmacy or pharmacist for sharing cost information with a consumer.
NE	LB 567	Referred to Health and Human Services Committee	Transparency	Under this bill, a manufacturer of a prescription drug with a wholesale acquisition cost (WAC) of more than $40 for a course of therapy must provide notice to state purchasers if the increase in the WAC is more than 16% over the previous two years. Notice of the price increase must be given within 60 days of the planned increase and must be accompanied by pricing information. This measure also requires manufacturers to notify the Department of Administrative Services if they plan to introduce a new drug to market that exceeds the threshold set for a specialty drug under Medicare and to provide pricing information.
NV	AB 141	Signed by Governor	Pharmacy Benefit Manager	This bill prohibits a pharmacy benefit manager from prohibiting a pharmacist or pharmacy from providing information to a consumer concerning the availability of a less expensive or more effective drug or a less expensive manner of acquiring a drug. This bill also prohibits a pharmacy benefit manager from penalizing a pharmacist or pharmacy for selling a less expensive generic drug or a more effective drug to such a person.
NV	AB 185	Failed upon adjournment	Other	This measure requires that during the 2019-2021 interim session, the Board of the Public Employees' Benefit Program conduct a study of establishing Medicare-based pricing for the health benefit plan for public employees. The study must include consideration of the coverage and pricing of prescription drugs by Medicare and whether establishing Medicare-based pricing is beneficial to employees. The report must be filed with the Legislature before January 1, 2021.
NV	SB 226	Failed upon adjournment	Volume Purchasing	This measure requires the Department of Health and Human Services to enter into agreements to purchase prescription drugs on behalf of certain health benefit plans. Under this bill, the department must develop a formulary of prescription drugs to be used for all health benefit plans funded by a state agency. The department will negotiate and enter into agreements to purchase drugs included in that formulary on behalf of those plans. This measure also requires an insurer to allow an enrollee to credit any mount saved by using a coupon for a drug toward any cost sharing that the enrollee is required to pay for the drug.
NV	SB 262	Signed by Governor	Transparency	This measure includes asthma medications in the state's 2017 essential diabetes drugs transparency law.
NV	SB 276	Signed by Governor	Study	This bill directs the Legislative Commission to appoint a committee to conduct an interim study into the issue of the costs of prescription drugs, including the impact of rebates, reductions in price, and other remuneration from drug manufacturers affecting prescription drug prices.
NV	SB 369	No further action allowed	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) or drug manufacturer from increasing the effective price of a prescription drug for a PBM during the plan year.

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NV	SB 378	Signed by Governor	Pharmacy Benefit Manager	This measure instructs the Department of Health and Human Services to directly manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision o prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program. If the department contracts with a pharmacy benefit manager (PBM), the PBM must disclose to the department any information relating to the services covered by the contract, including information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees imposed by the PBM.
NH	HB 656	Signed by Governor	Study	This measure creates the Commission to Study the Impact of Financial Initiatives for Commercially Insured Members by Drug Manufacturers on Prescription Drug Prices and Health Insurance Premiums. The commission must submit a report to the Legislature by Nov. 1, 2019.
NH	HB 659	House Commerce and Consumer Affairs Committee voted inexpedient to legislate	Transparency	This bill requires the insurance commissioner to request data from health carriers regarding prescription drug benefits that are outsourced to a pharmacy benefit manager or similar entity as part of the preparation for the insurance department's annual hearing requirement. Information reported must include spread amounts between payers and pharmacies and amounts paid to the pharmacy benefit manager by the carrier, and drug rebate amounts.
NH	HB 671	House Commerce and Consumer Affairs Committee voted inexpedient to legislate	Pharmacy Benefit Managers	This measure adds pharmacy benefit managers to statutes governing insurance and other health care entities.
NH	HB 695	Reported inexpedient to legislate	Transparency	This measure requires nonprofit organizations advocating on behalf of patients or that fund medical research to compile a report relative to payments received from pharmaceutical manufacturers or pharmacy benefit managers.
NH	HB 717	Referred to House Commerce and Consumer Affairs Committee	Coupons	This measure prohibits prescription drug manufacturers from offering coupons or discounts to cover insurance copayments or deductibles if a lower cost generic is covered under the individual's health insurance.
NH	SB 32	Senate Health and Human Services Committee reported inexpedient to legislate	Transparency	This measure reestablishes the Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs. The commission must submit a report to the Legislature by Nov. 1, 2020.
NH	SB 63	Amended; passed House Commerce and Consumer Affairs Committee	Pharmacy Benefit Manager	This measure requires that all rebates remitted by or on behalf of a pharmaceutical manufacturers, or to a pharmacy benefits manager under contract with an insurer, must be either remitted directly to an enrollee at the point of sale or retained by the insurer to off set premium costs.
NH	SB 222	Referred to Senate Executive Departments and Administration	Pharmacy Benefit Managers	This measure establishes the licensure and regulation of pharmacy benefit managers by the insurance commissioner.
NH	SB 226	Signed by Governor	Transparency	This bill gives the Insurance Commissioner the authority to examine and directly bill a pharmacy benefits manager as necessary to determine compliance with the law.
NH	SB 260	Amended, passed Senate Finance Committee	Other	This measure directs the Department of Health and Human Services to develop a prescription drug assistance program to pay out-of-pocket prescription drug costs for seniors who have reached the gap in standard Medicare Part D coverage. This will be a one-year long pilot program.
NJ	A 583/S 983	Referred to the Assembly Health and Senior Services Committee/ Senate Health and Human Services and Senior Citizens Committee	Cost Review (Rate Setting)	This measure establishes the Drug Review Commission within the Department of Consumer Affairs. It must compile a list of critical drugs based on cost to Medicaid and Family Care Programs, statewide cost and utilization, and availability and cost of therapeutically-equivalent treatments, among other factors. Manufacturers of drugs on the list would be required to report a variety of data, including research and development costs, marketing costs, prices out of state and outside the United States, and typical in-state prices. The commission would be authorized to set a price for any drug on the list that is considered excessively high.
NJ	A 999	Referred to Assembly Financial Institutions and Insurance Committee	Pharmacy Benefit Managers	This measure places restrictions on health insurance carriers and pharmacy benefit managers relating to the switching of drugs, step therapy, and fail-first practices. This measure requires communication when a switch is made. The Department of Banking and Insurance would develop the switch communication form.

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NJ	A 2214	Combined with A 3993	Pharmacy Benefit Managers	*This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist for informing the covered person about a lower cost including the cash price.*
NJ	A 2431/S 1865	Referred to Senate Budget and Appropriations Committee/Referred to Senate Budget and Appropriations Committee	Other	This bill requires insurers that offer plans in the individual and small employer markets to ensure that at least 25% of all plans, or at least one plan if the insurer offers less than four plans, offered by the insurer in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, shall conform with the following: (1) a contract that provides a silver, gold, or platinum level of coverage shall limit a covered person's cost-sharing financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug; and (2) a contract that provides a bronze level of coverage shall ensure that any required covered person's cost-sharing, including any copayment or coinsurance, does not exceed $250 per month for each prescription drug for up to a 30-day supply of any single drug. In the case of high-deductible plans, these cost-sharing limits apply at any point in the benefit design.
NJ	A 3993/ S 2690	Substituted by S 2690 and 2727/Signed by Governor	Pharmacy Benefit Managers	This measure would prohibit a pharmacy benefit manager (PBM) from charging a covered person a copayment for a prescription drug benefit in an amount that exceeds the cost of the prescription drug purchased without insurance. This measure also prohibits a PBM from stopping a pharmacy from disclosing lower cost prescription drug options to a covered person, including options that do not use insurance to purchase a prescription drug. This bill also requires a pharmacist to inform patients of the lowest cost option for the drug or whether there is a cheaper alternative available.
NJ	A 4216/S 2630	Referred to Assembly Health and Senior Services Committee/ Referred to Senate Health, Human Services and Senior Citizens Committee	Price Gouging	This bill mandates prescription drug disclosure requirements and measures. It requires pharmacy benefit managers (PBMs) to disclose information about drug pricing and generic substitutions to benefit plan purchasers. Under this bill, PBMs must disclose the methodology and sources used to determine multiple-source generic drug and biological products. The bill requires PBMs to disclose to purchasers whether the multiple-source generic pricing list used to bill the purchaser is the same as the list used to reimburse pharmacies. If the lists are not the same, the difference between the amount paid to the pharmacy and the amount charged to the purchaser shall be disclosed. This bill also establishes the Prescription Drug and Biological Review Commission, which must develop a list of critical prescription drug and biological products. Manufacturers of drugs on this list will be required to report development and marketing cost information. If the commission decides that a drug's price is excessively high, it will have the authority to establish a maximum price for the drug. This bill prohibits manufacturers and distributors from using price gouging in its sale of essential off-patent or generic drugs.
NJ	A 4846/S 3341	Withdrawn from consideration	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers to disclose rebate information to the Commissioner of Banking and Insurance.
NJ	A 5496/S 4210	Referred to Assembly State and Local Government Committee/Referred to Senate State Government, Wagering, Tourism and Historic Preservation Committee	Transparency	This measure requires a pharmacy benefit manager under contract with the State Health Benefit Program (SHBP) or the School Employee Health Benefit Program (SEHBP) to report prices paid to pharmacies and the amount charged to SHPB and SEHBP.
NJ	A 5548/S 3929	Referred to Assembly Human Services Committee/Referred to Senate Health, Human Services and Senior Citizens Committee	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers providing services within Medicaid to disclose certain information to the Department of Human Services. Under this bill, any contract entered into by a managed care organization that has contracted with the Division of Medical Assistance and Health Services in the Department of Human Services would require a pharmacy benefits manager (PBM) to disclose to the department all sources and amounts of income, including pricing discounts and rebates, all ingredient costs and dispensing fees made by PBMs to any pharmacy and the PBM's model for administrative fees.

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NJ	A 5743/S 4026	Referred to Assembly Financial Institutions and Insurance Committee; referred to Senate Commerce Committee	Other	This measure requires carriers to pass prescription drug savings on to consumers. This bill provides that all compensation paid by a pharmaceutical manufacturer to a pharmacy benefits manager (PBM) as a result of negotiations of a reduced prices for a pharmaceutical must be remitted to and retained by the carrier to lower premiums for enrollees. Additionally, this bill requires carriers to file annual reports with the insurance commissioner demonstrating how the carrier has complied with the provisions of the bill.
NJ	A 5786	Referred to Assembly Financial Institutions and Insurance Committee	Other	This measure limits how much an enrollee will pay for insulin to $100 per 30-day supply. This measure also requires the Division of Consumer Affairs in the Department of Law and Public Safety to investigate the pricing of insulin drugs in New Jersey.
NJ	A 5947	Referred to Assembly Health and Senior Services Committee	Importation	This measure allows for the importation of prescription drugs from Canada. This measure requires the Commissioner of Health to establish a program that meets federal requirements. The commission must seek federal approval for the program within 210 days of the effective date of this measure.
NJ	A 5948	Referred to Assembly Financial Institutions and Insurance Committee	Other	This measure limits how much an enrollee will pay for insulin to $100 per 30-day supply and limits how much an enrollee will pay for a package of two epinephrine auto-injectors to $100. This measure also requires the Division of Consumer Affairs in the Department of Law and Public Safety to investigate the pricing of insulin drugs in New Jersey.
NJ	A 5950	Referred to Assembly Health and Senior Services Committee	Price Gouging	This measure prohibits excessive charges for drugs developed by publicly-funded research. Under this bill, it would be unlawful for a person to sell an approved drug or biologic whose research and development was supported by the federal or state government a unit price that is greater than a benchmark unit price or that constitutes discriminatory pricing. The benchmark unit price for a drug is the lowest price charged to countries in the Organization for Economic Cooperation and Development.
NJ	A 5999	Referred to Assembly Financial Institutions and Insurance Committee	Pharmacy Benefit Manager	This measure prohibits pharmacy benefits manager (PBMs) from requiring enrollees to use mail service pharmacies.
NJ	S 727/ A 2033	Referred to Senate Commerce Committee/ Withdrawn from consideration.	Pharmacy Benefit Managers	This measure regulates pharmacy benefit managers as organized delivery systems and limits use of prior authorization.
NJ	S 728/ A 3717	Substituted by A 3717/ Amended; passed Assembly Financial Institutions and Insurance Committee; referred to Assembly Appropriations Committee	Pharmacy Benefit Managers	This measure prohibits pharmacy benefit managers from retroactively reducing payment amount on a properly-filed pharmacy claim, except if the claim is found to have complications that could delay payment during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy.
NJ	S 977	Amended; passed Senate Health, Human Services and Senior Citizens Committee; referred to Senate Budget and Appropriations Committee	Cost Review (Rate Setting)	This measure prohibits any person from charging excessive prices for drugs developed by direct or indirect publicly-funded research. It makes it illegal for any person to sell, offer to sell, or advertise for sale that publicly-funded drug to any purchaser in this state at a unit price that is greater than the lowest price in an Organization for Economic Cooperation and Development country with an economy comparable to the US economy. It would be unlawful to impose limits on supply or other discriminatory pricing that restricts access to such products.
NJ	S 1117	Referred to Senate Health, Human Services and Senior Citizens Committee	Coupons	This measure prohibits the distribution of manufacturer-sponsored drug coupons for brand-name drugs when other US Food and Drug Administration-approved, lower-cost generic drugs are available and are covered under the individual's health plan, and are not otherwise contraindicated for the condition for which the prescription drug is approved.
NJ	S 1590/A 3987	Referred to Senate Health Human Services and Senior Citizens Committee/ Referred to Assembly Health and Senior Services Committee	Price Gouging	This measure prohibits a pharmaceutical manufacturer or wholesaler from using price gouging in the sale of essential off-patent, generic drugs and biological products. This measure also requires the Division of Consumer Affairs in the Department of Law and Public Safety to report any suspected price gouging to the attorney general.

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NJ	S 1863	Referred to Senate Commerce Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBMs) to be certified by the Department of Banking and Insurance. This bill also requires benefits and coverage disclosures to covered persons. Under this bill, PBMs must disclose any drug manufacturer revenues, rebates, or discounts related to the purchaser's contract with the PBM. This measure requires a PBM to notify health practitioners, covered persons, and purchasers if the PBM seeks authorization to substitute a drug prescribed by a health care practitioner.
NJ	S 2060	Referred to Senate Commerce Committee	Pharmacy Benefit Managers	This measure requires pharmacy benefit managers (PBMs) to disclose information about drug pricing and generic substitutions to benefit plan purchasers. This measure also requires PBMs to disclose to purchasers whether the multiple source generic pricing list used to bill the purchaser is the same as the list used to reimburse all network pharmacies.
NJ	S 2389/A 5449	Referred to Assembly Health and Senior Services Committee/Referred to Assembly Health and Senior Services Committee	Transparency	This measure requires the Board of Pharmacy to establish a prescription drug pricing disclosure website and also requires pharmaceutical manufacturing companies that market drugs in the state to provide the current wholesale acquisition cost information for the drugs or biologics marketed in the state.
NJ	S 2438/ A 4041	Referred to Senate Commerce Committee/ Referred to Assembly Financial Institutions and Insurance Committee	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist from informing a patient about a lower cost option, including the cash price.
NJ	S 3568	Referred to Senate Commerce Committee	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to exercise good faith and fair dealing. This bill also requires a PBM to disclose, on a quarterly basis, information regarding aggregate wholesale acquisition costs from a manufacturer, as well as information about rebates. This measure also requires health benefit plans to require PBMs to register with the Department of Banking and Insurance.
NJ	S 3787	Referred to Senate Health, Human Services and Senior Citizens Committee	Pharmacy Benefit Manager	This measure requires prescription drug services covered by the Medicaid program to be provided through a fee-for-service delivery system. Under this bill, reimbursement for a covered drug will be the lower of certain thresholds plus a dispensing fee.
NM	HB 88/SB 101	Postponed Indefinitely	Transparency	This measure creates the Health Care Value and Access Commission, which, by November 1, 2020, must make recommendations on the development of health care and prescription drug cost transparency tools for consumers, payers and providers.
NM	SB 92	Postponed Indefinitely	Pharmacy Benefit Managers	This measure regulates the way in which providers may file a complaint against pharmacy benefit managers.
NM	SB 131	Signed by Governor	Volume Purchasing	This measure establishes the Interagency Pharmaceuticals Purchasing Council to review and coordinate cost-containment strategies for the procurement of pharmaceuticals and pharmacy benefits and the pooling of risk for pharmacy services by the constituent agencies; identify ways to leverage constituent agencies' pharmaceutical and pharmacy benefits procurement to maximize the purchasing power of New Mexico residents purchasing pharmaceuticals or pharmacy benefits in the private sector; and identify other cost-saving opportunities for New Mexico residents purchasing pharmaceuticals or pharmacy benefits in the private sector.
NM	SB 373	Postponed Indefinitely	Transparency	This measure requires drug manufacturers to provide 60 days' prior notice about a planned price increase if the manufacturer is increasing the wholesale acquisition cost (WAC) of a brand-name drug by more than 10% or by more than $10,000 dollars in a 12-month period or launching a new drug with a WAC of $30,000 or more per year. Generic manufacturers must provide notice if they are increasing the WAC by more than 25% or by more than $300 per year or launching a new drug with a WAC of more than $3,000 per year.
NM	SB 405/HB 416	Postponed Indefinitely	Importation	This measure creates a Medicaid-buy in program. The bill requires the program to seek a federal waiver to implement a wholesale drug importation program.

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NM	SB 415	Signed by Governor (Chapter 269)	Pharmacy Benefit Managers	This measure requires a pharmacy benefit manager (PBM) to reimburse a pharmacy or pharmacist in an amount equal to or greater than the amount that the PBM reimburses an affiliate for providing the same prescription. This measure also prohibits a PBM from prohibiting a pharmacist from providing cost information to a patient or from selling a more affordable alternative medication.
NY	AB 73	Referred to Assembly Health Committee	Pharmacy Benefit Managers	This measure prohibits prescribers, pharmacies, pharmacists, pharmacy benefit managers, or health plans from disclosing or selling any individual's identifying information for the purpose of marketing any drug.
NY	AB 2007/SB 1507	Passed Assembly Ways and Means Committee; substituted by SB 1507/Signed by Governor (Chapter 57)	Pharmacy Benefit Managers	This measure prohibits pharmacy benefit managers (PBMs) in the Medicaid program from retaining any portion of spread pricing. This measure also requires the registration of PBMs.
NY	AB 2969	Referred to Assembly Insurance Committee	Pharmacy Benefit Manager	This bill allows health plans to change their formularies midyear to remove a brand-name drug from its formulary or move a brand-name drug to a new cost-sharing tier if a generic-equivalent drug is approved.
NY	AB 5724	Referred to Assembly Insurance Committee	Other	This measure would prohibit any form of group health insurance policy that categorizes prescription medication based on specific disease or specific cost and charges a cost-sharing percentage for such prescription medication.
NY	AB 6056	Referred to Assembly Health Committee	Pharmacy Benefit Manager	This measure requires pharmacies to provide customers directly with the retail price (before insurance) of a prescription drug, in writing and electronically prior to purchase.
NY	AB 7196/SB 5169	Referred to Assembly Consumer Affairs and Protection Committee/Referred to Senate Consumer Protection Committee	Other	This measure requires prescription drug manufacturers to notify the attorney general of agreements between pharmaceutical manufacturers resulting in the delay of the introduction of generic medications. Within 30 days of receiving notice, the attorney general must share the information with the drug utilization review board, all Medicaid managed care plans, health carriers and pharmacy benefit managers doing business in the state. The attorney general will also post all notices on the department website.
NY	AB 7588/SB 5682	Referred to Assembly Higher Education/Referred to Senate Health Committee	Importation	This measure creates a wholesale prescription drug importation that will comply with federal standards and regulations.
NY	AB 7922	Referred to Assembly Health Committee	Transparency	This measure requires the Commissioner of Health to include in annual reports information regarding the cost and increase in cost of the 10 prescription drugs on which the state expends the most money and which have had wholesale acquisition cost increases of 50% in the past five years or 10% in the past year.
NY	A 8246/S 6303	Referred to Assembly Insurance Committee; Referred to Assembly Insurance Committee	Coupons	This measure requires any third-party payments, financial assistance, or discounts made on behalf of an enrollee to be applied to the enrollee's cost-sharing requirements when calculating the enrollee's overall contribution to any out-of-pocket maximum or cost-sharing requirement.
NY	S 141	Referred to Senate Consumer Protection Committee	Price Gouging	This measure prohibits a pharmaceutical manufacturer or wholesaler from selling pharmaceuticals for an amount that represents an unconscionably excessive price, which will be determined by a court. The court shall base its determination on whether the amount of the excess price is unconscionably extreme or whether there was an exercise of unfair leverage or unconscionable means. Proof that a violation of this measure has occurred will require evidence that either the amount charged represents a gross disparity between the market price of the pharmaceutical and the price of the same pharmaceutical over the previous six months before the price change, or the amount charged grossly exceeded the price at which the pharmaceuticals were readily obtainable by other purchasers. This bill gives the New York Attorney General the ability to penalize a manufacturer with a fine of up to $1 million.
NY	SB 1705/AB 2970	Referred to Senate Insurance Committee/Referred to Assembly Insurance Committee	Pharmacy Benefit Managers	This measure requires transparency from pharmacy benefit managers (PBMs). Under this bill, PBMs will be required to submit an annual report that contains information regarding the wholesale acquisition cost for each drug on its formulary, the amount of rebates and discounts that were passed through to a covered entity, and the amounts of any reimbursements that PBM pays the contracting pharmacies. Aggregate information will be made available to consumers each year in February.

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NY	SB 2087	Referred to Senate Health Committee	Pharmacy Benefit Managers	This measure establishes a fiduciary duty for pharmacy benefit managers (PBMs) to health plans. This measure also prohibits PBM contracts from prohibiting pharmacists from disclosing pricing information to consumers or offering the consumer a therapeutic equivalent. This measure also prohibits a PBM from collecting a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid. This measure also requires PBMs to report annually on the aggregate amount of rebates received from manufacturers for health plans.
NY	SB 5942/AB 8253	Referred to Senate Health Committee/Referred to Assembly Health Committee	Transparency	This measure requires a manufacturer of a prescription drug with a wholesale acquisition cost (WAC) of more than $40 for a course of therapy to notify the Drug Utilization Review Board if the increase in the WAC of the drug is more than 10%. Notice to the board must be given at least 60 days before the planned increase.
NY	SB 5943	Referred to Senate Health Committee	Transparency	This measure requires the Commissioner of Health to include in annual reports information regarding the cost and increase in cost of the 10 prescription drugs on which the state expends the most money and which have had certain costs increase. Manufacturers on the list will be required to submit pricing information.
NY	SB 6103	Referred to Senate Health Committee	Other	This measure prohibits a drug manufacturer from presenting a regulated advertisement in the state, unless the advertisement meets the requirements concerning misbranded drugs and devices and prescription drug advertising of federal law and regulations. This measure also requires a manufacturer that is required to report marketing costs to post information concerning any clinical trials.
NY	SB 6274	Referred to Senate Insurance Committee	Pharmacy Benefit Manager	This measure establishes registration and licensing requirements for pharmacy benefit managers (PBMs). This measure also prohibits PBMs from restricting pharmacies or pharmacists from disclosing cost information to enrollees at the point of sale. Under this bill, a PBM cannot charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid.
NY	SB 6297/AB 8165	Referred to Assembly Insurance Committee/Referred to Assembly Insurance Committee	Pharmacy Benefit Manager	This measure requires that any contract entered into by a health insurer for the provision of pharmacy benefit management services must be based on a pass-through pricing model. This bill also prohibits the use of spread pricing. In addition, payments to the PBM will be limited to the actual ingredient costs, dispensing fees paid to pharmacies and an administrative fee the covers the cost of providing pharmacy benefit management services. The PBM must identify all sources and amount of income, including any price discounts or rebates. Under this measure, PBMs must disclose the Insurance Department and to the health care plan the sources of income identified.
NY	SB 6531/AB 2836	Passed Assembly/Substituted by S 6531	Pharmacy Benefit Manager	This measure stipulates that all funds received by a pharmacy benefit manager (PBM) must be received by the PBM for the health plan or provider and must be used or distributed only pursuant to the PBM's contract with the PBM and the health plan or provider to compensate the PBM for its services. Any funds received by the PBM through spread pricing will be subject to that requirement. Under this bill, PBMs must periodically account to the health plan for any pricing discounts, rebates, clawbacks, or other benefits received by the PBM. PBMs must ensure that any portion of such income is passed through to the health plan or provider in full to reduce the reportable ingredient cost. Under this bill, a health plan or provider will have access to all of the PBM's financial and utilization information. This measure also contains maximum allowable cost list pricing requirements and a method for appeal, along with a prohibition on the use of gag clauses. Under this bill, each PBM must register with the Insurance Superintendent. Each year, every PBM must report to the superintendent information regarding rebates.
NC	HB 534/SB 632	Referred to House Insurance Committee/Referred to Committee on Rules and Operations of the Senate	Pharmacy Benefit Manager	This measure requires pharmacy benefit managers (PBMs) to obtain licensure from the Department of Insurance. This measure also prohibits a PBMs from penalizing a pharmacy or pharmacist for disclosing cost information to a consumer. Under this bill, a PBM cannot charge an insured a copayment that exceeds the total submitted charges by the network pharmacy, the contracted copayment amount, or the amount a consumer would pay without insurance. Additionally, this bill requires that when calculating an insured's overall contribution to any out-of-pocket maximum, an insurer must include any amounts paid on behalf of an enrollee. This measure also requires that PBMs disclose to health plans and providers any difference between the amount paid to a pharmacy and the amount charged to the plan. PBMs must also submit an annual report to the Insurance Commissioner the aggregate amount of all rebates received from manufacturers, including the amount that was not passed through to payers or insurers.

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NC	SB 432	Substituted; referred to House Committee on Finance	Pharmacy Benefit Manager	This measure requires a pharmacy benefits manager (PBM) to obtain a license from the Department of Insurance before operating in the state. This measure also requires that amounts paid on behalf of an insured by another person count toward any out-of-pocket maximum or cost-sharing requirement under the health benefit plan. This bill prohibits the retroactive denial or reduction of a claim for pharmacist services. This measure requires PBMs to establish an administrative appeals process for a pharmacists.
NC	SB 658	Filed	Transparency	This measure requires manufacturers to notify all interested parties of an upcoming substantial price increase at least 60 days prior to the increase. Within 30 days of notification the manufacturer must disclose a justification for the price increase, the previous year's marketing budget for the drug, the date and price of acquisition, and a schedule or price increases for the drug for the previous five years. Under this bill, "substantial price increase" means any increase in the price charged by a manufacturer for a prescription drug that would have the impact of increasing a drug's cost by 10% or more over 12 months.
ND	HB 1374	Conference committee passed House	Pharmacy Benefit Manager	This measure establishes a pharmacy management program to be used by the medical assistance program for Medicaid expansion for prescription drug coverage. This measure requires that any contract for the program provides the total dollars paid to the pharmacy benefits manager (PBM), the total amount of dollars paid to the PBM by the carrier that were not subsequently paid to a licensed pharmacy and payments made to all pharmacy providers. The state will also have full access to data regarding direct and indirect fees and data regarding average reimbursement. All rebates will be disclosed to the state. This measure also requires a study of the feasibility and desirability of the public employees retirement system entering into a separate contract for prescription drug coverage under the uniform group insurance program.
OH	HB 63	Referred to House Health Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager from requiring cost sharing in an amount greater than the lesser of either the amount an individual would pay without coverage or the net reimbursement paid to the pharmacy for the drug by the issuer.
OH	HB 166	Conference committee report adopted; passed House; passed Senate; signed and line-item vetoed by Governor	Pharmacy Benefit Manager	This is the budget. Under this measure, if the Department of Medicaid includes prescribed drugs in the care management system, the Medicaid Director will select a third-party administrator to serve as the single PBM used by Medicaid managed care organizations under the care system. The Medicaid director will determine the rate the state PBM is paid for its services. The state PBM will provide quarterly transparency report to the director. This measure also prohibits a health plan issuer, pharmacy benefit manager or any other administrator to require cost-sharing in an amount greater than the lesser of the amount an individual would pay for the drug if the drug were purchased without coverage under a health benefit plan or the net reimbursement paid to the pharmacy for the prescription drug by the health plan issuer, PBM or administrator. This bill also creates the Prescription Drug Transparency and Affordability Advisory Council within the Department of Administrative Services. The council must submit a report to the governor and General Assembly within six months of appointment. The report must include recommendations on all of the following: 1) how the state can best achieve drug price transparency; 2) new payment models or other avenues to create the most affordable environment for purchasing prescription drugs; 3) leveraging the state's purchasing power across all state agencies, boards, commissions and similar entities; 4) creating efficiencies across different health care systems; 5) which critical outcomes can be measured and used to improve the state's system of purchasing affordable prescribed drugs; and 6) how federal, state and local resources are being used to optimize these outcomes and identify where the resources can be better coordinated or redirected to meet the needs of consumers.
OH	HB 385	Referred to House Health Committee	Other	This measure requires the attorney general to investigate insulin pricing and prepare and submit a report.
OH	HB 396	Referred to House Health Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) contracted with a Medicaid managed care organization from engaging in spread pricing. This measure also prohibits a PBM from directly or indirectly retroactively denying a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated. This measure also prohibits PBMs from paying or reimbursing a pharmacy at an amount less than the national average drug acquisition cost. Additionally, this measure requires a PBM to report rebate information to the Superintendent of Insurance.

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OH	SB 14	Introduced	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager from requiring cost sharing in an amount greater than the amount an individual would pay for the drug if the drug were purchased without coverage.
OH	SB 231	Referred to Senate Finance Health and Medicaid Subcommittee	Other	This measure requires the attorney general to investigate insulin pricing and prepare and submit a report.
OK	HB 1059	Referred to House Rules Committee	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist for informing the covered person about the availability of alternative therapies or cost of the prescription. This measure authorizes a pharmacy or pharmacist to disclose information regarding the cost of a drug and to sell a more affordable alternative if one is available.
OK	HB 2137	Referred to House Business and Commerce Committee	Pharmacy Benefit Managers	This measure requires every pharmacy benefit manager (PBM) to obtain a license from the Insurance Commissioner. This measure also allows a pharmacist to provide a consumer with drug pricing information and prohibits PBMs from prohibiting pharmacists from disclosing information to the Insurance Commissioner.
OK	SB 841	Vetoed	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager (PBM) from reimbursing a pharmacy or pharmacist in an amount less than the amount that the PBM reimburses a pharmacy owner by or under common ownership with a PBM for providing the same covered services. This measure prohibits a PBM from prohibiting a pharmacist from disclosing cost information to consumers. This measure requires that all compensation remitted by a pharmaceutical manufacturer related to a health benefit plan be remitted to the plan for the purpose of lowering premiums or cost sharing for patients. This measure also requires PBMs to disclose compensation from pharmaceutical manufacturers.
OK	SB 940	Referred to Senate Health and Human Services Committee	Importation	This measure requires the Department of Health to work with the Health Care Authority to create a wholesale Canadian drug importation pilot program. The Health Care Authority will be responsible for identifying the five to 10 highly prescribed drugs through the state Medicaid program. The drugs identified will be imported from Canada.
OR	HB 2185	Signed by Governor	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) from requiring a prescription to be filled by a mail order pharmacy as a condition for reimbursing the cost of the drug. This measure does allow a PBM to require a prescription for a specialty drug to be filled at a specialty pharmacy as a condition for reimbursement of the cost of the drug. Under this bill, a PBM cannot reimburse a 340B pharmacy differently than any other network pharmacy based on its 340B status and cannot retroactively adjust claims. This bill also prohibits the use of gag clauses in PBM contracts with pharmacies.
OR	HB 2446	Failed upon adjournment	Other	This measure creates the Help in Cutting Costs for Unusual Pharmaceuticals program to reimburse high costs incurred by consumers to purchase drugs with an unusually high costs. This measure also requires the Department of Revenue to transfer a specific amount of corporate excise taxes paid on Oregon sales of pharmaceutical products by pharmaceuticals manufacturers doing business in the state to pay for the program.
OR	HB 2658	Signed by Governor	Transparency	This measure requires drug manufacturers to report any planned increase in the price of certain prescription drugs at least 60 days before the date of the increase. Advance notice of increases will be required for a brand-name prescription drug for which there was a cumulative increase of 10% or more or an increase of $10,000 or more during the past 12 months. Notification will be required for a generic drug for which the was a cumulative increase of 25% or more and an increase of $300 or more in the past 12 months.
OK	HB 2632	Signed by Governor	Pharmacy Benefit Manager	This measure minimizes pharmacy benefit manager (PBM) conflicts of interest by prohibiting higher reimbursement rates for PBM-owned pharmacies. This measure also prohibits retroactive claims adjustment and denials. Under this bill, a PBM cannot engage in false advertising or limit a pharmacy from disclosing cost information to enrollees.
OR	HB 2679	Failed upon adjournment	Volume Purchasing	This measure allows the administrator of the Oregon Prescription Drug Program to require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program only as necessary to enter into or carry out an agreement for the bulk purchasing of prescription drugs.
OR	HB 2680	Failed upon adjournment	Importation	This measure authorizes the administrator of the Oregon Prescription Drug Program to cooperate with Canadian provinces or territories to bulk purchase prescription drugs.
OR	HB 2689	Failed upon adjournment	Volume Purchasing	This measure allows the administrator of the Oregon Prescription Drug Program to require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program only as necessary to enter into or carry out an agreement for the bulk purchasing of prescription drugs.

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OR	HB 2690	Failed upon adjournment	Pharmacy Benefit Managers	This measure establishes the right of a consumer to be educated about ways to reduce the cost of prescription drugs and prevents insurers and pharmacy benefit managers (PBM) from interfering with that right. This measure also requires insurers and PBMs to apply the price paid by a consumer for a drug toward the deductible or out-of-pocket maximum regardless of whether the consumer used pharmacy benefits to purchase the drug.
OR	HB 2696	Failed upon adjournment	Cost Review (Rate Setting)	This measure establishes the Drug Cost Review Commission to determine excess costs of brand-name drugs that have increased in wholesale acquisition cost (WAC) more than 10% or $3,000 in a 12-month period, or drugs that will be introduced to the market with a WAC of $30,000 or more. This measure also requires manufacturers to notify the commission if a generic drug's WAC will increase by more than 25% or $300 or if a brand-name drug's WAC will increase by 25% or $10,000. Notice must be given at least 30 days prior to a planned increase. Manufacturers must provide justification for these increases. If the commission finds the cost of a drug will result in excess costs for payers, the commission must establish the maximum payment rate.
OR	HB 2799	Failed upon adjournment	Other	This measure requires health carriers to offer, in at least 25% of health benefit plans at each coverage level, that there be no deductible or other cost-sharing requirement other than a flat dollar copayment. The flat dollar copayment must be reasonably graduated from one tier to the next higher tier and must be proportional across all tiers.
OR	HB 2840	Failed upon adjournment	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager (PBM) from prohibiting a pharmacy or pharmacist from providing information to a consumer regarding cost sharing or lower-cost alternatives. This measure also prohibits a PBM from charging or collecting from an insured consumer a copayment for a drug in an amount that exceeds the reimbursement the PBM pays to the pharmacist or pharmacy for the drug.
OR	HB 3093/SB 872	Failed upon adjournment	Transparency	This measure requires pharmaceutical manufacturers to report to the Department of Consumer and Business Services (DCBS) the total amount of money spent on patient assistance programs, information on financial assistance provided to pharmacies, government agencies and advocacy organizations, and on the total amount of financial incentives paid to each pharmacy benefit manager (PBM). Additionally, this bill requires state-sponsored programs that use PBMs to use fee-only PBMs. Under this bill, insurers must post specified information regarding formularies, tiers, and costs for small employer and individual health benefit plans to insurers' websites. This measure requires a 60-day advance notice to the DCBS and to enrollees adversely affected by a change in a formulary. Under this measure, insurers must and pharmacies may notify enrollees when a retail price for a drug is less than an enrollee's out-of-pocket cost for the drug using the pharmacy benefit. Additionally, this bill requires hospitals and other medical providers to report to the Health Authority information regarding the 50 most prescription drugs and the 50 most expensive drugs prescribed by providers. Under this bill, insurers must include with rate filings certified statements regarding insurers' use of rebates. Finally, under this bill, pharmaceutical manufacturers must register with the State Board of Pharmacy.
OR	SB 409	Failed upon adjournment	Importation	This measure directs the State Board of Pharmacy to study the feasibility of implementing a wholesale prescription drug importation program and to develop a plan to implement importation.
PA	HB 568	Referred to House Insurance Committee	Transparency	This measure requires a manufacturer of a drug that has an average wholesale price of $5,000 or more annually or per course of treatment or has an annual wholesale price that has increased by 50% or more over five years or by 25% in the past year to file an annual report with the Insurance Department that contains cost information. Manufacturers must include a description of patient prescription assistance programs in the report.
PA	HB 569	Referred to House Insurance Committee	Pharmacy Benefit Manager	This measure requires a pharmacy benefit manager (PBM) to disclose to a health insurer whether or not the PBM uses the same multiple-source generic list when billing a health insurer as it does when reimbursing a pharmacy. This bill also requires that if a PBM uses more than one multiple source generic list, the PBM must disclose to an insurer any difference between the amount paid to a pharmacy and the amount charged to the insurer.
PA	HB 570	Referred to House Insurance Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager from restricting a pharmacist from disclosing information regarding the cost of a drug or the availability of any cheaper therapeutically alternatives.
PA	HR 187	Referred to House Health Committee	Study	This resolution directs the Joint State Government Commission to conduct a study on prescription drug pricing and issue a report.

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PA	HB 941	Passed House Appropriations Committee; passed House; referred to Senate Health and Human Services Committee	Pharmacy Benefit Manager	This measure prohibits a pharmacy benefit manager (PBM) that contracts with a medical assistance managed care organization (MCO) from using a confidentiality provision that prohibits the disclosure of information to the MCO or Department of Human Services upon request. This measure also requires PBMs under contract with MCOs to report differences between the amount paid by the MCO to the PBM and the amount paid by the PBM to pharmacies. Under this bill, the department will reimburse pharmacies in the fee-for-service delivery system as follows: the lower of the National Average Drug Acquisition Cost (NADAC) per unit with a dispensing fee or the usual and customary charge for the drug dispensed. If the NADAC is not available, reimbursement will be the lower of the wholesale acquisition cost with a dispensing fee or the usual and customary charge.
PA	HB 943	Passed House Appropriations Committee; passed House; referred to Senate Health and Human Services Committee	Pharmacy Benefit Manager	This measure allows a pharmacist to provide a covered individual with information concerning the cost of a prescription drug, including the individual's cost share. A contract between a pharmacy and a pharmacy benefits manager cannot prohibit a pharmacist from disclosing cost information to a consumer.
PA	HB 944	Passed House Appropriations Committee; passed House; referred to Senate Health and Human Services Committee	Pharmacy Benefit Manager	This measure provides for pharmacy benefits manager audits and defines obligations within the public assistance program.
PA	HB 945	Amended; passed House Health Committee	Pharmacy Benefit Manager	This measure allows the Department of Human Services to prevent a medical assistance managed care organization from entering into any contract for pharmacy services with a pharmacy benefits manager (PBM) if the PBM has ownership interest in a pharmacy providing the services or if the pharmacy providing the services has an ownership interest in the PBM. Additionally, a PBM may not require that a beneficiary use the services of a specific pharmacy for any drug, including a specialty drug.
PA	HB 1042	Referred to House Health Committee	Study	This measure creates the Prescription Drug Pricing Task Force to study the pricing of prescription drugs and issue a report. The task force must issue the report within a year of the first meeting and must focus on factors contributing to high out-of-pocket costs, patient adherence and access to drugs, manufacturer costs for research and development, profit margins, financial assistance offered by manufacturers and the relationship between manufacturers and the state's medical assistance program.
PA	SB 484	Referred to Senate Banking and Insurance Committee	Other	This measure limits how much a consumer will pay in cost-sharing for a specialty tier prescription drug to $100 per month for a 30-day supply. Additionally, this measure caps aggregate cost-sharing of all specialty tier prescription drugs at $200 per month.
PA	SB 639	Referred to Senate Banking and Insurance Committee	Pharmacy Benefit Manager	This measure gives a pharmacy or pharmacist the right to provide a covered individual with information concerning the cost of a prescription drug, including the individual's cost share. This bill prohibits a pharmacy benefit manager (PBM) from prohibiting the disclosure of cost information by a pharmacy or pharmacist.
PA	SB 731	Referred to Senate Banking and Insurance Committee	Coupons	Under this bill, an insurer must include any cost-sharing amounts paid by the insured or on behalf of the insurer by another person. A pharmacy benefits manager that administers pharmacy benefits for the insurer must include any cost-sharing amounts paid by the insured on or on health of the insured by another person.
PA	SB 789	Referred to Senate Health and Human Services Committee	Pharmacy Benefit Manager	This measure prohibits a medical assistance Medicaid managed care organization from entering into any contract for pharmacy services with a pharmacy benefits manager (PBM) if the PBM or corporate affiliate of the PBM has an ownership interest in a pharmacy providing the pharmacy services or if the pharmacy providing services has an ownership interest in the PBM or a corporate affiliate of the PBM. This bill also prohibits a PBM from requiring that an enrollee use the services of a specific pharmacy for a specialty drug.
PA	SB 829	Referred to Senate Health and Human Services Committee	Pharmacy Benefit Manager	This measure allows the Department of the Auditor General to conduct an audit and review of a pharmacy benefits manager (PBM) that contracts with a medical assistance managed care organization (MCO) under contract with the department. This measure also stipulates that a PBM owes a duty of care and loyalty and is obligated to act in good faith in relation to the department and any medical assistance MCO with which the PBM contracts.

RI	H 5094	Referred to House Corporations Committee	Transparency	This measure requires the identification of 15 prescription drugs for which the state spends significant health care dollars due to an increase in costs and requires the drugs' manufacturers to provide relevant information to justify price increases. Drugs that have increased in price by 50% or more over the past five years, or by 15% or more in the last year, may be added to the list. This measure also instructs the Department of Health to study how other states' Medicaid programs use 340B pricing and the possible benefits of offering 340B pricing to consumers. Additionally, this bill requires the department to convene an advisory commission to develop options for all qualified health benefit plans to be offered for the 2021 plan year, including one or more plans with a higher out-of-pocket limit on prescription drug coverage than the limit established under current law and two or more plans with an out-of-pocket limit at or below the limit established under current law.
RI	S 136	Held in Senate Health and Human Services Committee	Other	This measure requires prescription drug manufacturers to file a detailed, updated list of each pharmaceutical sales representative.
RI	S 137	Referred to Senate Health and Human Services Committee	Coupons	This measure requires a manufacturer who offers a discount or coupon to publish on any accompanying advertisement and website a message that a generic alternative may be available at a lower price. This bill also requires that if a manufacturer makes available to an insured consumer any discount, the manufacturer must make that same discount available to any person in the state, whether or not that person has health insurance.
SC	S 359	Signed by Governor	Pharmacy Benefit Managers	This measure establishes a licensure requirement for pharmacy benefit managers (PBM). This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist form informing a patient about therapies or risks. This measure authorizes a pharmacist to provide information to the insured about the total cost for pharmacist services for a prescription drug.
SD	HB 1137	Signed by Governor	Pharmacy Benefit Managers	This measure stipulates that no pharmacy benefit manager (PBM) may require a health plan or pharmacist to collect from an insured a cost-share for a prescription that exceeds the amount retained by the pharmacist from all payment sources. This bill also prohibits a PBM from retroactively adjusting claim payments for the benefit of a covered individual if there was an error in the adjudication of a claim submitted on behalf of the enrollee.
TN	HB 786/SB 650	Signed by Governor	Manager	This measure prohibits a pharmacy benefit manager (PBM) from reimbursing a pharmacy or pharmacist for a drug in an amount less than the covered entity or PBM reimburses itself or an affiliate for providing the same drug.
TN	HB 884	Introduced	Pharmacy Benefit Manager	This measure prohibits pharmacy benefit managers from prohibiting a pharmacy or pharmacist from informing patients of all relative options pertaining to their prescription medications, including the cost or effectiveness of alternative medications, and whether a cash payment would cost less than any cost-sharing amounts.
TN	HB 887/SB 963	Referred to House Health Subcommittee on Mental Health and Substance Abuse/referred to Senate Commerce and Labor Committee	Transparency	This measure prohibits pharmacy benefit managers from prohibiting a pharmacy or pharmacist from informing patients of all relative options pertaining to their prescription medications, including the cost or effectiveness of alternative medications, and whether a cash payment would cost less than any cost-sharing amounts.
TN	HB 1179/ SB987	Referred to House Insurance Subcommittee on Life and Health Insurance/Referred to Senate Commerce and Labor General Subcommittee	Pharmacy Benefit Manager	This measure authorizes the Bureau of TennCare to negotiate supplemental manufacturer rebates for TennCare prescription drug purchases. When conducting negotiations, the bureau must utilize the average manufacturer's price as the cost basis for the product.
TX	HB 437	Failed upon adjournment	Other	This measure allows Medicaid managed care organizations to adopt their own drug formularies.

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TX	HB 697	Failed upon adjournment	Transparency	This measure requires the Health and Human Services Commission to annually identify the prescription drugs and the wholesale price for each drug the commission determines is essential to treating diabetes in the state, including insulin and biguanides. The commission will place the diabetes drugs on a list posted to its website if the drug's wholesale price has increased in an amount equal to or greater than the average price increase in the medical care component of the consumer price index (CPI) or two times the percentage of price increase in the medical care component of the CPI as published during the prior two calendar years. This measure also requires that for the drugs identified, manufacturers must report pricing information, including a history of increases and the aggregate amount of rebates paid to pharmacy benefit managers (PBMs). This must be accompanied by a justification for any price increase. PBMs must also file similar information about their negotiated rebates.
TX	HB 698	Failed upon adjournment	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist for informing the patient about a lower-cost option or from selling a prescription drug covered by a health benefit plan that costs less than the enrollee's copayment, deductible, or coinsurance.
TX	HB 1298	Failed upon adjournment	Transparency	This measure requires the Health and Human Services Commission to annually compile a list of drugs by wholesale acquisition cost (WAC). The list must include 10 dugs on which the state spends a significant amount of money and for which the WAC has increased by at least 50% in the past five years or 15% in the previous year. The list must also include at least one generic and one brand-name drug, indicate which drugs are specialty drugs, include the percentage increase of WAC for each drug, rank the drugs from largest to smallest increase, and provide the state's total expenditure for each drug. A separate list will be compiled based on state cost with similar increase thresholds. Health plans are also required to create a similar list and submit it to the attorney general. The attorney general, in turn, can require price justification from manufacturers for certain drugs.
TX	HB 1794	Failed upon adjournment	Transparency	This measure requires manufacturers of expensive drugs to report to the Department of Health and Human Services. Under this bill, "expensive" means a prescription drug with a wholesale acquisition cost (WAC) of $2,500 or more per year or course of treatment. The report must include information about research and development costs, marketing costs, direct costs for materials, the total amount of financial assistance to patients the manufacturer provided, including rebates, and other information. The report will be considered public information. This measure also requires manufacturers to provide written notices at least 60 days before a price increase. Disclosure will be required if the price of a drug increases 10% or by $2,500 in one year or 15% cumulatively during any two-year period. The notice must include a justification for the increase.
TX	HB 2231/SB 2261	Failed upon adjournment	Pharmacy Benefit Manager	This measure establishes a fiduciary duty for pharmacy benefit managers (PBMs) to health plans. This measure also requires a PBM to transfer to a health benefit plan issuer the entire amount of any rebate that the PBM receives. This bill also prohibits a PBM from prohibiting a pharmacist from disclosing cost information to an enrollee.
TX	HB 2536	Signed by Governor	Transparency	This measure requires annual reports from pharmaceutical manufacturers that contain the wholesale acquisition cost (WAC) information for approved drugs sold in the state that have a WAC of at least $100 for a 30-day supply. Additionally, within 30 days of a 40% or more price increase over the preceding three years or a 15% or more price increase over the preceding year, a manufacturer must submit pricing information.
TX	HB 3388/SB 2262	Conference committee appointed/Referred to Senate Finance Committee	Pharmacy Benefit Manager	This measure stipulates that a managed care organization (MCO) that contracts with the state or a pharmacy benefit manager (PBM) administering a pharmacy benefit program on behalf of the MCO must reimburse a pharmacy not less than the lesser of the reimbursement amount for the drug under the vendor drug program or the amount claimed by the pharmacy.
TX	HB 4185	Failed upon adjournment	Pharmacy Benefit Manager	This measure gives the Insurance Commissioner the authority to examine the records of a pharmacy benefit manager to determine compliance with existing law.
TX	HB 4401	Failed upon adjournment	Other	This measure prohibits a managed care organization from maintaining an outpatient pharmacy benefit plan for recipients. This includes Medicaid. Under this bill, the Health and Human Services Commission will provide outpatient prescription drug benefits through the vendor program using a transparent fee-for-service delivery model.

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TX	SB 469	Failed upon adjournment	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting a pharmacy or pharmacist from informing an enrollee of any difference between the enrollee's out-of-pocket cost for a prescription drug under the enrollee's benefit plan and the out-of-pocket cost without submitting a claim under the plan.
UT	HB 267	Failed upon adjournment	Importation	This measure creates a wholesale Canadian prescription drug importation program.
UT	HB 370	Signed by Governor	Pharmacy Benefit Manager	This measure specifies that a pharmacy benefit manger has a fiduciary responsibility to an insurer and requires a PBM to report information about rebates and administrative fees to the state's Insurance Department.
UT	SB 223	Failed upon adjournment	Transparency	This measure requires a pharmacy benefit manager (PBM) to obtain a license from the Insurance Department. This bill also requires an insurer to make the plan's formulary easily accessible to enrollees. Under this bill, insurers, PBMs, pharmaceutical wholesalers or distributors, pharmacy services administrative organizations and pharmacies must report annually drug cost information to the Department of Insurance. The information will include the amount of rebates PBMs negotiate. Using this information, the department will create an annual report that contains aggregate data. The report will detail trends in pricing and the impact of pharmacy costs on premiums. This bill also requires the Department of Insurance to identify annually up to 25 drugs on which the state spends significant health care dollars or for which the wholesale acquisition cost has increased by 10% or more over a year. For each drug on the list, the department will require manufacturers to submit cost information. This measure also requires that upon the request of an insurer, a PBM must report annually to the insurer the aggregate of all drug utilization payments received by the PBM and the aggregate of all payments passed on to the insurer. This bill additionally requires a manufacturer to submit notice to purchasers for a price increase of a drug that will result in an increase in the wholesale acquisition cost (WAC) of a drug that is equal to 10% or more in a year for a drug that has a WAC of $150-$1,000 or 5% or more in a year for a drug that has a WAC of more than $1,000. Notice must be submitted at least 60 days prior to the planned increase. If a manufacturer introduces a new drug to market at a WAC that exceeds the payment threshold for a new drug as determined by federal law, the manufacturer must submit a written notice of the introduced to the Insurance Department. This measure requires each patient assistance program that receives a contribution from an applicable entity to submit an annual report that includes a list of all contributions. This bill requires PBMs to report annually information regarding the aggregate amount of rebates received from all manufacturers. This bill also requires a manufacturer to provide a list of all pharmaceutical sales representatives employed by the manufacturer. Under this bill, pharmaceutical representatives must supply providers with the average wholesale price of drugs.
VT	H 542	Signed by Governor	Importation	This measure serves as the budget. This bill directs the Agency of Human Services to extend the deadline by which the Agency of Human Services must implement a wholesale drug importation program. On or before Jan. 15, 2020, the Board of Pharmacy must provide findings on whether any new prescription drug wholesaler license categories would be necessary in order to operate the program.
VT	S 136	Referred to Senate Health and Welfare Committee	Importation	This measure designates the Agency of Human Services as the state entity responsible for developing and implementing a wholesale Canadian drug importation program. This measure also authorizes the Vermont Board of Pharmacy to create two new prescription drug wholesaler licenses for certain market participants in the program.
VA	HB 2516	Laid on Table	Pharmacy Benefit Managers	This measure requires the State Corporation Commission to treat the price spread on any contract between the issuer of a health benefit plan and its pharmacy benefit manager as an administrative cost of the issuer. Under this bill, the issuer's administrative costs will be excluded from the amount of benefits provided under a health benefit plan's anticipated loss ratio.

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VA	SB 1308	Passed by Indefinitely	Price Gouging	This measure requires the director of Medical Assistance Services (Virginia's Medicaid program) to notify the attorney general of an increase in the price of an essential off-patent generic drug if the increase would result in 50% or more in the wholesale acquisition cost, or if the cost of a 30-day supply of the maximum recommended dosage of the drug would cost more than $80 at wholesale acquisition cost. This measure prohibits a manufacturer or wholesale distributor from engaging in price gouging in the sale of an essential off-patent or generic drug. The secretary will have the power to designate essential drugs.
VA	SB 1596/HB 2515	Signed by Governor (Chapter 662)/Signed by Governor (Chapter 661)	Coupons	This measure requires any carrier issuing a health plan to count any payments made by another person on the enrollee's behalf, as well as payments made by the enrollee, when calculating the enrollee's overall contribution to any out-of-pocket, cost-sharing requirement under the carrier's health plan.
WA	HB 1224/SB 5292	334)/amended; passed	Transparency	This measure requires pharmaceutical manufacturers to disclose certain pricing information. Each year, each health plan issuer must submit to the data organization the 25 most prescribed drugs, the 25 costliest drugs by total plan spending, the
WA	HB 1562/SB 5601	Referred to House Health Care and Wellness Committee/Referred to Senate Health and Long Term Care Committee	Pharmacy Benefit Managers	This measure requires health benefit managers to obtain a license and prohibits a health benefit manager from reimbursing a pharmacy or pharmacist in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for providing the same services.
WA	HB 1911	Referred to House Health Care and Wellness Committee	Pharmacy Benefit Manager	This measure requires licensure for pharmacy benefit managers.
WA	SB 5251	Introduced; referred to Senate Health and Long Term Care Committee	Transparency	This measure requires insurers to submit an annual report to the Office of Financial Management with drug cost information for the top 25 most frequently prescribed drugs, the top 25 costliest drugs, and top 25 drugs with the highest year-over-year increase in spending. Insurers must also report the per member, per month year-over-year increase in the total annual cost of each category listed, as well as the 25 most frequently prescribed drugs for which the issuer received rebates from manufacturers. This measure also requires pharmacy benefit managers to submit information on rebates. The office will compile the information into a report for the public and the legislature. This measure requires prescription drug manufacturers to provide notice to the Health Care Authority when the manufacturer has filed a new drug application or biologics license application for a pipeline drug or biosimilar drug. Notice must be provided within 60 days of the manufacturer receiving an action date from the US Food and Drug Administration. This measure requires the Health Care Authority to create an annual drug list of the 10 prescription drugs that have a large impact on state spending or a critical to public health. Drugs will only be included if they have increased by at least 20% in a year or 50% in three years and if they cost at least $100 for a 30-day supply. Manufacturers of drugs on this list must provide information regarding the prices of the drugs.
WA	SB 5422	Referred to Senate Health and Long Term Committee	Pharmacy Benefit Managers	This measure establishes that pharmacy benefit managers (PBMs) have a fiduciary duty to a health carrier client. This measure also prohibits a PBM from requiring an enrollee to make a payment at the point of sale for a covered prescription medication in an amount greater than the lesser of the applicable copayment or the allowable claim amount, the amount an enrollee would pay without insurance, or the amount the PBM or carrier will reimburse the pharmacy for the drug. This measure also requires PBMs to submit annually a transparency report regarding aggregate rebates.
WA	SB 5982	Referred to Senate Health and Long Term Care Committee	Pharmacy Benefit Manager	This measure requires the licensure, rather than registration, of pharmacy benefit managers (PBMs). This measure also establishes that a PBM has a fiduciary duty to a health carrier client. This bill prohibits a PBM from reimbursing a pharmacy an amount less than the amount the PBM reimburses a PBM affiliate for providing the same services. Under this bill, a PBM may not deny, reduce, or recoup payment to a pharmacy after adjudication of a claim.
WV	HCR 24	Failed upon adjournment	Importation	This measure requests a study regarding a state-administered wholesale prescription drug importation program.
WV	HB 2319	Failed upon adjournment	Importation	This measure authorizes the creation of a state-administered wholesale drug importation program.
WV	HB 2428	Failed upon adjournment	Importation	This measure creates a state-administered wholesale drug importation program.

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WV	HB 2651	Failed upon adjournment	Pharmacy Benefit Managers	This measure requires the Public Employees Insurance Agency to submit quarterly reports regarding the amount paid to the pharmacy provider per claim, dispensing fees, copayments and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager (PBM).
WV	HB 2700	Failed upon adjournment	Pharmacy Benefit Managers	This measure requires the Public Employees Insurance Agency to use the West Virginia Medicaid Prescription Plan as its pharmacy benefit manager, provided the cost to the consumer is lower.
WV	HB 2770/SB 509	Signed by governor/Failed upon adjournment	Coupons	This measure requires that when calculating an insured's contribution to any applicable cost-sharing requirement, including the annual limitation on cost sharing, a pharmacy benefit manager must include any cost-sharing amounts paid by the insured or on behalf of the insured by another person.
WV	SB 250	Failed upon adjournment	Importation	This measure creates the Wholesale Prescription Drug Importation Program. The program must use Canadian drug suppliers.
WV	SB 488	Failed upon adjournment	Pharmacy Benefit Manager	This measure requires the Public Employee Insurance Agency to execute contracts for group prescription drug insurance. Under this bill, a pharmacy benefit manager (PBM) must report the amount paid to pharmacy providers for all pharmacy claims, including the cost of drug reimbursement, dispensing fees, copayments and the amount charged to the agency for each claim by the PBM. In the event there is a difference between these amounts for any claim, the PBM will report an itemization of all administrative fees, rebates or processing charges associated with the claim.
WV	SB 489/HB 2806	Signed by Governor (Chapter 145)/Died upon adjournment	Pharmacy Benefit Managers	This measure requires licensure of pharmacy benefit managers.
WI	AB 62	Referred to Assembly Insurance Committee	Transparency	This measure imposes disclosure requirements on drug manufacturers and health insurers. This bill requires that a manufacturer of a drug with a wholesale acquisition cost (WAC) that exceeds $40 notify purchasers of the drug when the cost for a course of therapy increases by more than 16%. This notice must be provided at least 60 das prior to the price increase. Manufactures must provide cost information to the Insurance Office. Under the bill, a manufacturer must also notify Insurance Office if the manufacturer releases a new drug with a WAC that exceeds the specialty drug tier threshold under the Medicare Part D program, which is currently $670 for a one-month supply.
WI	SB 100/AB 114	Referred to Senate Health and Human Services Committee/Referred to House Health Committee	Pharmacy Benefit Manager	This bill requires pharmacy benefit managers (PBMs) to register with the Insurance Commissioner. This measure also prohibits a PBM from reimbursing a pharmacy less than the amount reimbursed to a PBM's affiliate. Additionally, this bill prohibits a PBM from retroactively denying a pharmacist's claim unless the claim was fraudulent. This measure authorizes pharmacists to disclose financial information to enrollees, as well as the availability of cheaper alternatives. This bill also sets a limitation on the amount of cost sharing an enrollee must pay. A PBM cannot require an enrollee to pay an increased amount of cost sharing for a newly prescribed drug.
WI	SB 340/AB 411	Referred to Senate Insurance, Financial Services, Government Oversight and Courts Committee/Referred to Assembly Insurance Committee	Other	This measure prohibits insurers from imposing cost sharing on insulin in an amount that exceeds the lesser of $100 for a one-month supply or the greater of 125 percent of the cost of insulin or the amount generated by subtracting 51% of the total rebates received by the policy or plan from the cost-sharing amount if insulin were treated as any other prescription drug under the plan. This measure also requires the Commissioner of Insurance to prepare a report on insulin pricing practices and any policy recommendations to control overpricing of prescription insulin.
WY	HB 63	Signed by Governor	Pharmacy Benefit Managers	This measure prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacy or pharmacist for informing a covered person about a lower cost, including the cash price. This measure also allows a pharmacist to offer an individuals a more affordable alternative to the prescribed drug if one is available.
WY	HB 287	Not considered for introduction	Importation	This measure requires the Department of Health to identify three prescription drugs with the highest potential for consumer savings through importation from outside the United States that could be used in a limited prescription wholesale importation program. The program will only apply to five counties in the state.

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WY	HB 292	Died in House Labor Committee	Transparency	This measure requires health plans to provide data relating to the claims of people covered by the plan that are necessary to calculate the cost of effectiveness of benefits provided by the insurer. Data must include the total amount charged to any person for each drug available to the person, and all payments or reimbursements made to any health care provider, administrator, pharmaceutical company or pharmacy benefit manager.