

## **OVERVIEW**



AMCP is the nation's leading professional association dedicated to increasing patient access to affordable medicines, improving health outcomes and ensuring the wise use of health care dollars. AMCP supports efforts to reduce drug prices by encouraging both meaningful transparency within health care and robust market competition.

Currently, the U.S. spends more on healthcare than any other nation in the world. In 2017, the U.S. was projected to spend almost \$3.5 trillion dollars, or over \$10,000 dollars per person, on healthcare. CMS projects that, under current law, U.S. health expenditures will continue to increase, reaching an estimated \$5.7 trillion dollars by 2026. Prescription drug costs make up almost 10% of these expenditures.<sup>1</sup> Research has revealed that, when appropriate, the exchange of branded medicines for generics and biosimilars is an effective strategy to facilitate market competition and reduce costs while ensuring delivery of consistent therapeutic outcomes.<sup>2</sup> The Administration, Congress, and states are all focused on measures to support greater competition within the health care market to curb price increases.

## **THE ADMINISTRATION**

In May, the release of [The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs](#) focused on improving competition, increasing negotiation, lowering list prices, and reducing out-of-pocket costs in an effort to lower drug prices in the United States. AMCP submitted [comments](#) on the Blueprint. Those comments encouraged CMS to allow health plans more flexibility in managing Medicare Part B and Part D drugs. AMCP also voiced support for both the Food and Drug Administration's (FDA) efforts to curb the inappropriate use of Risk Evaluation and Mitigation Strategy program (REMS) to deter generic entry into the market and its work to spur generic and biosimilar market competition. Finally, AMCP advocated for the development of policies relating to [value-based contracting](#).

The United States Department of Health and Human Services (HHS) Secretary Alex Azar has commented on the [department's plan](#) to support the Blueprint by enhancing negotiation for Medicare Part B and

<sup>1</sup> CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES FACT SHEET, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last modified Apr. 17, 2018).

<sup>2</sup> "Generic Drug Access & Savings in the U.S." 2018. Accessed August 24, 2018. [https://accessiblemeds.org/sites/default/files/2018\\_aam\\_generic\\_drug\\_access\\_and\\_savings\\_report.pdf](https://accessiblemeds.org/sites/default/files/2018_aam_generic_drug_access_and_savings_report.pdf).

Medicare Part D. Additionally, the FDA has released its Drug Competition Action Plan, which is focused largely on getting safe and effective generic drugs on the market in an efficient way and ensuring that FDA regulations do not create an obstacle to new competition.<sup>3</sup> FDA Commissioner Scott Gottlieb has also spoken publicly on the need to lower prescription drug prices by increasing both drug pricing transparency for consumers and [market competition](#) for prescription drugs.

## CONGRESS

Congress is currently considering several pieces of legislation aimed at drug pricing. Many legislative approaches parallel those offered by the Administration in the Blueprint. A few of the legislative approaches follow:

- The Senate passed a [bi-partisan amendment](#) that provides HHS with funding to implement measures requiring pharmaceutical companies to disclose drug prices in direct-to-consumer advertisements. This measure is pending reconciliation with the House Drug-Price Transparency in Communications Act, H.R. 6576.
- [The Creating and Restoring Equal Access to Equivalent Samples \(CREATES\) Act](#), S. 964, is a bipartisan bill that aims to prevent brand pharmaceutical companies from refusing to sell to generic pharmaceutical companies' drug samples that they require to develop generic drugs. If passed, this bill would encourage increased market competition and reduced drug prices by facilitating the introduction of less costly generic drugs to the market. [AMCP supports S. 964](#).
- The [Biosimilars Competition Act of 2018](#), H.R. 6478, would enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce anti-trust laws regarding biologic and biosimilar drugs. Proponents of this bill believe that increasing competition in the biosimilar market would help reduce prescription drug costs and increase patient access to life-saving medications. [AMCP supports H.R. 6478](#).
- The Patient Right to Know Drug Prices Act, [S. 2554](#) and [H.R. 6143](#), are identical "gag clause" bills that would ensure that health insurance issuers and group health plans do not prohibit pharmacists from providing certain information to enrollees. Legislators seek to ensure that patients always pay the lowest cost for their medications at the pharmacy counter.

Lastly, in July, the U.S. House of Representatives Subcommittee on Oversight and Investigations held a hearing entitled "[Examining State Efforts to Improve Transparency of Health Care Costs for Consumers](#)." During this hearing, two witnesses testified on existing state policies aimed to improve transparency of health care costs and the impact that they have on drug prices. The first witness, [Jaime King](#), testified that price transparency initiatives could be successful if they engage all stakeholders in the healthcare market including patients, providers, payers, and policymakers, such as all-payer claims databases. The second witness, [Michael Chernew](#), testified that improved information in health care would not have a significant impact on lowering drug prices due to other complicating factors in the health care market.

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<sup>3</sup> U.S. Food & Drug Administration. "FDA Tackles Drug Competition to Improve Patient Access." News release, June 27, 2017. Accessed August 24, 2018. <https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm564725.htm>.

However, he asserted that policymakers could encourage lower drug prices by supporting measures to increase health care market competition.

## 2018 STATE LEGISLATIVE ACTIVITY

Many state legislatures are taking active measures to lower prescription drug prices. Although strategies have varied substantially, several common trends in state legislation have surfaced, including measures to regulate maximum allowable costs (MACs) for drug payments, remove gag clauses from PBM contracts, and promote price transparency among stakeholders.

Some of this drug pricing legislation has been highly contentious and has even led to legal opposition by manufacturers, health insurers, and PBMs. For example, earlier this year in [Pharmaceutical Care Management Association \(PCMA\) v. Rutledge](#), PCMA sued the Attorney General of Arkansas to overturn Act 900, an Arkansas law that set MACs for PBMs. The Eighth United States Circuit Court of Appeals ruled in favor of PCMA in a unanimous three-judge decision, finding that Medicare Part D and the Employee Retirement Income Security Act (ERISA) preempted Act 900.

This year, state legislatures enacted more than 40 drug pricing related laws. Most of these laws fall into the following three categories.

**“Gag Clause”** - These measures prohibit contracts between PBMs, health plans, and pharmacies that prevent pharmacists from discussing lower out-of-pocket cost options with beneficiaries.

**Maximum Allowable Cost (MAC)**- This type of legislation requires PBMs to disclose how a MAC list is formulated, imposes requirements on PBMs seeking to add or remove drugs from MAC lists, requires disclosure of relationships between PBMs and manufacturers, and/ or requires PBMs to establish processes by which a contracted pharmacy or pharmacist may appeal their reimbursements for drugs subject to MAC pricing.

**Price Transparency**- Price transparency bills require drug manufacturers, health insurers, and PBMs to provide price transparency and increased access to more generic drugs.

**Other Legislation Topics**- Some states, such as New Hampshire, established task forces to study drugs costs and pricing, and others required PBMs and manufacturers to report drug cost and pricing information, created limits on drug prices and co-payments, and limited the use of prior authorization by health plans.

As of September, 8 states and the District of Columbia are still in session: **Illinois, Ohio, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, and Wisconsin**. A summary of legislative activity in the states that have adjourned for 2018 follows.

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State	Effective Date	Summary
<a href="#">Alabama</a>		<p><b>Act Relating to Auditing Procedures for Pharmacy Records</b></p> <ul style="list-style-type: none"> <li>• Prohibits an auditing entity from subjecting a pharmacy to a charge-back or recoupment for a clerical error in a required document or record unless the error resulted in overpayment to the pharmacy.</li> <li>• Prohibits the amount charged back or recouped due to overpayment from exceeding the amount the pharmacy was overpaid.</li> <li>• Specifies that the auditing entity may not include the dispensing fee in the calculation of an overpayment unless the prescription is considered a “misfill.”</li> <li>• Defines "misfill" as a prescription that was not dispensed, a prescription in which the prescriber denied the authorization request, a prescription in which an additional dispensing fee was charged, or a prescription error.</li> <li>• Prohibits an auditing entity from auditing a sample size greater than 150 prescriptions (excluding refills).</li> <li>• Prohibits an auditing entity from compensating an employee or contractor who conducts an audit based on the amount claimed or the actual amount recouped by the pharmacy being audited.</li> </ul>
<b>H.B. 457</b>	6/01/2018	
<a href="#">Arizona</a>		<p><b>Prescription Drug Pricing Patient Protection Act</b></p> <p>A PBM may not:</p> <ol style="list-style-type: none"> <li>(1) Prohibit a pharmacist or pharmacy from providing an insured individual information on the amount of the insured's cost share for the insured's prescription drug or the clinical efficacy of a more affordable alternative drug.</li> <li>(2) Penalize a pharmacist for disclosing such information or selling a more affordable alternative.</li> <li>(3) Require a pharmacist to charge or collect from an insured a copayment that exceeds the total submitted charges by the network pharmacy.</li> </ol>
<b>H.B. 2107</b>	7/04/2018	
<a href="#">Arkansas</a>		<p><b>Arkansas PBM Licensure Act (Only Gag Clause Provisions Summarized)</b></p> <p><b>PBM Licensure</b> Requires PBMs to obtain a license from the Insurance Commissioner (the “Commissioner”).</p> <p><b>Gag Order</b></p> <ul style="list-style-type: none"> <li>• Allows pharmacies and pharmacists to provide information regarding an enrollee's total cost for pharmacist services for a prescription drug.</li> <li>• Prohibits PBMs from penalizing a pharmacy or pharmacist for discussing the total cost for pharmacist services or selling a more affordable alternative.</li> </ul>
<b>H.B. 1010/ S.B. 2</b>	3/20/2018	

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<p><a href="#">Colorado</a></p> <p><b>H.B. 1284</b></p>	<p>8/07/2018</p>	<p><b>Patient Drug Costs Savings Act</b></p> <p>Any carrier that has a contract with a pharmacy or pharmacist, or any PBM acting on behalf of a carrier, may not:</p> <p>(1) Prohibit a pharmacy or pharmacist from, or penalize a pharmacy or pharmacist for, providing a covered person information on the amount of the covered person's cost share for the covered person's prescription drug and the clinical efficacy of any more affordable alternative drugs that are therapeutically equivalent.</p> <p>(2) Require a pharmacy to charge or collect a copayment from a covered person that exceeds the total submitted charges by the network pharmacy.</p>
<p><a href="#">Connecticut</a></p> <p><b>H.B. 5384</b></p>	<p>1/01/2020</p>	<p><b>Requirements on PBMs</b></p> <ul style="list-style-type: none"> <li>• Requires PBMs to file an annual report with the Insurance Commissioner (the “Commissioner”) that contains the following information:             <ol style="list-style-type: none"> <li>(1) The aggregate dollar amount of all rebates that the PBM received from pharmaceutical manufacturers.</li> <li>(2) The aggregate dollar amount of all rebates that the PBM received from pharmaceutical manufacturers, excluding any portion of such rebates received by a health carrier.</li> </ol> </li> </ul> <p><b>Requirements on Insurers</b></p> <ul style="list-style-type: none"> <li>• Requires each insurer to submit the following:             <ol style="list-style-type: none"> <li>(1) A list of the 25 most frequently prescribed outpatient prescription drugs.</li> <li>(2) The 25 outpatient prescription drugs that the insurer covered at the greatest cost.</li> <li>(3) The 25 outpatient prescription drugs that experienced the greatest year-over-year increase in cost.</li> </ol> </li> <li>• Requires that insurers must also submit the following information:             <ol style="list-style-type: none"> <li>(1) The portion of the premium for such health care plan that is attributable to brand name, generic and specialty drugs.</li> <li>(2) The year-over-year increase in the total annual cost of each category of covered outpatient prescription drugs.</li> <li>(3) A comparison of the year-over-year increase in the cost of drugs to the year-over-year increase in the costs of other contributors to the premium cost of the plan.</li> <li>(4) The name of each specialty drug covered during the calendar year.</li> <li>(5) The names of the 25 most frequently prescribed outpatient drugs for which the insurer received rebates from the manufacturer.</li> </ol> </li> <li>• Requires that the insurer submit an annual form that certifies that the insurer accounted for all rebates in calculating the premium for health care plans.</li> </ul>

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<b>Connecticut Cont'd</b>	<ul style="list-style-type: none"> <li>• Requires the Commissioner to submit a report to the General Assembly that contains the above information as well as a description of the impact of the cost of outpatient drugs on premiums.</li> </ul> <p><b>Requirements on Manufacturers</b></p> <ul style="list-style-type: none"> <li>• Requires the Office of Health Strategy (the "Office") to prepare a list of 10 prescription drugs that are either provided at substantial cost to the state or are critical to public health.</li> <li>• Requires that the list include prescription drugs from different therapeutic classes of drugs and at least one generic prescription drug.</li> <li>• Provides that a drug will be on the list only if:             <ol style="list-style-type: none"> <li>(1) The wholesale acquisition cost (WAC) increased by 20% or more during the preceding calendar year.</li> <li>(2) The WAC increased by 50% during the immediately preceding three calendar years.</li> <li>(3) The drug was not less than \$60 for a 30-day supply or a course of treatment lasting less than 30 days.</li> </ol> </li> <li>• Requires the manufacturer of a drug included on the above list to provide the Office with a written, narrative description, suitable for public release, of all factors that caused the increase in the WAC and aggregate, company-level research as well as development costs and other capital expenditures.</li> <li>• Requires sponsors of new drugs to submit written notice informing the Office that the sponsor has filed the following with the FDA:             <ol style="list-style-type: none"> <li>(1) A new drug application or biologics license application for a pipeline drug.</li> <li>(2) A biologics license application for a biosimilar drug.</li> </ol> </li> <li>• Requires the Office to conduct a study of each pharmaceutical manufacturer of a pipeline drug that may have a significant impact on state expenditures for drugs.</li> <li>• Requires each manufacturer that is the subject of the study to submit to the Office the following information for the pipeline drug:             <ol style="list-style-type: none"> <li>(1) the primary disease, condition or therapeutic area studied in connection with such drug and whether such drug is therapeutically indicated for such disease, condition or therapeutic area;</li> <li>(2) each route of administration studied for the drug;</li> <li>(3) clinical trial comparators;</li> <li>(4) the estimated year of market entry;</li> <li>(5) whether the FDA has designated the drug an orphan drug, a fast track product or a breakthrough therapy; and</li> <li>(6) whether the FDA has designated the drug for accelerated approval and, if such drug contains a new molecular entity, for priority review.</li> </ol> </li> </ul>
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<p><a href="#">Florida</a></p> <p><b>H.B. 351</b></p>	<p>7/01/2018</p>	<p><b>Prescription Drug Pricing Transparency</b></p> <p><b>Information Disclosure</b></p> <ul style="list-style-type: none"> <li>• Requires a pharmacist, or his or her employee, to inform customers of a less expensive generically equivalent prescription drug and if the customer’s cost sharing obligation exceeds the retail price of the drug in the absence of prescription drug coverage.</li> </ul> <p><b>PBM Contracts</b></p> <ul style="list-style-type: none"> <li>• Requires a PBM to update MAC pricing information at least every seven calendar days and to maintain a process that will eliminate drugs in a timely manner from MAC lists or modify drug prices to remain consistent with the changes in pricing data used in formulating MAC prices and product availability.</li> <li>• Prohibits PBMs from limiting a pharmacy's or pharmacist's ability to substitute a less expensive, generically equivalent drug, or to disclose whether a subscriber's cost-sharing obligation exceeds the retail price for a covered prescription drug and availability of a more affordable alternative drug, effective July 1, 2018.</li> <li>• Prohibits a PBM from requiring a subscriber to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of:             <ol style="list-style-type: none"> <li>(1) the applicable cost-sharing amount;</li> <li>(2) the total submitted charges for the prescription drug; or</li> <li>(3) the retail price of the drug in the absence of prescription drug coverage or programs that otherwise reduce the cost of a drug to the patient.</li> </ol> </li> </ul>
<p><a href="#">Indiana</a></p> <p><b>H.B. 1317</b></p>	<p>7/01/2018</p>	<p><b>Gag Order Provisions</b></p> <ul style="list-style-type: none"> <li>• Provides that a pharmacy or pharmacist has the right to provide a covered individual with information concerning the amount of the covered individual's cost share for a prescription drug.</li> <li>• Prohibits a PBM, insurer, or HMO from proscribing a pharmacy or pharmacist from discussing the above information or from selling to a covered individual a more affordable alternative if one is available.</li> <li>• Prohibits a PBM, insurer, or HMO from including a provision that requires a covered individual to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of the following:             <ol style="list-style-type: none"> <li>(1) the contracted copayment amount; or</li> <li>(2) the amount of total approved charges by the PBM at the point of sale.</li> </ol> </li> </ul>
<p><a href="#">Kansas</a></p> <p><b>S.B. 351</b></p>	<p>7/01/2018</p>	<ul style="list-style-type: none"> <li>• Provides that a pharmacy or pharmacist has the right to provide a covered person with information regarding their cost share for a prescription drug.</li> </ul>

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<p><b>Kansas</b> <b>Cont'd</b></p>		<ul style="list-style-type: none"> <li>• Prohibits a PBM from proscribing a pharmacy or a pharmacist from discussing any such information, or for selling a more affordable alternative, to the covered person if such an alternative is available.</li> <li>• Prohibits co-payments applied by a health carrier for a prescription drug from exceeding the total submitted charges by the network pharmacy.</li> </ul>
<p><b><u>KENTUCKY</u></b></p>	<p><b>H.B. 463</b></p>	<p>1/01/2019</p> <ul style="list-style-type: none"> <li>• Prohibits an insurer or PBM from:               <ol style="list-style-type: none"> <li>(1) requiring an enrollee purchasing a drug to pay a cost-sharing amount greater than the amount they would pay for the drug if they were to purchase the drug without using insurance;</li> <li>(2) prohibiting a pharmacy from discussing the applicable limitations on cost-sharing; and</li> <li>(3) imposing a penalty on a pharmacy for complying with this bill.</li> </ol> </li> <li>• Requires any cost-sharing paid to count towards any annual out-of-pocket maximums.</li> <li>• Prohibits an insurer or PBM from charging an insured individual any more than the cost-sharing amount for a drug.</li> <li>• Provides that a pharmacist has the right to provide information regarding any applicable limitations on cost-sharing required by this bill for a prescription drug.</li> </ul>
<p><b>S.B. 5</b></p>	<p>1/01/2019</p>	<ul style="list-style-type: none"> <li>• Requires PBMs contracting with a Medicaid managed care organization (MMCO) to provide the following information annually to the Department for Medicaid Services (DMS):               <ol style="list-style-type: none"> <li>(1) The total Medicaid dollars paid to the PBM and the total Medicaid dollars not subsequently paid to a pharmacy.</li> <li>(2) The average reimbursement paid, by drug ingredient cost, dispensing fee, and any other fee, and any direct or indirect fees, charges, or any kind of assessments imposed by the PBM to pharmacies: in which the PBM has a financial interest, pharmacies which operate more than 10 locations, or pharmacies which operate 10 or fewer locations.</li> <li>(3) Any financial interest held by the PBM in an MMCO.</li> </ol> </li> <li>• Authorizes DMS to set, create, approve, and change at any time the reimbursement rates between a PBM and a contracted pharmacy and requires DMS to approve of any contract between a PBM and a pharmacy before it may go into effect.</li> <li>• Requires PBMs to notify DMS 30 days in advance of any rate changes of over 5%.</li> </ul>
<p><b><u>LOUISIANA</u></b></p>		<p><b>Gag Order Provision</b></p> <ul style="list-style-type: none"> <li>• Prohibits a PBM, insurer, or other entity that administers prescription drug benefits programs in the state from prohibiting by contract a pharmacy or pharmacist from informing a patient of all relevant options when acquiring prescription medication. This includes the cost and clinical efficacy of a more affordable alternative if one is available and the ability to pay cash if a cash price for the same drug is less than an insurance copayment or deductible payment amount.</li> </ul>



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<p><b>Louisiana</b> <b>Cont'd</b></p>		<p><b>Reimbursements</b></p> <ul style="list-style-type: none"> <li>• Prohibits a PBM from reimbursing a pharmacy or pharmacist an amount less than the amount that the PBM reimburses an affiliate of the PBM for providing the same services.</li> <li>• Requires that for every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM must make available to all pharmacies information identifying the national drug pricing compendia or sources used to obtain the drug price data and the comprehensive list of drugs subject to MAC by plan and the actual MAC for each drug.</li> </ul> <p><b>Appeals</b></p> <ul style="list-style-type: none"> <li>• Permits a pharmacy to file an appeal within 15 days, rather than 7 days, after the applicable fill date, and requires a PBM to respond within 15 days, rather than 7 days.</li> <li>• Authorizes PBMs to take the following actions if a pharmacy appeal relative to MAC is granted:             <ol style="list-style-type: none"> <li>1) Make the change in the MAC List to the initial date of service the appealed drug was dispensed.</li> <li>2) Permit the appealing pharmacy and all other pharmacies in the network that filled prescriptions for patients covered under the same health benefit plan to reverse and resubmit claims and receive payment based on the adjusted MAC from the initial date of service the appealed drug was dispensed.</li> <li>3) Make the change effective for each similarly situated pharmacy as defined by the payor subject to the MAC List and individually notify all pharmacies in the PBM's network.</li> <li>4) Make retroactive price adjustments in the next payment cycle.</li> </ol> </li> <li>• Specifies that, for every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM must make available to the Commissioner, upon request, information that is needed to investigate the complaint.</li> <li>• Specifies that, if the Commissioner is unable to obtain information from the PBM that is necessary to resolve the complaint, the reimbursement amount requested in the pharmacist's appeal must be granted.</li> <li>• Requires that complaints be submitted within 15 business days.</li> <li>• Requires that, if the complaint investigation determines that the PBM's final decision was not in compliance, the appealing pharmacy must be reimbursed the higher of the pharmacy's actual acquisition cost of the drug or the MAC price.</li> </ul>
<p><b>H.B. 436</b></p>	<p>1/01/2019</p>	
<p><b>S.B. 130</b></p>	<p>8/01/2018</p>	<p><b>Medicaid Contracts for PBM Services</b></p> <ul style="list-style-type: none"> <li>• Requires that Medicaid PBM contracts be limited to a set per transaction rate for every pharmacy claim paid.</li> <li>• Prohibits PBMs from retaining state supplemental drug rebates, credits, or "spread pricing" amounts.</li> </ul>

## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<p><b>Louisiana Cont'd</b></p>		<ul style="list-style-type: none"> <li>• Prohibits a PBM or Medicaid MCO that subcontracts, or has a subsidiary PBM, from denying any Louisiana licensed pharmacy or pharmacist the right to be a participating provider in the MCO or PBM's provider network if the pharmacy or pharmacist meets all requirements of participation in the state Medicaid program.</li> <li>• Defines "spread pricing" as any amount charged or claimed by a PBM to an MCO that is more than the amount paid to the pharmacy that filled the prescription.</li> </ul>
<p><b>S.B. 241</b></p>	<p>8/01/2018</p>	<p><b>Pharmacy Gag Order Provisions</b></p> <ul style="list-style-type: none"> <li>• Prohibits a PBM or other entity that administers prescription drug benefits in the state from prohibiting by contract a pharmacy or pharmacist from informing a patient of all relevant options when acquiring their prescription medication, including the cost and clinical efficacy of a more affordable alternative if one is available and the ability to pay cash if a cash payment for the same drug is less than an insurance copayment or deductible payment amount.</li> <li>• Voids any provision of a contract that violates this prohibition.</li> </ul>
<p><b>S.B. 282</b></p>	<p>8/01/2018</p>	<p><b>Prescription Drug Pricing</b></p> <ul style="list-style-type: none"> <li>• Requires, beginning January 1, 2020, that health insurance issuers notify enrollees that they are subject to an excess consumer cost burden when they are charged more for a prescription drug than their insurer pays or would pay after considering drug rebates from the drug manufacturer into the total cost of the drug.</li> <li>• Requires that this notice be provided in the coverage agreement, formulary, or preferred drug guide issued by the health plan.</li> <li>• Requires, beginning January 1, 2020, that health insurance issuers make available to the Commissioner of Insurance information regarding the value of rebates expressed as a percentage that the health insurance issuer made available to enrollees at the point of sale.</li> <li>• Provides that this measure applies to any PBM that has a contract with the Department of Health or is subcontracted with an MCO.</li> </ul>
<p><b>S.B. 283</b></p>	<p>8/01/2018 (Sec. 3 and 4); January 1, 2020 (Sec. 1 and 2)</p>	<p><b>PBM Transparency Reporting</b></p> <ul style="list-style-type: none"> <li>• Requires any PBM that has a contract with the Department of Health, or is a subcontractor with a managed care organization, to provide the Department of Insurance with (1) the formulary of each health benefit plan with which it is contracted and (2) timely notification of formulary changes and product exclusions, which will be available on the Department's website.</li> <li>• Requires each licensed PBM to submit an annual transparency report beginning June 1, 2020, as a condition of licensure.</li> <li>• Requires that the report contain the following information, which will be published on the Department's website:             <ol style="list-style-type: none"> <li>(1) The aggregate amount of all rebates that the PBM received from pharmaceutical manufacturers.</li> <li>(2) The aggregate administrative fees that the PBM received.</li> </ol> </li> </ul>

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<p><b>Louisiana</b> <b>Cont'd</b></p>		<p>(3) The aggregate rebates that the PBM received from pharmaceutical manufacturers and did not pass through to the health benefit plan or health insurance issuer.</p> <ul style="list-style-type: none"> <li>• Requires that, not more than 30 days after an increase in WAC of 50% or greater for a drug with a WAC of \$100 or more for a 30-day supply, a pharmaceutical drug manufacturer must notify the Commissioner of Insurance by e-mail of any such change.</li> </ul>
<p><a href="#"><u>Maine</u></a></p>		<p><b>Prescription Drug Information</b></p> <ul style="list-style-type: none"> <li>• Requires the Maine Health Data Organization to provide a report to the Maine Legislature by December 1, 2018 and annually thereafter.</li> <li>• Requires that the report contain information about prescription drugs, both brand name and generic, including:             <ol style="list-style-type: none"> <li>(1) The 25 most frequently prescribed drugs in the state.</li> <li>(2) The 25 costliest drugs as determined by total spending in the state.</li> <li>(3) The 25 drugs with the highest year-over-year cost increases as determined by the total amount spent on those drugs in the state.</li> </ol> </li> </ul>
<p><b>L.D. 1406</b></p>	<p>7/17/2018</p>	
<p><a href="#"><u>MARYLAND</u></a></p>		<p><b>Pharmacy Gag Order Provisions</b></p> <p>Prohibits a PBM from prohibiting a pharmacy or pharmacist from providing a beneficiary with information regarding, or discussing with a beneficiary, the retail price of a prescription drug or the amount of the cost share for a prescription for which the beneficiary is responsible.</p>
<p><b>H.B. 736/ S.B. 576</b></p>	<p>10/01/2018</p>	
<p><b>H.B. 1349</b></p>	<p>6/01/2018</p>	<p><b>Reimbursement</b></p> <ul style="list-style-type: none"> <li>• Prohibits a PBM from reimbursing a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the PBM reimburses itself or an affiliate for providing the same product or service.</li> <li>• Provides that this does not apply to reimbursement for specialty drugs, mail order drugs, or to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.</li> </ul> <p><b>Pricing Information</b></p> <p>Requires PBMs to:</p> <ol style="list-style-type: none"> <li>(1) Update pricing information on their website at least every 7 days.</li> <li>(2) Establish a reasonable process by which a contracted pharmacy has access to the current and applicable MAC price lists in an electronic format as updated in accordance with the requirements.</li> <li>(3) Immediately after a pricing information update, use the updated pricing information in calculating the payments made to all contracted pharmacies</li> </ol>
<p><a href="#"><u>Mississippi</u></a></p>		<p><b>Pharmacy Gag Order Provisions</b></p> <ul style="list-style-type: none"> <li>• Specifies that any provision of any contract or agreement which would prohibit a pharmacist from providing additional information to a patient about an affordable alternative payment option which acquiring prescriptions is void.</li> </ul>
<p><b>H.B. 709</b></p>	<p>7/01/2018</p>	

# OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

Mississippi Cont'd		<ul style="list-style-type: none"> <li>Prohibits the Board of Pharmacy, a PBM, or any other third party from penalizing a pharmacist for acting or failing to act in compliance with this bill.</li> </ul>
<a href="#">MISSOURI</a>		<p><b>Generic Drug Substitution</b></p> <ul style="list-style-type: none"> <li>Permits a pharmacist who receives a prescription for a brand name drug or biological product to select a less expensive generically-equivalent or interchangeable biological product unless (1) the patient requests a brand name drug or biological product or (2) the prescribing practitioner indicates that substitution is prohibited or displays “brand medically necessary”, “dispense as written”, “do not substitute”, “DAW”, or words of similar import on the prescription, rather than only when a prescriber has signed on the "Substitution Permitted" line.</li> </ul> <p><b>Pharmacy Gag Order Provisions</b></p> <ul style="list-style-type: none"> <li>Specifies that no PBM can prohibit a pharmacist or pharmacy with which the PBM has entered a contract from requiring a covered person from making a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of (1) the copayment amount as required under the health benefit plan or (2) the amount an individual would pay for a prescription if that individual paid with cash.</li> <li>Specifies that a pharmacy or pharmacist has the right to provide to a covered person information regarding the amount of the covered person's cost share for a prescription drug, the cost of an alternative drug, and the cost of the drug without adjudicating the claim through the PBM and prohibits a PBM from proscribing a pharmacy or pharmacist from providing this information.</li> <li>Prohibits a PBM from directly or indirectly charging or holding a pharmacist or pharmacy responsible for any fee amount related to a claim that is not known at the time of the claim's adjudication, unless the amount is a result of improperly paid claims or charges for administering a health benefit plan.</li> </ul>
S.B. 826	7/09/2018	
<a href="#">NEW HAMPSHIRE</a>		<p><b>The Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs (the "Commission")</b></p> <ul style="list-style-type: none"> <li>Establishes the Commission and requires the Commission to study how to achieve greater transparency in pharmaceutical costs by (1) identifying and analyzing certain critical prescription drugs and their role in overall health care spending in the New Hampshire, and (2) by analyzing the amounts rebated by drug manufacturers for certain high cost and high utilization prescription drugs.</li> <li>Requires this study to include the following:             <ol style="list-style-type: none"> <li>Strategies available to achieve greater transparency in pharmaceutical costs determined by identifying and analyzing certain critical prescription drugs and their role in overall health care spending and the impact of price increases on patients and their families.</li> <li>A review of legislative efforts in other states, taking advantage of any other analysis by outside organizations or foundations.</li> </ol> </li> </ul>
H.B. 1418	11/01/2018	

## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<p><b>New Hampshire</b> <b>Cont'd</b></p>		<p>(3) An analysis of the impact of drug prices on insurance premium costs, consumer out-of-pocket costs for prescription drugs, and state and county purchasing of prescription drugs.</p> <p>(4) An analysis of the potential impact of transparency in relation to the practices of pharmaceutical manufacturers and PBMs, including how research and development, marketing, and rebates affect drug prices.</p> <p>(5) Proposals to change New Hampshire law, as needed, to reduce the rising cost of pharmaceuticals.</p> <ul style="list-style-type: none"> <li>• Requires the Commission to study the role PBMs play in the cost, administration, and distribution of drugs, if greater transparency in pharmaceutical costs to purchasers would lower costs in overall health care spending in New Hampshire and the amounts rebated by drug manufacturers for prescription drugs passed to purchasers and patients.</li> <li>• Provides that the Commission shall include:             <ol style="list-style-type: none"> <li>(1) three members of the House of Representatives,</li> <li>(2) one member of the Senate</li> <li>(3) the Insurance Commissioner, or designee,</li> <li>(4) the Commissioner of the Department of Health and Human Services, or designee,</li> <li>(5) one public member to be appointed by the Governor,</li> <li>(6) a representative of the New Hampshire Hospital Association, appointed by the association,</li> <li>(7) a physician,</li> <li>(8) the executive director of New Futures, or designee,</li> <li>(9) a representative of the New Hampshire Pharmacists Association, appointed by the association,</li> <li>(10) a representative of the Business and Industry Association of New Hampshire, appointed by the association,</li> <li>(11) a member representing PBM, appointed by the Pharmaceutical Care Management Association,</li> <li>(12) a representative of America's Health Insurance Plans (AHIP), appointed by that organization, and</li> <li>(13) a representative of Pharmaceutical Research and Manufacturers of America, appointed by that organization.</li> </ol> </li> <li>• Requires the Commission to report its findings and any recommendations to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2018.</li> </ul>
<p><b>H.B. 1791</b></p>	<p>1/01/2019</p>	<ul style="list-style-type: none"> <li>• Prohibits any contract between an insurance carrier or PBM and a contracted pharmacy from prohibiting disclosure to a covered person or the insurance department relative to monetary matters which would prove beneficial in lowering costs to such covered person.</li> <li>• Allows a pharmacist to substitute an interchangeable biological product if it has been licensed by the FDA as an interchangeable biological product and they inform the patient.</li> </ul>

## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

New Hampshire Cont'd		<ul style="list-style-type: none"> <li>• Prohibits a pharmacist from substituting a biological product if the prescriber indicates that substitution is not authorized.</li> </ul>
S.B. 591	6/08/2018	<ul style="list-style-type: none"> <li>• Prohibits a PBM from requiring accreditation of providers other than by the New Hampshire pharmacy board or other state or federal entity.</li> <li>• Provides that the measure sunsets on June 30, 2020.</li> </ul>
<a href="#">Oregon</a>		<p><b>Drug Pricing Transparency Requirements on Drug Manufacturers</b></p> <ul style="list-style-type: none"> <li>• Requires drug manufacturers to report information regarding each prescription drug for which:               <ol style="list-style-type: none"> <li>(1) the price was \$100 or more for a one-month supply or for a course of treatment lasting less than one month; and</li> <li>(2) there was a net increase of 10% or more in the price of the prescription drug during the previous calendar year.</li> </ol> </li> <li>• For each drug that meets the above criteria, a manufacturer is required to report the following:               <ol style="list-style-type: none"> <li>(1) Name and price of the drug and the price increase.</li> <li>(2) Length of time the drug has been on the market.</li> <li>(3) Factors that contributed to the price increase.</li> <li>(4) Name of any generic version of the drug.</li> <li>(5) Research and development costs associated with the prescription drug that were paid using public funds.</li> <li>(6) Direct costs incurred by the manufacturer to manufacture, market and distribute the drug.</li> <li>(7) Total sales revenue for the drug during the previous year.</li> <li>(8) Manufacturer's profit attributable to the drug during the previous calendar year.</li> <li>(9) Introductory price of the drug when approved by the FDA and net yearly increase during the previous five years.</li> <li>(10) 10 highest prices paid for the drug during the previous calendar year in any other country than the United States.</li> <li>(11) Documentation that supports the above information.</li> </ol> </li> <li>• Requires that, no later than 30 days after a manufacturer introduces a new drug for sale at a price that exceeds the CMS threshold for specialty drugs in the Medicare Part D program, the manufacturer must report to the Department the following:               <ol style="list-style-type: none"> <li>(1) Description of the marketing used for the drug.</li> <li>(2) Methodology used to establish the price of the new drug.</li> <li>(3) Whether the FDA granted the new drug a breakthrough therapy designation or a priority review.</li> <li>(4) If the new drug was not developed by the manufacturer, the date of and price paid for acquisition of the new drug by the manufacturer.</li> <li>(5) Manufacturer's estimate of the average number of patients who will be prescribed the new prescription each month.</li> <li>(6) Research and development costs associated with the new drug.</li> </ol> </li> </ul>
H.B. 4005	3/12/2018	

# OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<p><b>Oregon</b> <b>Cont'd</b></p>		<ul style="list-style-type: none"> <li>• A manufacturer must accompany reports with the following information about each patient assistance program offered to consumers:               <ol style="list-style-type: none"> <li>(1) The number of consumers who participated in the programs.</li> <li>(2) The total value of the coupons, discounts, copayment assistance or other reduction in costs provided to consumers.</li> <li>(3) For each drug, the number of refills that qualify for the program.</li> <li>(4) The period during which the program is available to consumers.</li> <li>(5) The relevant eligibility criteria.</li> </ol> </li> <li>• Requires the Department to compile and report information collected to the interim committees of the Legislative Assembly related to health. The report must include recommendations, if any, for legislative changes to contain the cost of prescription drugs and reduce the impact of price increases on consumers.</li> <li>• Requires the Department to post information regarding drug prices to its website.</li> </ul> <p><b>Requirements on Insurers</b> Requires insurers to include the following information regarding drugs reimbursed by the insurer in the filing of rates for health insurance:</p> <ol style="list-style-type: none"> <li>(1) The 25 most frequently prescribed drugs.</li> <li>(2) The 25 most costly drugs as a portion of total annual spending.</li> <li>(3) The 25 drugs that have caused the greatest increase in total plan spending from one year to the next.</li> <li>(4) The impact of the costs of drugs on premium rates.</li> </ol>
<p><b>South Carolina</b></p>		<p><b>Pharmacy Gag Order Provisions</b></p> <ul style="list-style-type: none"> <li>• Prohibits a PBM from:           <ol style="list-style-type: none"> <li>(1) prohibiting a pharmacist or pharmacy from providing an insured information on the amount of the insured's cost share for a prescribed drug (a pharmacist or pharmacy may not be penalized by a PBM for discussing such information to an insured or for selling a more affordable alternative to the insured if one is available);</li> <li>(2) prohibiting a pharmacist or pharmacy from offering and providing direct delivery services to an insured as an ancillary service of the pharmacy;</li> <li>(3) charging or collecting a copayment from an insured that exceeds the total submitted charges by the network pharmacy;</li> <li>(4) charging or holding a pharmacist or pharmacy responsible for a fee relating to the adjudication of a claim unless the fee is reported on the remittance advice of the adjudicated claim or is set out in contract between the PBM and the pharmacy; or</li> <li>(5) penalizing or retaliating against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this chapter.</li> </ol> </li> </ul>
<p><b>H.B. 5038</b></p>	<p>5/3/2018</p>	

## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<a href="#">South Dakota</a>		<b>Pharmacy Gag Order Provisions</b> Prohibits a PBM from prohibiting or penalizing a pharmacist or pharmacy for providing cost-sharing information on the amount a covered individual may pay for a prescription drug and designates doing so as a false, misleading, deceptive, or unfair practice.
<b>S.B. 141</b>	5/28/2018	
<a href="#">TENNESSEE</a>		Provides that any agreement purporting to limit the ability of a pharmacist to discuss any issue related to the dispensing of a controlled substance with a patient is void and unenforceable.
<b>H.B. 1831</b>	1/01/2019	
		<b>Pharmacy Gag Order Provisions</b> <ul style="list-style-type: none"> <li>• Provides that a pharmacy or pharmacist has the right to provide an insured information regarding the amount of the insured's cost share for a prescription drug.</li> <li>• Prohibits a PBM from penalizing a pharmacy or a pharmacist for discussing such information or for selling a lower priced drug to the insured if one is available.</li> </ul>
<b>S.B. 2362</b>	7/1/2018	
<a href="#">UTAH</a>		<b>Pharmacy Gag Order Provisions</b> <ul style="list-style-type: none"> <li>• Prohibits a PBM or coordinator from prohibiting or penalizing the disclosure by a pharmacist of the following:               <ol style="list-style-type: none"> <li>(1) An insured customer's cost share for a covered prescription drug.</li> <li>(2) The availability of any therapeutically equivalent alternative medications.</li> <li>(3) Alternative payment methods, including paying cash price, that are less expensive than the cost share of the prescription drug.</li> </ol> </li> <li>• Provides that a PBM or coordinator may not require a patient to pay, for a covered prescription drug, more than the lesser of the following:               <ol style="list-style-type: none"> <li>(1) The applicable copayment for the prescription drug being dispensed.</li> <li>(2) The retail price of the drug without prescription coverage.</li> </ol> </li> </ul>
<b>S.B. 208</b>	10/02/2018	
<a href="#">VERMONT</a>		<b>Biologics, Biosimilars, and Interchangeables</b> <ul style="list-style-type: none"> <li>• Requires that, when a pharmacist receives a prescription for a biological product, the pharmacist must select the lowest priced product that is listed as interchangeable in the FDA's Lists of Licensed Biological Products with Reference Product Exclusivity and Biosimilarity or Interchangeability Evaluations (the "Purple Book").</li> <li>• Allows for an exception if the pharmacist is otherwise instructed by the prescriber or the purchaser if the purchaser agrees to pay any additional cost more than the benefits provided by the health benefit plan if allowed under the legal requirements applicable to the plan or otherwise to pay the full cost for the higher priced biological product.</li> <li>• Provides that, when refilling a prescription, pharmacists shall receive the consent of the prescriber to dispense a drug or biological product different from that originally dispensed, and shall inform the purchaser that a generic substitution shall be made unless (1) the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal</li> </ul>
<b>S.B. 92</b>	5/30/2018	



# OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<b>Vermont Cont'd</b>	<p>requirements applicable to the plan or otherwise (2) to pay the full cost for the higher priced drug or biological product.</p> <ul style="list-style-type: none"> <li>• Requires every pharmacy in the state to post a sign in a prominent place stating: “Vermont law requires pharmacists in some cases to select a less expensive generic equivalent drug or interchangeable biological product for the drug or biological product prescribed unless you or your physician direct otherwise. Ask your pharmacist.”</li> <li>• Requires a health insurance or other health benefit plan offered by a health insurer or by a PBM on behalf of a health insurer that provides coverage for prescription drugs to apply the same cost-sharing requirements to interchangeable biological products as apply to generic drugs under the plan.</li> </ul> <p><b>Drug Pricing Transparency</b></p> <ul style="list-style-type: none"> <li>• Requires health insurers with more than 1,000 covered lives in the state for major medical health insurance to report to the Green Mountain Care Board (the "Board"), for all covered prescription drugs, including generic, brand-name, and specialty drugs provided in an outpatient setting or sold in a retail setting the following:             <ol style="list-style-type: none"> <li>(1) The 25 most frequently prescribed drugs and the average wholesale price for each drug.</li> <li>(2) The 25 most costly drugs by total plan spending and the average wholesale price for each drug.</li> <li>(3) The 25 drugs with the highest year-over-year price increases and the average wholesale price for each drug.</li> </ol> </li> <li>• Specifies that a health insurer will not be required to provide to the Board the actual price paid, net of rebates, for any prescription drug.</li> <li>• Requires Board to compile the information into a consumer-friendly report that demonstrates the overall impact of drug costs on health insurance premiums and to post that information on its website on or before January 1 of each year.</li> <li>• Requires the Department of Vermont Health Access (the "Department"), rather than the Board, to annually create a list of 10 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 during the previous calendar year.</li> <li>• Requires that the list include at least one generic and one brand-name drug and indicate each of the drugs that the Department considers to be specialty drugs.</li> <li>• Requires the Department to:             <ol style="list-style-type: none"> <li>(1) Include the percentage of the WAC increase for each drug.</li> <li>(2) Rank the drugs from those with the largest increase in WAC to those with the smallest increase.</li> <li>(3) Indicate whether each drug was included based on its cost increase over the past five years or during the previous calendar year, or both.</li> </ol> </li> </ul>
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## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

<p><b>Vermont Cont'd</b></p>	<p>(4) Provide the Department's total expenditure for each drug during the most recent calendar year.</p> <ul style="list-style-type: none"> <li>• Requires that each health insurer with more than 5,000 covered lives in the state for major medical health insurance must create annually a list of 10 prescription drugs on which its health insurance plans spend significant amounts of their premium dollars and for which the cost to the plans, net of rebates and other price concessions, has increased by 50% or more over the past five years or by 15% or more during the previous calendar year.</li> <li>• Requires that each list include at least one generic and one brand-name drug and indicate each of the drugs that the health insurer considers to be specialty drugs. The health insurer must rank the drugs from those with the greatest increase in net cost to those with the smallest increase and indicate whether each drug was included based on its cost increase over the past five years or during the previous calendar year, or both.</li> <li>• Requires health insurers to provide the percentage by which the net cost to its plans for any prescription drug increased over the applicable period or periods for each drug, as well as the insurer's total expenditure, net of rebates and other price concessions, for each drug during the most recent calendar year.</li> <li>• Requires that, for the drugs identified in these lists, the Office of the Attorney General (the "Office") must identify 15 drugs by the following method:             <ol style="list-style-type: none"> <li>(1) Of the drugs appearing on more than one payer's list, the Office must identify the top 15 drugs on which the greatest amount of money was spent across all payers during the previous calendar year, to the extent information is available.</li> <li>(2) If fewer than 15 drugs appear on more than one payer's list, the Office must rank the remaining drugs based on the amount of money spent by any one payer during the previous calendar year, in descending order, and select as many of the drugs at the top of the list as necessary to reach a total of 15 drugs.</li> </ol> </li> <li>• Requires the manufacturers of drugs identified in this list to provide to the Office justification for the increase in the net cost of the drug, rather than the wholesale acquisition cost, to the Department, to one or more health insurers, or both, including each factor that specifically caused the net cost increase.</li> <li>• Directs the Board to post on its website the report prepared by the Office and the public version of each manufacturer's information submitted.</li> <li>• Permits manufacturers to redact information in the publicly-available version of the information, provided that any redactions are subject to approval by the Office.</li> </ul>
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## OVERVIEW OF DRUG PRICING RELATED STATE LEGISLATION ENACTED IN 2018

S.B. 262	6/1/2018	<ul style="list-style-type: none"> <li>Repeals 33 V.S.A. § 2010- Actual price disclosure and certification, which required manufacturers of prescription drugs dispensed in Vermont under a health program directed or administered by the state to report quarterly the prices already required to be provided to the Medicaid program under federal law and the price each wholesaler pays the manufacturer to purchase the drug.</li> </ul>
<a href="#">VIRGINIA</a>		<p><b>Pharmacy Gag Order Provision</b></p> <ul style="list-style-type: none"> <li>Prohibits a provider contract between a carrier or its PBM and a pharmacy or pharmacist from:               <ol style="list-style-type: none"> <li>(1) authorizing the carrier or its PBM to charge,</li> <li>(2) requiring the pharmacy or pharmacist to collect, or</li> <li>(3) requiring an enrollee to make a cost-sharing payment for a covered prescription drug in an amount that exceeds the lesser of:                   <ol style="list-style-type: none"> <li>(a) the applicable cost-sharing payment for the prescription drug, or</li> <li>(b) the cash price the enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using the enrollee's health plan.</li> </ol> </li> </ol> </li> <li>Requires that provider contracts between a health carrier or its PBM and a pharmacy or its contracting agent contain provisions that allow a pharmacy to:               <ol style="list-style-type: none"> <li>(1) Disclose to an enrollee information relating to the availability of a more affordable therapeutically equivalent prescription drug;</li> <li>(2) Sell a more affordable therapeutically equivalent prescription drug to an enrollee if one is available; and</li> <li>(3) Offer and provide direct and limited delivery services to an enrollee as an ancillary service of the pharmacy.</li> </ol> </li> <li>Prohibits a PBM or a carrier from penalizing a pharmacy for discussing information or for selling a more affordable alternative.</li> </ul>
H.B. 1177/ S.B. 933	7/01/2018	
<a href="#">West Virginia</a>		<p><b>Pharmacy Gag Order Provision</b></p> <ul style="list-style-type: none"> <li>Allows a pharmacist and pharmacy technician to provide healthcare consumers with information related to lower cost alternatives and cost-sharing for prescription drugs.</li> <li>Prohibits PBMs from collecting a cost share charge that exceeds the total submitted charges by a pharmacy or pharmacist.</li> <li>Prohibits PBMs from holding a pharmacy, pharmacy technician or pharmacist responsible for a fee related to a claim if:               <ol style="list-style-type: none"> <li>(1) the total amount of the fee is identified, reported, and specifically explained for each line item; or</li> <li>(2) the total amount of the fee is apparent at the point of sale.</li> </ol> </li> </ul>
S.B. 46	6/8/2018	