SLS 26RS-518 **REENGROSSED**

2026 Regular Session

SENATE BILL NO. 387

BY SENATORS BASS AND TALBOT

HEALTH/ACC INSURANCE. Provides relative to pharmacy benefit managers. (1/1/27)

AN ACT

To amend and reenact R.S. 22:1856.1(B)(2)(a), 1863, and 1865(A) and R.S. 44:4.1(B)(11), to enact R.S. 22:1867.1 and 1868.2, and to repeal R.S. 22:1868.1, relative to pharmacy benefit managers; to provide for definitions; to provide for appeals; to provide for a duty to enrollees, health plans, and providers; to provide for compensation; to provide for rebates, formularies, and cost-sharing; to provide for a private cause of action; to provide for audits; to provide for contract and other requirements; to provide for penalties; to provide for a public records exemption; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1856.1(B)(2)(a), 1863, and 1865(A) are hereby amended and reenacted and R.S. 22:1867.1 and 1868.2 are hereby enacted to read as follows:

§1856.1. Pharmacy record audits; recoupment; appeals

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B. Notwithstanding any other provision of law to the contrary, when an audit of the records of a pharmacy is conducted by an entity, the audit shall be conducted in accordance with the following criteria:

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(2)(a) No entity shall conduct an audit at a particular pharmacy more than one time annually. **The audit shall be limited to claims submitted not more than twelve months prior to date the audit begins.** However, the provisions of this Paragraph shall not apply when an entity must return to a pharmacy to complete an audit already in progress, or there is an identified history of errors, an identified activity which a reasonable ~~man~~ **person** would believe to be inappropriate, or illegal activity that the entity has brought to the attention of the pharmacy owner or corporate headquarters of the pharmacy.

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§1863. Definitions

As used in this Subpart, the following definitions apply:

(1) "Drug Shortage List" means a list of drug products posted on the United States Food and Drug Administration drug shortage website.

(2) "Effective rate pricing" means any payment reduction for pharmacist or pharmacy services by a pharmacy benefit manager under a reconciliation process for direct or indirect remuneration fees, a brand or generic effective rate of reimbursement, or any other reduction or aggregate reduction of payment.

(3) "Enrollee" means any individual entitled to coverage of healthcare services from a health insurance issuer under a health plan.

~~(3)~~**(4)** "Health benefit plan", "health plan", "plan", "benefit", or "health insurance coverage" means services consisting of medical care provided directly through insurance, reimbursement, or other means, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization contract, or health maintenance organization contract offered by a health insurance issuer. However, excepted benefits are not included as a "health benefit plan".

(5) "Healthcare service" means an item or service furnished to any individual for the purpose of preventing, diagnosing, alleviating, curing, or

healing human illness, injury, or physical disability.

~~(4)~~**(6)** "Health insurance issuer" means any entity that offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" shall also include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Code.

~~(5)~~**(7)** "Local pharmacy" means a pharmacy as defined in the North American Industry ~~Classsification~~ **Classification** System (NAICS) Code 456110, which is domiciled in Louisiana and has fewer than ten retail outlets under its corporate umbrella.

~~(6)~~**(8)** "Maximum Allowable Cost List" means a listing of the National Drug Code used by a pharmacy benefit manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist may be based. "Maximum Allowable Cost List" shall include any term that a pharmacy benefit manager or a healthcare insurer may use to establish reimbursement rates for generic and multi-source brand drugs to a pharmacist or pharmacy for pharmacist services.

~~(7)~~**(9)** "NDC" means the National Drug Code, a numerical identifier assigned to all prescription drugs.

(10) "Person" includes a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision, or agency.

~~(8)~~**(11)** "Pharmacist" means a licensed pharmacist as defined in R.S. 22:1852.

~~(9)~~**(12)** "Pharmacist services" means products, goods, or services provided as a part of the practice of pharmacy as defined in R.S. 22:1852.

~~(10)~~**(13)** "Pharmacy" means any appropriately licensed place where prescription drugs are dispensed as defined in R.S. 22:1852.

(14) "Pharmacy benefit management fee" means a fee that covers the cost of providing one or more pharmacy benefit management services and that

does not exceed the value of the service or services actually performed by the pharmacy benefit manager.

(15) "Pharmacy benefit management service" means any of the following:

(a) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions.

(b) Managing any aspect of a prescription drug benefit including but not limited to the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, managing or providing data relating to the prescription drug benefit, or the provision of services related thereto.

(c) Performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing service.

(d) Such other services as the commissioner may define by rule or regulation.

~~(11)~~**(16)** "Pharmacy benefit manager" **or "PBM"** has the same meaning as the term defined in R.S. 22:1641 and includes any person, either directly or indirectly, that provides one or more pharmacy benefit management services on behalf of an insurer or health plan, and any agent, contractor, intermediary, affiliate, subsidiary, or related entity of such person who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

~~(12)~~**(17)** "Pharmacy benefits plan" or "pharmacy benefits program" means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in Louisiana.

(18) "Provider" means an individual or entity that furnishes, provides, dispenses, or administers one or more units of a prescription drug.

~~(13)~~**(19)** "Rebates" means **either of the following:** ~~all rebates, discounts, and~~

~~other price concessions, based on utilization of a prescription drug and paid by the manufacturer or other party other than an enrollee, directly or indirectly, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy. Rebates shall include a reasonable estimate, as determined by the commissioner, of any volume-based discount or other discounts.~~

(a) Negotiated price concessions including but not limited to base price concessions, whether described as a rebate or otherwise, and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue directly or indirectly to the health insurance issuer or health plan, or other party on behalf of the health insurance issuer or health plan, including a pharmacy benefit manager, during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug.

(b) Reasonable estimates of any negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the health insurance issuer or health plan and serve to reduce the health insurance issuer or health plan's liabilities for a prescription drug.

(20) "Related entity" means either of the following:

(a) Any entity, whether foreign or domestic, that is a member of any controlled group of corporations, as defined in Section 1563(a) of the Internal Revenue Code, except that "fifty percent" shall be substituted for "eighty percent" wherever the latter percentage appears in the code, of which a pharmacy benefit manager is a member.

(b) Any of the following persons or entities that are treated as a related entity to the extent provided in rules adopted by the commissioner:

(i) A person other than a corporation that is treated under the rules as a related entity of a pharmacy benefit manager.

(ii) A person or entity that is treated under the rules as affiliated with a

pharmacy benefit manager in cases where the pharmacy benefit manager is a person other than a corporation.

~~(14)~~**(21)** "Specialty drug" means a drug that meets all of the following criteria:

(a) The drug is used to treat and is prescribed for a person with a complex, chronic, or rare medical condition that is progressive, can be debilitating or fatal if left untreated or undertreated, or for which there is no known cure.

(b) The drug is not routinely stocked at a majority of pharmacies within this state.

(c) The drug has special handling, storage, inventory, or distribution requirements.

(d) Patients receiving the drug require complex education and treatment maintenance, such as complex dosing, intensive monitoring, or clinical oversight.

~~(15)~~**(22)** "Spread pricing" means any amount charged or claimed by a pharmacy benefit manager for a prescription drug that exceeds the amount paid by the pharmacy benefit manager to the pharmacist or pharmacy for the dispensing of the prescription drug, minus a pharmacy benefit management fee.

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§1865. Appeals; maximum allowable costs

A.**(1)** The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs for a specific NDC or NDCs as not meeting the requirements of this Subpart or being below the cost at which the pharmacy may obtain the NDC. Within fifteen business days after the applicable fill date, a pharmacy may file an appeal by following the appeal process as provided for in this Subpart. The pharmacy benefit manager shall respond to a challenge within fifteen business days after receipt of the challenge.

(2) The administrative appeal procedure shall allow a pharmacy or pharmacist the option to submit a consolidated appeal representing multiple

substantially similar claims.

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§1867.1 PBM duty; compensation; audits; contract and other requirements

A. PBM Duty

(1) A pharmacy benefit manager shall owe the pharmacy benefit manager duty to any enrollee, health plan, or provider that receives pharmacy benefit management services from the pharmacy benefit manager or that furnishes, covers, receives, or is administered a unit of a prescription drug for which the pharmacy benefit manager has provided pharmacy benefit management services.

(a) Duty to enrollees. The pharmacy benefit manager fiduciary duty owed to enrollees shall include duties of care and good faith and fair dealing. The commissioner shall adopt rules and regulations defining the scope of the duties owed to enrollees, including by obligating pharmacy benefit managers to provide all pharmacy benefit management services related to formulary design, utilization management, and grievances and appeals in a transparent manner to enrollees that is consistent with the best interest of enrollees and to disclose all conflicts of interest to enrollees.

(b) Duty to health plans. The pharmacy benefit manager duty owed to health plans shall include duties of care and good faith and fair dealing. The commissioner shall adopt rules and regulations defining the scope of the duties owed to health plans, including by obligating pharmacy benefit managers to provide transparency to health plans about amounts charged or claimed by the pharmacy benefit manager in a manner that is adequate to identify all instances of spread pricing and to disclose all conflicts of interest to health plans.

(c) Duty to providers. The pharmacy benefit manager duty owed to providers shall include duties of care and good faith and fair dealing. The commissioner shall adopt rules and regulations defining the scope of the duties owed to providers, including by obligating pharmacy benefit managers to

provide transparency to providers about amounts charged or claimed by the pharmacy benefit manager in a manner that is adequate to identify all instances of spread pricing and to disclose all conflicts of interest to providers.

(2) Where there is a conflict between the pharmacy benefit manager duties owed in accordance with this Section, the pharmacy benefit manager fiduciary duty owed to an enrollee shall be primary over the duty owed to any other party.

(3) A pharmacy benefit manager shall not:

(a) Obtain a rebate, or any other incentive or inducement including but not limited to discounts, on a name brand drug in exchange for not placing other name brand drugs, biosimilars, generic drugs, or any other drug in the same class of drugs on the PBM formulary.

(b) Design a prescription drug formulary to favor a certain branded pharmaceutical or biologic over a therapeutically equivalent generic or biosimilar, unless the branded pharmaceutical or biologic has a lower net acquisition cost and that lower cost is reflected in a lower out-of-pocket expense for consumers.

(c) Charge an out-of-pocket cost share that is based on a prescription drug price greater than the pharmacy benefit manager's net acquisition cost of the prescription drug.

(d) Use its formulary to effectively ban the use of certain pharmacies by an insured.

(4) A person who is aggrieved by a violation of this Section may bring a civil action before a state court of competent jurisdiction against a pharmacy benefit manager.

B. PBM Compensation

(1) A pharmacy benefit manager or group purchasing organization may negotiate but shall not retain rebates and fees. All manufacturer rebates, whether accrued to a pharmacy benefit manager, a pharmacy benefit manager's

affiliated group purchasing organization, or any other pharmacy benefit manager owned or affiliated entity shall be passed through to the pharmacy benefit manager's healthcare plan sponsor client as described in this Section.

(2) A pharmacy benefit manager may earn income only from the following sources:

(a) The assessment of a flat dollar service fee charged on either a per-person per-month or a per-prescription basis which shall cover all of the pharmacy benefit manager's administrative, clinical, print, electronic, and related costs for the provision of prescription benefit management services to a client health benefit plan. The flat dollar service fee may vary among a pharmacy benefit manager's clients based on the number of health benefit plan participants and clinical and administrative services provided, and shall be set forth in a written agreement between the parties.

(b) A flat dollar performance bonus payment, which may be paid by a client health benefit plan to a pharmacy benefit manager for meeting specified benchmarks in reducing the client health benefit plan's aggregated overall drug spending over a specific period of time. A flat dollar performance bonus payment shall be set forth in a written agreement between the parties.

(3) Pharmacy benefit management fees charged by or paid to a pharmacy benefit manager from a health insurance issuer or health plan shall not be directly or indirectly based or contingent upon any of the following:

(a) The acquisition cost or any other price metric of a drug.

(b) The amount of savings, rebates, or other fees charged, realized, or collected by or generated based on the activity of the pharmacy benefit manager.

(c) The amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected by the pharmacy benefit manager from patients or other persons on behalf of a patient.

(4)(a) A pharmacy benefit manager or group purchasing organization

shall not earn any income based directly on prescription drug list prices, acquisition cost, average wholesale cost, or any other metric for prescription drug pricing or fulfillment at any stage in the drug supply chain, including but not limited to prescription drug markups, up-charging, spread pricing of any kind, manufacturer-derived revenues of any sort, which shall include but not be limited to price protection, group purchasing organization retained rebates or fees of any kind, rebate aggregator administrative or any other fees charged or collected, coupon compensation and patient assistance compensation fees, retained discounts and rebates, and other manufacturer payments, and any other arrangements on price of prescription drugs.

(b) Any prohibited pharmacy benefit manager income that a pharmacy manager may receive during the course of a pharmacy benefit manager's operations in service of its Louisiana client health plans shall be considered prohibited income that the pharmacy benefit manager shall pass through in its entirety to the pharmacy benefit manager's Louisiana health benefit plan clients on a quarterly basis.

(5) Annually by December thirty-first, each pharmacy benefit manager operating in the state shall certify to the commissioner that it has fully and completely complied with the requirements of this Subsection throughout the prior calendar year. The certification shall be signed by the chief executive officer or chief financial officer of the pharmacy benefit manager.

C. PBM Audits

(1) The commissioner and any health insurance issuer or health plan contracted with a pharmacy benefit manager holding a license issued by the commissioner may audit the pharmacy benefit manager once per calendar year. This audit right is in addition to, and shall not be construed to limit, any other audit rights authorized by law or contract. The commissioner may also examine the books or records of any entity in a pharmacy benefit manager's corporate vertical structure, including but not limited to the insurer, group purchasing

organization, manufacturer, wholesale distributor, special or mail order pharmacy, retail or long-term care pharmacy, and provider. As part of any audit, the commissioner, health insurance issuer, or health plan may request information including but not limited to any of the following:

(a) All reimbursement paid to retail pharmacies, on a claim level, for all customers of the pharmacy benefit manager in the state, including drug-specific reimbursement, dispensing fees, all rebates, other fees, ancillary charges, clawbacks, or adjustments to reimbursement.

(b) Any difference in reimbursement paid to affiliated pharmacies and unaffiliated pharmacies, including differences in reimbursed ingredient costs and dispensing fees.

(c) Historical claims data including ingredient cost, quantity, dispensing fee, sales tax, usual and customary price, channel such as mail or retail, health insurance issuer or health plan paid amount, days' supply, the amount paid by the covered individual, formulary tier, acquisition cost, and any administrative fee associated with the claim, as applicable.

(d) Aggregate rebate amounts received directly or indirectly from manufacturers, including from any other entity affiliated with or related to the pharmacy benefit manager that negotiates or contracts with manufacturers, such as group purchasing organizations and rebate aggregators, by calendar quarter.

(2) The pharmacy benefit manager shall provide information pursuant to Paragraph (1) of this Subsection no later than thirty days after its receipt of any request from the commissioner, health insurance issuer, or health plan.

(3) The commissioner may dictate the form in which the pharmacy benefit manager will provide information in response to an audit pursuant to Paragraph (1) of this Subsection.

(4) The pharmacy benefit manager shall certify that all information submitted to the commissioner or any health insurance issuer or health plan in

accordance with this Subsection is accurate and complete in all material respects. The certification shall be signed by the chief executive officer or chief financial officer of the pharmacy benefit manager.

(5) The commissioner and any health insurance issuer or health plan contracted with a pharmacy benefit manager holding a license issued by the commissioner shall not directly or indirectly publish or otherwise disclose any confidential, proprietary information, including but not limited to any information that would reveal the identity of a specific health plan or manufacturer, the price charged for a specific drug or class of drugs, the amount of any rebates provided for a specific drug or class of drugs, or that would otherwise have the potential to compromise the financial, competitive, or proprietary nature of the information. Any such information shall be protected as confidential and proprietary information, and is not a public record and is exempt from disclosure pursuant to the Public Records Law, R.S. 44:4.1 et seq. The commissioner and any health insurance issuer or health plan contracted with a pharmacy benefit manager holding a license issued by the commissioner shall impose the confidentiality protections and requirements of this Paragraph on any agent or downstream third party that may receive or have access to this information.

D. PBM Contract and Other Requirements

(1) A pharmacy benefit manager contract with a health insurance issuer or health plan entered into, amended, extended, or renewed on or after January 1, 2027, shall do both of the following:

(a) Specify all forms of revenue, including pharmacy benefit management fees, to be paid by the health insurance issuer or health plan to the pharmacy benefit manager.

(b) Acknowledge that spread pricing is not permitted in accordance with R.S. 22:1867.

E.(1) In addition to any other civil or criminal penalty authorized by law,

a violation of this Section shall be punishable by the commissioner through a civil monetary penalty of twenty-five thousand dollars for each and every act or violation, with no aggregate penalty maximum.

(2) If a violation for which the commissioner has imposed a fine in accordance with this Subsection is not corrected within thirty days after notice of the violation is received by the pharmacy benefit manager, the commissioner shall suspend or revoke the pharmacy benefit manager's license in accordance with R.S. 49:977.3.

F. In implementing the requirements of this Section, the state shall regulate a pharmacy benefit manager or health insurance issuer only to the extent permissible under applicable law.

G. The provisions of this Section shall not apply to health benefit plans that are established under and regulated by the Employee Retirement Income Security Act (ERISA) of 1974.

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§1868.2. Pharmacy benefit manager formularies

A. As used in this Section, the following terms have the following meanings:

(1) "Affiliated manufacturer" means a drug or biological product manufacturer that, either directly or indirectly through one or more intermediaries, meets one or more of the following criteria:

(a) Has an investment or ownership interest greater than five percent in a pharmacy benefit manager.

(b) Shares common ownership with a pharmacy benefit manager.

(c) Has an investor or a holder of an ownership interest in a pharmacy benefit manager.

(2) "Biological product" has the same meaning as in the Public Health Service Act, 42 U.S.C. 262.

(3) "Biosimilar" has the same meaning as in the Public Health Service

Act, 42 U.S.C. 262.

(4) "Interchangeable" has the same meaning as in the Public Health Service Act, 42 U.S.C. 262.

B.(1) A pharmacy benefit manager revising the formulary of covered prescription drugs at the beginning of a plan year shall provide a sixty day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the insured for a period of sixty days.

(2) The sixty day continuity-of-care period commences upon notification to the insured by the insurer.

(3) This Subsection does not apply if any of the following have occurred regarding the covered prescription drug:

(a) The prescription drug has been made available over the counter by the United States Food and Drug Administration and has entered the commercial market as such.

(b) The prescription drug has been removed or withdrawn from the commercial market by the manufacturer.

(c) The prescription drug is subject to an involuntary recall by state or federal authorities and is no longer available on the commercial market.

C. A pharmacy benefit manager shall not require an insured to receive a drug or biological product that is manufactured by an affiliated manufacturer when there is an available generically equivalent drug, or an available biological product that is biosimilar to and interchangeable for the prescribed biological product.

D. A pharmacy benefit manager shall not require an insured to receive a more expensive name brand drug when less expensive name brand drugs, biosimilars, generic drugs, or any other drug in the same class of drugs are available.

E. Other than at the time of coverage renewal, while an insured is taking

a prescription drug a pharmacy benefit manager shall not do any of the following:

(1) Remove the prescription drug from its list of covered drugs during the policy year unless any of the following have occurred:

(a) The United States Food and Drug Administration has issued a statement about the drug which calls into question the clinical safety of the drug.

(b) The manufacturer of the drug has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 356c.

(c) The drug has been approved and made available over the counter by the United States Food and Drug Administration and entered the commercial market as such.

(2) Reclassify the drug to a more restrictive drug tier or increase the amount that an insured must pay for a copayment, coinsurance, or deductible for prescription drug benefits, or reclassify the drug to a higher cost-sharing tier during the policy year.

F. This Section does not prohibit the addition of prescription drugs to the formulary during the policy year.

G. The provisions of this Section shall not apply to health benefit plans that are established under and regulated by the Employee Retirement Income Security Act (ERISA) of 1974.

Section 2. R.S. 44:4.1(B)(11) is hereby amended and reenacted to read as follows:

§4.1. Exceptions

* * *

B. The legislature further recognizes that there exist exceptions, exemptions, and limitations to the laws pertaining to public records throughout the revised statutes and codes of this state. Therefore, the following exceptions, exemptions, and

limitations are hereby continued in effect by incorporation into this Chapter by citation:

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(11) R.S. 22:2, 14, 31, 42.1, 88, 244, 263, 265, 461, 550.7, 550.22, 550.29, 550.30, 571, 572, 572.1, 572.2, 574, 601.3, 618, 639, 691.4, 691.5, 691.6, 691.7, 691.8, 691.9, 691.9.1, 691.10, 691.38, 691.56, 732, 752, 753, 771, 834, 972(D), 976, 1008, 1019.2, 1203, 1460, 1464, 1466, 1483.1, 1488, 1546, 1559, 1566(D), 1644, 1656, ~~1657.1,~~ 1660.7, 1723, 1796, 1801, 1808.3, **1867.1,** 1869, 1927, 1929, 1983, 1984, 2036, 2045, 2056, 2085, 2091, 2293, 2303, 2508

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Section 3. R.S. 22:1868.1 is hereby repealed.

Section 4. This Act shall take effect and become operative if and when the Act which originated as Senate Bill No. 401 of this 2026 Regular Session of the Legislature is enacted and becomes effective. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the date that Senate Bill No. 401 becomes effective.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Senate Legislative Services. The keyword, summary, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

DIGEST

SB 387 Reengrossed 2026 Regular Session Bass

Present law provides for definitions.

Proposed law retains present law and adds definitions for "enrollee", "healthcare service", "person", "pharmacy benefit management fee", "pharmacy benefit management service", "provider", and "related entity". Proposed law also amends the definition for "rebates".

Proposed law provides for a PBM's fiduciary duty of care and good faith and fair dealing to enrollees.

Proposed law provides for PBM compensation through pharmacy benefit manager flat dollar fees and flat dollar performance bonus and prohibits a PBM from retaining rebates and fees.

Proposed law allows the commissioner of insurance and any health insurance issuer or health plan contracted with a PBM to audit the PBM once per calendar year. Proposed law further provides for information that may be requested as part of the audit and provides for the protection of confidential and proprietary information through a public records exemption, including the books and records from any entity in the PBM's vertical corporate structure.

Proposed law requires PBM contracts to specify all forms of revenue to be paid by the health insurance issuer or health plan to the pharmacy benefit manager and to acknowledge that spread pricing is not permitted.

Proposed law provides that, in addition to any other civil or criminal penalty authorized by law, a violation of proposed law is punishable by the commissioner through a civil monetary penalty of $25,000 for each and every act or violation, with no aggregate penalty maximum.

Proposed law further provides that if a violation is not corrected within 30 days after notice of the violation is received by the PBM, the commissioner must suspend or revoke the pharmacy benefit manager's license.

Proposed law is to be implemented to regulate a pharmacy benefit manager or health insurance issuer only to the extent permissible under applicable law.

Present law allows a PBM to audit pharmacy claims. Proposed law limits to the audit to claims filed within the 12 months prior to the start of the audit.

Proposed law allows a pharmacy to submit a consolidated appeal to a PBM of substantially similar claims.

Proposed law prohibits a PBM from using its formulary to obtain inducements, favor certain drugs over substantially similar drugs with a lower cost, charge more that the PBM's net acquisition cost of a drug, or ban the use of certain pharmacies by an insured.

Proposed law provides for a 60-day continuity of care for an enrollee when a formulary is changed and removes a drug prescribed to an enrollee.

Proposed law provides that proposed law is not applicable to ERISA plans.

Effective January 1, 2027.

(Amends R.S. 22:1856.1(B)(2)(a), 1863, 1865(A), and R.S. 44:4.1(B)(11); adds R.S. 22:1867.1 and 1868.2; repeals R.S.22:1868.1)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Limits a PBM pharmacy audit to claims submitted not more than 12 months prior to the audit.

2. Allows for consolidated appeals.

3. Provides that a PBM owes a fiduciary duty to enrollees, pharmacies, and plans.

4. Prohibits a PBM from obtaining an inducement on a name brand drug in exchange for not placing other drugs of the same class on the PBM formulary.

5. Prohibits a PBM from favoring certain drugs over others on a formulary.

6. Prohibits a PBM from charging a cost greater than net acquisition cost.

7. Prohibits a PBM from using its formulary to ban the use of certain pharmacies.

8. Prohibits a PBM or GPO from retaining rebates and fees, requiring them to be passed through to the plan.

9. Allows a PBM to earn income only from a flat dollar fee.

10. Allows a PBM to receive a flat dollar performance bonus.

11. Allows the commissioner of insurance to examine the books or records of any entity in a PBM's corporate structure.

12. Requires continuity of care for enrollees when a PBM formulary is changed.

13. Provides that proposed law becomes effective if SB 401 is enacted.

14. Makes technical changes.

Senate Floor Amendments to engrossed bill

1. Provides that PBMs do not owe a fiduciary duty to plans or pharmacies.

2. Provides that the provisions of proposed law are not applicable to ERISA plans.

3. Makes technical changes.