State PBM Reform Inventory

Updated October 2026

Texas

Issue	Summary	Citation
Licensing/Registration	PBMs are classified as third-party administrators and must obtain an annual license.	Tex. Ins. Code § 4151.001

Reporting Requirements	Not later than March 1 of each year, each PBM shall file a report with the commissioner. The report must state for the immediately preceding calendar year:
	• The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and
	• The aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:
	  ○ Passed to health benefit plan issuers or enrollees at the point-of-sale; or
	  ○ Retained by the PBM
		Tex. Ins. Code § 1369.502

PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A health benefit plan issuer or a PBM may not steer or direct a patient to use an affiliated provider through any oral or written communication. This does not prohibit a health benefit plan issuer or PBM from including the issuer's or manager's affiliated provider in a patient or prospective patient communication, if the communication: • Is regarding information about the cost or service provided by pharmacies or durable medical equipment providers in the network of a health benefit plan in which the patient or prospective patient is enrolled; and • Includes accurate comparable information regarding pharmacies or durable medical equipment providers in the network that are not the issuer's or manager's affiliated providers. A health benefit plan issuer or PBM may not:	Tex. Ins. Code § 1369.554; Tex. Ins. Code § 1369.555; Tex. Ins. Code § 1369.604; Tex. Ins. Code § 1369.351; Tex. Ins. Code § 1369.352; Tex. Ins. Code § 1369.353;

	• Require a patient to use an affiliated provider to receive the maximum benefit for the service under the patient's health benefit plan; • Offer or implement a health benefit plan that requires or induces a patient to use an affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider; • Solicit a patient or prescriber to transfer a patient's prescription to an affiliated provider; or • Require a pharmacy or durable medical equipment provider that is not the issuer's or manager's affiliated provider to transfer a patient's prescription to an affiliated provider without the prior written consent of the patient. A PBM may not pay an affiliated pharmacist or pharmacy a reimbursement amount that is more than the amount the PBM pays a nonaffiliated pharmacist or pharmacy for the same pharmacist service. **MAC Pricing:** A health benefit plan issuer or PBM may not include a drug on a MAC list unless: • The drug has an "A" or "B" rating in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or is rated "NR" or "NA" or has a similar rating by a nationally recognized reference; and • The drug is generally available for purchase by pharmacists and pharmacies in this state from a national or regional wholesaler; and not obsolete. A health benefit plan issuer or PBM must disclose to a pharmacist or pharmacy the sources of the pricing data used in formulating MAC prices, both at the date the contract begins and at the request of the pharmacy or pharmacist. A health benefit plan issuer or PBM shall establish a process that will in a timely manner eliminate drugs from MAC lists or modify MAC prices to remain consistent with changes in pricing data used in formulating MAC prices and product availability. The entity shall review and update MAC price	Tex. Ins. Code § 1369.354; Tex. Ins. Code § 1369.355; Tex. Ins. Code § 1369.356; Tex. Ins. Code § 1369.357; Tex. Ins. Code § 1369.358

	information for each drug at least once every 7 days to reflect any modification of MAC pricing. A health benefit plan issuer or PBM must provide in the contract with each pharmacist or pharmacy a procedure for the pharmacist or pharmacy to appeal a MAC price of a drug on or before the 10th day after the date a pharmacy benefit claim for the drug is made. The health benefit plan issuer or PBM shall respond to an appeal in a documented communication not later than the 10th day after the date the appeal is received. • If the appeal is successful, the health benefit plan issuer or PBM shall adjust the MAC price that is the subject of the appeal effective on the day after the date the appeal is decided, apply the adjusted MAC price to all similarly situated pharmacists and pharmacies as determined by the health benefit plan issuer or PBM, and allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefit claim giving rise to the appeal. • If the appeal is not successful, the health benefit plan issuer or PBM shall disclose to the pharmacist or pharmacy each reason why the appeal is denied and the NDC number from the national or regional wholesalers from which the drug is generally available for purchase by pharmacists and pharmacies in this state at the MAC price that is the subject of the appeal.	
Patient Cost-Sharing	**Copay Cap:** A health benefit plan may not impose a cost-sharing provision for insulin that is included in the health benefit plan's formulary if the total amount the enrollee is required to pay exceeds $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription. A health benefit plan must include at least one insulin from each therapeutic class in the plan's formulary. **Copay Adjustment Programs:** A health benefit plan issuer that covers prescription drugs or a PBM shall apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket	Tex. Ins. Code § 1358.103; Tex. Ins. Code § 1369.0542

	expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan. This requirement only applies to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which: • A generic equivalent or interchangeable biological product does not exist; or • A generic equivalent or interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using a prior authorization process, a step therapy protocol, or the issuer's exceptions and appeals process.	