

Bi-monthly Publication

Senators Warren, Hawley Introduce Bipartisan Bill That Would Force Insurers, Pharmacies To Sell Off PBMs

Democratic and Republican lawmakers are calling on insurers and pharmacy benefit managers (PBMs) to divest any pharmacies they own in bills introduced to Congress Dec. 11.

While PBM reform has been a widely supported but largely fruitless endeavor so far, mandating insurers sell their pharmacies is one of the most sweeping changes suggested to date.

The mirrored bills were introduced by Senators Elizabeth Warren, D-Massachusetts, and Josh Hawley, R-Missouri and House representatives Jake Auchincloss, D-Massachusetts, and Diana Harshbarger, R-Tennessee.

Auchincloss said the Patients Before Monopolies (PBM) Act implements a critical “firewall” between drug manufacturers and health plans, brokers and sponsors in a LinkedIn post.

Under the bill, insurers would need to sell its pharmacy businesses within three years. If an insurer is found in violation with the act, the Federal Trade Commission, Department of Health and Human Services, the Department of Justice and state attorneys can instruct the health plans to return all revenue earned following the violation. The FTC would then return the revenue to “harmed communities.”

“PBMs have manipulated the market to enrich themselves — hiking up drug costs, cheating employers, and driving small pharmacies out of business,” said Warren in a statement. “My new bipartisan bill will untangle these conflicts of interest by reining in these middlemen.”

The PBM Act is endorsed by the American Economic Liberties Project, National Community Pharmacists Association and alternative PBM AffirmedRx, among other backers.

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Employers Face Higher Health-Care Costs In 2025, And May Adopt New Approaches

Large employers are looking at higher healthcare costs in the coming year, and they will face growing pressure to consider new strategies to control costs.

The Business Group on Health, a trade group which represents large employers on health policy issues, said those higher costs top their trends to watch in the coming year. The organization released a report outlining its 2025 projections earlier this week.

Businesses are facing healthcare cost increases that are expected to be the highest in a decade, and that’s going to drive companies to take a closer look at how much they’re spending and what they’re getting, the report suggests.

The report suggests the higher costs are partly driven by conditions such as cancer, heart disease, autoimmune diseases and mental health.

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With or Without ACA Repeal, ACA and Medicaid Cuts Are Looming

Unlike in many previous national elections, the 2024 presidential election was not one in which health reform was front and center. The Affordable Care Act (ACA) received some attention—most notably when President-elect Donald Trump said he had “concepts of a plan” to replace the ACA, but it never became a focal point of the campaign. Medicaid was hardly mentioned.

Yet, with Trump returning to the White House and Republicans in charge of Congress, big changes could be coming to the ACA and Medicaid, with potential cuts in federal spending that shift financial responsibility and decision-making to states, and consequently, the number of people who are uninsured could increase substantially.

With many tax cuts from the 2017 Tax Cuts and Jobs Act expiring at the end of 2025, a high-profile Congressional debate over extending those tax reductions and enacting new ones is likely. There will be pressure from some in Congress for spending cuts to help pay for those tax cuts. Trump has said that Social Security and Medicare cuts are off the table, and defense reductions are unlikely as well. That means almost half of federal spending would be protected from cuts, leaving Medicaid, which is the next largest source of federal spending, and the ACA as prime targets for spending cuts. The math is inescapable.

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Federal Court Blocks ACA Coverage For Dreamers

A federal court in North Dakota has blocked Affordable Care Act (ACA) coverage for immigrants that came into the U.S. illegally as children, also known as “Dreamers.”

U.S. District Judge Daniel M. Traynor on Monday granted Kansas, alongside 18 other states, a stay regarding a final rule from the Biden administration allowing some Dreamers access to the ACA marketplace, according to court documents. He also granted Kansas and the other states a preliminary injunction barring the federal government “enforcing the Final Rule against” them.

In May, the Biden administration announced the final rule, from the Centers for Medicare and Medicaid Services (CMS) that would let active recipients of Deferred Action for Childhood Arrivals (DACA) enroll in a qualified or basic health plan under the ACA, as well as forms of financial assistance.

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Reforming ERISA to Help States Control Health Care Costs

Although U.S. health policy has maintained a significant role for state authority,¹ state health reform remains subject to one of the broadest federal preemptions in any area of law: the Employee Retirement Income Security Act of 1974 (ERISA).² ERISA preempts state laws that regulate employer-sponsored health benefits, even when those state laws do not directly conflict with federal requirements. Because nearly 155 million people get coverage through employer-sponsored benefits,³ ERISA preemption impedes state health reforms, from incremental measures such as claims data collection all the way to comprehensive proposals for state single-payer systems.⁴

Critiques of ERISA's preemption provision focus on its unpredictable breadth and its unintended consequences for regulation of health benefits. ERISA supplies relatively few federal rules for health benefits, making the statute's preemption of state laws largely deregulatory. Critics say this creates a preemption "vacuum" when ERISA supplies no federal rule on a topic but preempts states from enforcing their own rules. For example, ERISA has no requirement that employers contribute to their employees' health care coverage. When states have passed laws requiring employers to contribute to employee health care in various ways, employers have sued to prevent enforcement of the law, losing in some courts but winning in others. [Read More Here...](#)

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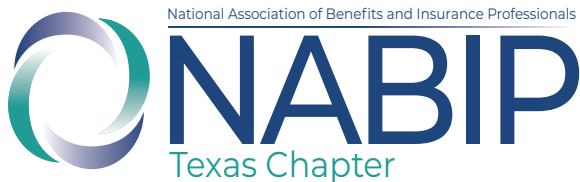


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7 AM - 1 PM

Texas State Capitol Building

1100 Congress Avenue, Austin, TX



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Hosted by NABIP-TX Austin Chapter
Member: \$35
Non-Member: \$50

THURSDAY, JANUARY 23

Texas State Capitol
1100 Congress Avenue, Austin, TX

7 - 8:30 am Registration and Breakfast
7:30 - 8:15 am Agency Roundtable Discussion:
By Invitation Only
8:30 am - 1 pm Speakers, Lunch and Networking Time
1 - 5 pm Lobbying with Legislators at the Capitol

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Members Leaving Medicare Advantage Have Higher Expenses, KFF Finds: 5 Things To Note

Medicare spends more on beneficiaries who switch from Medicare Advantage to traditional Medicare compared to those who remained enrolled in traditional Medicare, a report from KFF found.

The report, published Dec. 6, compared spending for beneficiaries who switched from Medicare Advantage in 2021 to traditional Medicare in 2022 with spending for those continuously enrolled in traditional Medicare.

The report, “raises a lot of questions” as to why enrollees leave Medicare Advantage plans, Jeannie Fuglesten Biniek, associate director of the program on Medicare at KFF and an author of the study, told the Wall Street Journal.

“Were they not getting the medical care they needed in Medicare Advantage?” Ms. Biniek said.

An investigation published in the Wall Street Journal in November found beneficiaries were more likely to drop out of Medicare Advantage plans when they faced higher-acuity conditions, especially in the last year of their life.

Here are five findings to note:

1. Medicare spent an average of \$2,585 more for beneficiaries who disenrolled from Medicare Advantage than those continuously enrolled in traditional Medicare.
2. Differences in spending were higher among enrollees with certain chronic conditions. The federal government spent 34% more on average for enrollees with diabetes who disenrolled from MA compared to individuals with diabetes continuously enrolled in traditional Medicare.
3. Spending differences were more pronounced among older beneficiaries. Medicare spent 46% more on beneficiaries aged 85 and older who disenrolled from Medicare Advantage than on those continuously enrolled in the same age group.

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M E R R Y
CHRISTMAS



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