By: Armbrister S.B. No. 1536

A BILL TO BE ENTITLED

AN ACT

relating to prescription drug benefits under certain health benefit plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter E, Chapter 21, Insurance Code, is amended to read as follows:

Article 21.52B-1. DELIVERY OF PRESCRIPTION DRUGS BY MAIL ORDER; ALTERNATIVE REQUIRED

SECTION 1. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this article, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 of this code;

(3) a fraternal benefit society operating under Chapter 885 of this code;

(4) a stipulated premium insurance company operating under Chapter 884 of this code;

(5) an exchange operating under Chapter 942 of this code;

(6) a health maintenance organization operating under Chapter 843 of this code;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 of this code;

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 of this code;

(9) a third-party administrator operating under Chapter 4151 of the Texas Insurance Code;

(10) a pharmacy benefit manager operating under Chapter 4151 of the Texas Insurance Code;

(11) the Teacher Retirement System of Texas operating under Title 34 of the Texas Administrative Code;

(12) the Employees Retirement System of Texas operating under Title 34 of the Texas Administrative Code; or

(13) any state agency.

(b) "Health benefit plan" does not include:

(1) a plan that provides coverage only:

(A) for benefits for a specified disease or for another limited benefit other that for cancer;

(B) for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) for dental or vision care; or

(G) for indemnity for hospital confinement;

(2) a small employer health benefit plan offered in accordance with Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g) (1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a worker's compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (s) of this section.

Sec. 2. DELIVERY BY MAIL ORDER. For purposes of this article, a prescription drug is obtained by mail order if it is delivered to an enrollee by the United States Postal Service or a commercial delivery service and not provided to the enrollee in an over-the-counter transaction in a community pharmacy.

Sec. 3. REQUIREMENTS. A health benefit plan must:

(1) not require any person to obtain prescription drugs or pharmacy services exclusively from a mail order pharmacy as a condition of obtaining benefits or reimbursement for the drugs;

(2) not discriminate between different providers of pharmacy services by requiring the payment of different copayments, coinsurance levels, deductible, or prescription quantity limits or

days' supply by the covered pharmacy patient depending on the identity or nature of the provider of pharmacy services, whether a mail service pharmacy or a retail pharmacy;

(3) not impose a monetary advantage or penalty that would affect a beneficiary's choice among the pharmacy providers who have agreed to participate according to the terms and conditions offered;

(4) not prohibit a qualified pharmacy provider from becoming a provider under the policy if the pharmacy meets and accepts all the terms and conditions; and

(5) offer all providers of pharmacy services the same terms and conditions including, but not limited to: reimbursement based on identical national drug code numbers, identical average wholesale price or other benchmark, and identical maximum allowable costs.

Sec. 4. VIOLATION. Any medical, sickness, or health care coverage policy or plan that provides for payment of all or a portion of prescription costs or reimbursement of prescription costs, including any form of self-insurance, in this state that does not conform to this section shall not be approved. It is a violation of this section for any insurer, entity, or person, or any person or entity acting on their behalf, to offer or provide any medical or health benefit coverage to residents of this state that does not conform to this section. A violation of this section creates a civil cause of action for injunctive relieve in favor of any person or pharmacy aggrieved by the violation.

Sec. 5. EFFECTIVE DATE. This Act shall take effect

September 1, 2005.