By: Gattis, Hopson, Taylor, Gonzalez Toureilles, Brown of Kaufman, et al. H.B. No. 1613

A BILL TO BE ENTITLED

AN ACT

relating to the delivery of prescription drugs for certain state health plans by mail order and to the payment of certain pharmacy or pharmacist claims; providing an administrative penalty.

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

SECTION 1. Subtitle H, Title 8, Insurance Code, is amended by adding Chapter 1560 to read as follows:

CHAPTER 1560. DELIVERY OF PRESCRIPTION DRUGS BY MAIL

Sec. 1560.001. DEFINITIONS. In this chapter:

(1) "Community retail pharmacy" means a pharmacy that is licensed as a Class A pharmacy under Chapter 560, Occupations Code.

(2) "Mail order pharmacy" means a pharmacy that is licensed under Chapter 560, Occupations Code, and that primarily delivers prescription drugs to an enrollee through the United States Postal Service or a commercial delivery service.

(3) "Prescription drug formulary" means a list of prescription drugs preferred for use and eligible for coverage under a health benefit plan.

Sec. 1560.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit 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 or administered by:

(1) the Teacher Retirement System of Texas under Chapter 1575 or 1579; or

(2) the Employees Retirement System of Texas under Chapter 1551.

Sec. 1560.003. ACCESS TO PHARMACIES. (a) Notwithstanding any other law, an issuer of a health benefit plan that provides pharmacy benefits to enrollees may not:

(1) require an enrollee, as a condition of obtaining benefits or reimbursement for prescription drugs or pharmacy services, to obtain the drugs or services exclusively from a mail order pharmacy;

(2) discriminate between different pharmacies based on whether the pharmacy is a mail order pharmacy or a community retail pharmacy by:

(A) limiting the quantity of a prescription drug an enrollee may obtain from the pharmacy, including limiting the number of days of supply or number of units of a prescription drug or the number of prescriptions or refills of a prescription drug the enrollee may obtain;

(B) requiring an enrollee to pay a different copayment, coinsurance, or deductible amount; or

(C) using different prescription drug formularies for mail order pharmacies and community retail pharmacies;

(3) provide a monetary incentive or impose a monetary penalty on an enrollee that could reasonably be expected to affect the enrollee's choice among pharmacies that have agreed to participate in the health benefit plan; or

(4) prohibit a pharmacy licensed under Chapter 560, Occupations Code, from participating under the health benefit plan if the pharmacy meets all of the conditions of and agrees to all of the terms of participation in the health benefit plan.

(b) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall offer all pharmacies the same conditions and terms of participation in the health benefit plan, including prescription drug reimbursement rates, regardless of whether a pharmacy is a mail order pharmacy or a community retail pharmacy.

Sec. 1560.004. PRESCRIPTION DRUG REIMBURSEMENT RATES. (a) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall reimburse pharmacies participating in the health plan using prescription drug reimbursement rates that are based on a current and nationally recognized benchmark index for both brand name and generic prescription drugs.

(b) An issuer of a health benefit plan shall use the same benchmark index, including the same national prescription drug codes, to reimburse all pharmacies participating in the health benefit plan, regardless of whether the pharmacy is a mail order pharmacy or a community retail pharmacy.

Sec. 1560.005. ACQUISITION COSTS AND REBATES. An issuer of a health benefit plan that contracts with a third-party

administrator, pharmacy benefit manager, or other entity to manage pharmacy benefits provided to enrollees through a mail order pharmacy shall require the managing entity to:

(1) provide the issuer of the health benefit plan with an annual electronic report containing:

(A) the actual acquisition cost of all drugs purchased by the managing entity in relation to the pharmacy benefits under the health benefit plan; and

(B) an identification of the source, type, and amount of all rebates, rebate administrative fees, and other monetary benefits received by the managing entity from a drug manufacturer in relation to the pharmacy benefits under the health benefit plan; and

(2) not later than the 30th day after the date the managing entity receives a rebate, rebate administrative fee, or other monetary benefit from a drug manufacturer in relation to the pharmacy benefits under the health benefit plan, reimburse or credit to the issuer of the health benefit plan an amount equal to the amount of the rebate, rebate administrative fee, or other monetary benefit received by the managing entity.

Sec. 1560.006. PHARMACY BENEFIT MANAGERS: DESIGNATION OF CONFIDENTIAL INFORMATION. (a) A pharmacy benefit manager may designate as confidential any information the pharmacy benefit manager is required to disclose under Section 1560.005.

(b) Information designated as confidential under this section may not be disclosed to any person without the consent of the pharmacy benefit manager unless the disclosure is:

(1) ordered by a court for good cause shown;

(2) made under seal in a court filing; or

(3) made to the commissioner of insurance or the attorney general in connection with an investigation authorized by this code, the Government Code, or any other law.

Sec. 1560.007. COMPLAINT AND ENFORCEMENT; ADMINISTRATIVE PENALTIES. (a) The department shall investigate any complaint that the department receives concerning conduct regulated by this chapter.

(b) Following an investigation under Subsection (a), the commissioner shall issue a written determination of the outcome of the investigation, including whether the department has taken or intends to take any action under Chapters 81-86.

(c) If, as a result of a complaint investigated under Subsection (a), the commissioner determines that an issuer of a health benefit plan has violated this chapter, the commissioner shall impose an administrative penalty against the issuer of the health benefit plan in accordance with Chapter 84. The amount of an administrative penalty imposed under this subsection may not exceed $1,000 per prescription that was filled or that was not filled in violation of this chapter. The limitation on the amount of an administrative penalty under Section 84.022 does not apply to an administrative penalty imposed under this subsection.

SECTION 2. Section 1551.219, Insurance Code, as added by Chapter 213, Acts of the 78th Legislature, Regular Session, 2003, is amended to read as follows:

Sec. 1551.219. MAIL ORDER REQUIREMENT FOR PRESCRIPTION DRUG

COVERAGE PROHIBITED. The board of trustees or a health benefit plan under this chapter that provides benefits for prescription drugs may not require a participant in the group benefits program to purchase a prescription drug through a mail order program. The board or health benefit plan may not [~~shall~~] require that a participant who chooses to obtain a prescription drug through a retail pharmacy or other method other than by mail order pay a deductible, copayment, coinsurance, or other cost-sharing obligation to cover the additional cost of obtaining a prescription drug through that method rather than by mail order.

SECTION 3. (a) Section 843.338, Insurance Code, is amended to read as follows:

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections [~~Section~~] 843.3385 and 843.339, not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim from a participating physician or provider that is electronically submitted, the health maintenance organization shall make a determination of whether the claim is payable and:

(1) if the health maintenance organization determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is payable, pay the portion of the claim that

is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

(b) Section 843.339, Insurance Code, is amended to read as follows:

Sec. 843.339. DEADLINE FOR ACTION ON [~~CERTAIN~~] PRESCRIPTION CLAIMS; PAYMENT. (a) Not later than the 21st day after the date a health maintenance organization affirmatively adjudicates a pharmacy claim that is electronically submitted, the health maintenance organization shall pay the total amount of the claim. A health maintenance organization shall pay a pharmacy claim that is submitted in a nonelectronic format not later than the deadline provided under Section 843.338.

(b) Except as provided by Subsection (c), a pharmacy benefit manager that administers a pharmacy claim for a health maintenance organization shall pay the provider through electronic funds transfer not later than the 14th day after the date on which the claim is determined under this subchapter to be affirmatively adjudicated.

(c) If the provider is unable to receive payment of a claim described by Subsection (b) through electronic funds transfer, the pharmacy benefit manager shall pay the claim not later than the 21st day after the date on which the claim is determined under this subchapter to be affirmatively adjudicated.

(c) Section 843.340, Insurance Code, is amended by adding

Subsection (f) to read as follows:

(f) A pharmacy benefit manager who performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy shall provide the provider written notice of the audit and it must be sent by certified mail not later than the 15th day before the date on which the audit is scheduled to occur.

(d) Section 1301.001(1), Insurance Code, is amended to read as follows:

(1) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.

(e) Section 1301.103, Insurance Code, is amended to read as follows:

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections 1301.104 and [~~Section~~] 1301.1054, not later than the 45th day after the date an insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date an insurer receives a clean claim from a preferred provider that is electronically submitted, the insurer shall make a determination of whether the claim is payable and:

(1) if the insurer determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and

notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

(f) Section 1301.104, Insurance Code, is amended to read as follows:

Sec. 1301.104. DEADLINE FOR ACTION ON [~~CERTAIN~~] PHARMACY CLAIMS; PAYMENT. (a) Not later than the 21st day after the date an insurer affirmatively adjudicates a pharmacy claim that is electronically submitted, the insurer shall pay the total amount of the claim. An insurer shall pay a pharmacy claim that is submitted in a nonelectronic format not later than the deadline provided under Section 1301.103.

(b) Except as provided by Subsection (c), a pharmacy benefit manager that administers a pharmacy claim for an insurer under a preferred provider benefit plan shall pay the provider through electronic funds transfer not later than the 14th day after the date on which the claim is determined under this subchapter to be affirmatively adjudicated.

(c) If the provider is unable to receive payment of a claim described by Subsection (b) through electronic funds transfer, the pharmacy benefit manager shall pay the claim not later than the 21st day after the date on which the claim is determined under this subchapter to be affirmatively adjudicated.

(g) Section 1301.105, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) A pharmacy benefit manager who performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy shall provide the provider reasonable written notice of the audit and it must be sent by certified mail not later than the 15th day before the date on which the audit is scheduled to occur.

(h) The change in law made by this section applies only to a claim submitted by a provider to a health maintenance organization or an insurer on or after the effective date of this Act. A claim submitted before the effective date of this Act is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose.

SECTION 4. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2008, is covered by the law in effect at the time the policy was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2007.