BILL ANALYSIS

C.S.H.B. 1696
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Pharmacy benefit managers (PBMs) are the largely unregulated third-party payors that administer the prescription benefit portion of health insurance plans for private companies, unions, and governments. The first PBM, the Pharmaceutical Card System, was created in 1969. From 1969 until the late 1980s, PBMs simply administered prescription claims payments. In the late 1980s, PBMs began providing online claims adjudication. Since the mid-1990s, PBMs have become involved in utilization review, formulary development, disease management programs, and a number of other practices that many perceive as practicing medicine, practicing pharmacy, or engaging in the business of insurance. PBMs have done this without the traditional state patient protection regulations imposed on pharmacists, physicians, other health care providers, insurers, and managed care organizations. Troublesome practices by PBMs include failure to return negotiated discounts to the consumers, failure to make prompt payment for claims, design of formularies based on manufacturer rebates, rather than clinical effectiveness, and restriction of consumer access to participating pharmacies in favor of a PBM-owned mail order or retail chain pharmacy. Several PBMs are facing litigation under the federal False Claims Act, laws relating to antitrust, unfair competition and deceptive practices, and for their roles as fiduciaries. PBMs are also under scrutiny for switching patients to different medications without prescriber authority. Laws regulating certain aspects of PBM operations have been enacted in 16 states and the District of Columbia.

C.S.H.B. 1696 sets out provisions relating to the regulation of PBMs and authorizes the commissioner of insurance to adopt rules and standards as necessary to implement those provisions for the purpose of increasing transparency and accountability in the industry.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1696 amends the Insurance Code to prohibit a person from acting as or representing that the person is a pharmacy benefit manager (PBM) in Texas unless the person is covered by and is engaging in business under a certificate of authority as a third-party administrator issued under state laws governing such administrators, and clarifies that the state laws governing such administrators apply to pharmacy benefit managers. The bill establishes provisions relating to the operations of PBMs, including the exercise of good faith and fair dealing and required notification to covered entities of potential conflicts of interest; parameters of contact with covered individuals; the dispensing of substitute prescription drugs for prescribed drugs; and duties to the pharmacy network provider. The bill makes these provisions applicable to each PBM providing claims processing services, other prescription drug or device services, or both claims processing services and other prescription drug or device services to covered individuals who are residents of Texas and authorizes the commissioner of insurance to adopt rules and standards as necessary to implement these provisions.

C.S.H.B. 1696 requires a PBM that administers pharmacy claims for a health maintenance organization (HMO), in addition to the HMO itself, that affirmatively adjudicates an electronically submitted pharmacy claim to pay the total amount of the claim. The bill specifies that such a claim is required to be paid through electronic funds transfer and reduces the deadline for paying the total amount of the claim from the 21st day to the 14th day after the date on which the claim was affirmatively adjudicated. The bill requires an HMO, or a PBM that administers its pharmacy claims, that affirmatively adjudicates a non-electronically submitted pharmacy claim to pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated. The bill also applies these requirements to a pharmacy claim submitted by a preferred provider benefit plan (PPBP) insurer.

C.S.H.B. 1696 prohibits an HMO or a PBM that administers its pharmacy claims from using extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. The bill prohibits the HMO or a PBM that administers its pharmacy claims from requiring extrapolation audits as a condition of participation in the HMO's contract, network, or program for a provider who is a pharmacist or pharmacy. The bill requires an HMO, or a PBM that administers its pharmacy claims, that performs an on-site audit of a provider who is a pharmacist or pharmacy to provide reasonable notice of the audit and to accommodate the provider's schedule to the greatest extent possible. The bill requires the notice to be in writing and to be sent by certified mail to the provider not later than the 15th day before the date on which the on-site audit is scheduled to occur. The bill also applies these provisions to an audit conducted by a PPBP insurer.

C.S.H.B. 1696 defines "extrapolation" for the purposes of provisions relating to an HMO or a PPBP insurer to mean a mathematical process or technique used by an HMO or insurer, or a PBM that administers pharmacy claims for an HMO or insurer, in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the HMO, insurer, or the HMO's or insurer's PBM.

C.S.H.B. 1696 sets forth procedures relating to the Texas Department of Insurance's enforcement of a pharmacy claim for an HMO or a PPBP insurer, including the submission of complaints to and the resolution of a dispute by the commissioner of insurance, a hearing by the State Office of Administrative Hearings, a final order by the commissioner of insurance, and judicial review in Travis County. The bill establishes the intent of the legislature regarding payment of such claims to providers who are pharmacists or pharmacies.

C.S.H.B. 1696 includes a pharmacist or pharmacy in the definition of "health care provider" as the term applies to PPBPs. The bill defines "covered entity," "covered individual," "pharmacy benefit management," and "pharmacy benefit manager."

C.S.H.B. 1696 makes its provisions applicable only to a contract between a PBM and an HMO or PPBP insurer entered into or renewed on or after January 1, 2010.

EFFECTIVE DATE

September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 1696 removes a provision in the original that includes in the definition of a "pharmacy benefit manager" a health insurer that holds a certificate of authority to engage in the business of insurance in Texas if the health insurer or any subsidiary provides pharmacy benefit management services exclusively to its own insureds.

C.S.H.B. 1696 differs from the original by authorizing a PBM to substitute a lower priced generic drug for a higher priced prescribed drug or to request a therapeutic interchange, whereas the original authorizes a PBM to request the substitution of a lower priced generic drug for a higher priced prescribed drug. The substitute adds language not in the original requiring the PBM to disclose certain information to the prescribing practitioner before requesting any therapeutic interchange, and sets forth the information that must be disclosed. The substitute adds a provision not in the original requiring the PBM to notify the covered individual of the change from the originally prescribed drug to the substituted drug if the therapeutic exchange is approved by the prescribing practitioner.