BILL ANALYSIS

H.B. 2293
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Pensions, Investments & Financial Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Pharmacy benefit managers administer prescription drug benefit programs for health plans and employers. The state contracts with pharmacy benefit managers to obtain prescription drugs at a lower cost than community pharmacies. However, as the pharmacy benefit manager industry has evolved, large managers have started to operate their own mail order pharmacies. This places those managers in the position of being both negotiator and provider of a plan's prescription drug services. As a result, the state does not always save money by using the pharmacy benefit manager, and managers often offer community pharmacies take-it-or-leave-it contracts providing no option for negotiation, resulting in a significant loss of business because patients are required to choose between using the manager's mail order pharmacy to obtain maintenance drugs or paying higher co-pays at the local pharmacy.

H.B. 2293 requires the Employees Retirement System of Texas (ERS) and the Teacher Retirement System of Texas (TRS) to reimburse a pharmacy at the same rate as a pharmacy benefit manager using nationally recognized price benchmarks and other standards, and to offer a pharmacy benefit allowing beneficiaries access to the same types of medicine at a community retail pharmacy at the same co-pay and supply-limit amounts as those at a pharmacy benefit manager's mail order pharmacy. The bill requires managers contracting with ERS and TRS to provide a confidential annual electronic report of the actual acquisition cost of the drugs purchased by the managers, to identify the source, type, and amount of all rebates and other monetary benefits related to the health plan received by the manager from drug manufacturers, and to provide or credit the health plan with all of the rebates or monetary benefits within 30 days receipt of by the manager.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

H.B. 2293 amends the Insurance Code to establish provisions relating to delivery of prescription drugs that apply 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 the Teacher Retirement System of Texas (TRS) or the Employees Retirement System of Texas (ERS).

H.B. 2293 requires an issuer of certain health benefit plans that provides pharmacy benefits to enrollees to allow an enrollee to obtain from a community retail pharmacy a multiple-month supply of any prescription drug under the same terms and conditions applicable when the prescription drug is obtained from a mail order pharmacy, if the community retail pharmacy agrees to accept reimbursement on exactly the same terms and conditions that apply to a mail

order pharmacy. The bill defines "multiple-month supply" for this provision as a supply for 60 or more days. The bill specifies that this provision does not require the issuer to contract with a retail pharmacy that does not agree to accept reimbursement on exactly the same terms and conditions that apply to a mail order pharmacy or more than one mail order pharmacy, nor does it require a community retail pharmacy to provide a multiple-month supply of a prescription drug under the same terms and conditions applicable when the prescription drug is obtained from a mail order pharmacy or agree to accept reimbursement on exactly the same terms and conditions that apply to a mail order pharmacy.

H.B. 2293 requires an issuer of a health benefit plan that provides pharmacy benefits to enrollees to reimburse pharmacies participating in the health plan using prescription drug reimbursement rates, for both brand name and generic prescription drugs, that are based on a current and nationally recognized benchmark index that includes average wholesale price and maximum allowable cost. The bill requires an issuer to use the same benchmark index, including the same average wholesale price, maximum allowable cost, and national prescription drug codes, to reimburse all pharmacies participating in the health benefit plan, regardless of whether a pharmacy is a mail order pharmacy or a community retail pharmacy.

H.B. 2293 requires an issuer 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 to require the managing entity to provide the issuer of the health benefit plan with an annual electronic report containing the actual acquisition cost of all drugs purchased by the managing entity and 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 not later than the 30th day after the date the managing entity receives such a rebate, rebate administrative fee, or other monetary benefit to 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.

H.B. 2293 authorizes a pharmacy benefit manager to designate as confidential any information the pharmacy benefit manager is required to disclose relating to such acquisition costs and rebates. The bill prohibits information designated as confidential from being disclosed to any person without the consent of the pharmacy benefit manager unless the disclosure is ordered by a court for good cause shown, made under seal in a court filing, or made to the commissioner of insurance or the attorney general in connection with an investigation authorized by law.

H.B. 2293 requires the Texas Department of Insurance to investigate any complaint that the department receives concerning conduct regulated under these provisions. The bill requires the commissioner of insurance to issue a written determination of the outcome of an investigation, including whether the department has taken or intends to take any disciplinary or enforcement action. The bill requires the commissioner to impose an administrative penalty against an issuer if the commissioner determines that the issuer has violated these provisions. The bill prohibits the amount of an administrative penalty from exceeding $1,000 per prescription that was or was not filled in violation of the provisions, and excludes an administrative penalty imposed for these purposes from the $25,000 limitation on the amount of an administrative penalty under the discipline and enforcement provisions.

H.B. 2293 prohibits the ERS board of trustees or a health benefit plan from requiring a participant who obtains a multiple-month supply of a prescription drug from a retail pharmacy to pay a deductible, copayment, coinsurance, or other cost-sharing obligation that differs from the amount the participant pays for a multiple-month supply of that drug through a mail order program.

H.B. 2293 applies its provisions to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010.

H.B. 2293 defines "community retail pharmacy," "mail order pharmacy," and "prescription drug formulary."

EFFECTIVE DATE

September 1, 2009.