By: Hunter H.B. No. 1770

A BILL TO BE ENTITLED

AN ACT

relating to access to pharmacists, pharmacies, and pharmaceutical care under certain health benefit plans.

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

SECTION 1. Chapter 1451, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. ACCESS TO PHARMACIES, PHARMACISTS, AND PHARMACEUTICAL CARE

Sec. 1451.501. DEFINITIONS. In this subchapter:

(1) "Drug," "pharmaceutical care," "pharmacist," "pharmacy," and "prescription drug" have the meanings assigned by Section 551.003, Occupations Code.

(2) "Enrollee" means an individual who is covered under a health benefit plan, including a covered dependent.

(3) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Sec. 1451.502. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Section 1451.503, this subchapter applies only to a health benefit plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, an accident, sickness, or substance abuse, 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;

(3) a health maintenance organization operating under Chapter 843;

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

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

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to health benefit plan coverage provided under:

(1) Chapter 1551;

(2) Chapter 1575;

(3) Chapter 1579; and

(4) Chapter 1601.

(c) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

Sec. 1451.503. EXCEPTION TO APPLICABILITY OF SUBCHAPTER.

This subchapter does not apply to a self-insured, self-funded, or other employee welfare benefit plan that is exempt from state regulation under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Sec. 1451.504. SELECTION OF PHARMACIST AND PHARMACY. A health benefit plan issuer or a pharmacy benefit manager administering pharmacy benefits under a health benefit plan may not:

(1) prohibit or limit an enrollee from selecting a pharmacist or pharmacy of the enrollee's choice to furnish prescription drugs or pharmaceutical care covered by the health benefit plan; or

(2) interfere with an enrollee's selection of a pharmacist or pharmacy to furnish prescription drugs or pharmaceutical care covered by the health benefit plan.

Sec. 1451.505. PARTICIPATION OF PHARMACISTS AND PHARMACIES. (a) Subject to Subsection (b), a health benefit plan issuer or a pharmacy benefit manager administering pharmacy benefits under a health benefit plan may not deny a pharmacist or pharmacy the right to participate as a provider or preferred provider, as applicable, under the health benefit plan if the pharmacist or pharmacy agrees to:

(1) provide prescription drugs and pharmaceutical care in accordance with the terms of the health benefit plan; and

(2) accept the administrative, financial, and professional conditions that apply to pharmacists and pharmacies who have been designated by the health benefit plan or the pharmacy

benefit manager as providers or preferred providers, as applicable, under the health benefit plan.

(b) The conditions described by Subsection (a)(2) must be applied uniformly to all pharmacists and pharmacies who have been designated by the health benefit plan or the pharmacy benefit manager as providers or preferred providers, as applicable, under the health benefit plan.

Sec. 1451.506. MANDATORY PARTICIPATION PROHIBITED. A health benefit plan issuer or a pharmacy benefit manager administering pharmacy benefits under a health benefit plan may not require a pharmacist or pharmacy to participate as a provider or preferred provider under a health benefit plan as a condition of participating as a provider or preferred provider under another health benefit plan.

Sec. 1451.507. DOSAGE AND QUANTITY REQUIREMENTS. (a) A health benefit plan issuer or a pharmacy benefit manager administering pharmacy benefits under a health benefit plan may not require an enrollee to obtain or request a specific quantity or dosage supply of prescription drugs.

(b) Notwithstanding Subsection (a), an enrollee's physician or other prescribing health care provider may prescribe prescription drugs in a quantity or dosage supply the physician or provider determines appropriate and that is in compliance with state and federal statutes.

Sec. 1451.508. COST SAVING MEASURES ALLOWED. (a) Subject to Subsection (b), this subchapter does not prohibit a health benefit plan issuer or pharmacy benefit manager administering

pharmacy benefits under a health benefit plan from, in an effort to achieve cost savings to the health benefit plan or the enrollee:

(1) limiting the quantity or dosage supply of a drug covered under the plan; or

(2) providing a financial incentive to encourage an enrollee or physician or other prescribing health care provider to use certain drugs in certain quantities.

(b) The quantity or dosage limitations and the financial incentives described by Subsection (a) must be applied or provided uniformly to all pharmacists and pharmacies who have been designated by the health benefit plan or pharmacy benefit manager as providers or preferred providers, as applicable, under the health benefit plan.

Sec. 1451.509. PHARMACY BENEFIT CARD PROGRAM. This subchapter does not prohibit a health benefit plan issuer or pharmacy benefit manager administering pharmacy benefits under a health benefit plan from establishing or administering a pharmacy benefit card program that is a "discount health care program" for purposes of Chapter 562 that authorizes an enrollee to obtain prescription drugs and pharmaceutical care from designated providers.

Sec. 1451.510. APPLICATION AND RENEWAL FEES. This subchapter does not prohibit a health benefit plan issuer or pharmacy benefit manager administering pharmacy benefits under a health benefit plan from establishing reasonable and uniform application and renewal fees for a pharmacist or pharmacy to participate as a provider or preferred provider, as applicable,

under the health benefit plan.

Sec. 1451.511. COVERAGE NOT REQUIRED. This subchapter does not require a health benefit plan to provide coverage for drugs or pharmaceutical care.

Sec. 1451.512. CONFLICTING CONTRACT PROVISION VOID. A provision of a health benefit plan or of a contract with a pharmacy benefit manager that conflicts with this subchapter is void to the extent of the conflict.

Sec. 1451.513. INJUNCTIVE RELIEF. A pharmacist, pharmacy, or enrollee adversely affected by a violation of this subchapter may bring suit in district court for injunctive relief to enforce this subchapter.

Sec. 1451.514. DEPARTMENT MONITORING. The commissioner shall monitor health benefit plans and pharmacy benefit managers to ensure compliance with this subchapter.

SECTION 2. Section 843.303(b), Insurance Code, is amended to read as follows:

(b) Unless otherwise limited by Subchapter K, Chapter 1451 [~~Article 21.52B~~], this section does not prohibit a health maintenance organization from rejecting an initial application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

SECTION 3. Section 843.304(c), Insurance Code, is amended to read as follows:

(c) This section does not require that a health maintenance organization:

(1) use a particular type of provider in its

operation;

(2) accept each provider of a category or type, except as provided by Subchapter K, Chapter 1451 [~~Article 21.52B~~]; or

(3) contract directly with providers of a particular category or type.

SECTION 4. Article 21.52B, Insurance Code, is repealed.

SECTION 5. This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2016. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 6. This Act takes effect September 1, 2015.