86R26825 PMO-F

By:  Blanco, Oliverson, Sheffield H.B. No. 698

Substitute the following for H.B. No. 698:

By:  Lucio III C.S.H.B. No. 698

A BILL TO BE ENTITLED

AN ACT

relating to certain protected practices of pharmacists and pharmacies regarding amounts charged for prescription drugs.

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

SECTION 1.  Chapter 1369, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. PROTECTED PRACTICES REGARDING PRESCRIPTION DRUG CHARGES

Sec. 1369.501.  DEFINITIONS. In this subchapter:

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

(2)  "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

Sec. 1369.502.  APPLICABILITY OF SUBCHAPTER. (a) This subchapter 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 issued 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 other law, this subchapter applies to:

(1)  a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2)  a standard health benefit plan issued under Chapter 1507;

(3)  a basic coverage plan under Chapter 1551;

(4)  a basic plan under Chapter 1575;

(5)  a primary care coverage plan under Chapter 1579;

(6)  a plan providing basic coverage under Chapter 1601;

(7)  health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8)  group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9)  the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10)  the child health plan program under Chapter 62, Health and Safety Code;

(11)  a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12)  a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c)  This subchapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Sec. 1369.503.  PROTECTED PRACTICES BY PHARMACISTS AND PHARMACIES. An issuer of a health benefit plan that covers prescription drugs or a pharmacy benefit manager as defined by Section 4151.151 may not, as a condition of a contract with a pharmacist or pharmacy providing a prescription drug or in any other manner, prohibit or otherwise restrict a pharmacist or pharmacy from or penalize a pharmacist or pharmacy for:

(1)  informing an enrollee that the amount the pharmacist or pharmacy charges for a prescription drug is less than the enrollee's copayment, deductible, or coinsurance for the drug under the plan or otherwise providing information to the enrollee regarding the cost of the drug; or

(2)  selling a prescription drug covered by the plan for an amount that is less than the enrollee's copayment, deductible, or coinsurance for the drug under the plan.

SECTION 2.  Subchapter K, Chapter 1369, Insurance Code, as added by this Act, applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020. A plan delivered, issued for delivery, or renewed before January 1, 2020, 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 3.  If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 4.  This Act takes effect September 1, 2019.