By: Oliverson H.B. No. 2231

A BILL TO BE ENTITLED

AN ACT

relating to the practices and operation of pharmacy benefit managers; providing administrative penalties.

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

SECTION 1. The heading to Subchapter H, Chapter 1369, Insurance Code, is amended to read as follows:

SUBCHAPTER H. PRICING AND REIMBURSEMENT PRACTICES; APPEALS AND COMPLAINTS [~~MAXIMUM ALLOWABLE COST~~]

SECTION 2. Subchapter H, Chapter 1369, Insurance Code, is amended by adding Sections 1369.3581, 1369.3582, and 1369.3583 to read as follows:

Sec. 1369.3581. PROHIBITED REIMBURSEMENT PRACTICES; RETROACTIVE REDUCTION OR DENIAL OF CLAIM. A pharmacy benefit manager may not on an aggregated basis or otherwise reduce or deny a claim for pharmacy services after adjudication of the claim unless the pharmacy benefit manager produces to the pharmacist or pharmacy prima facie evidence of:

(1) fraud or intentional misrepresentation related to the claim; and

(2) actual financial harm to the relevant enrollee or health benefit plan issuer.

Sec. 1369.3582. PRICING APPEALS GENERALLY. (a) The commissioner by rule shall:

(1) prescribe a standard procedure by which a

pharmacist or pharmacy may appeal to the pharmacy benefit manager any pricing decision made by a pharmacy benefit manager;

(2) require a pharmacy benefit manager to use only the prescribed procedure for a pharmacist's or pharmacy's appeal of the pharmacy benefit manager's pricing decision; and

(3) require a pharmacy benefit manager who denies an appeal to:

(A) provide to the appealing pharmacist or pharmacy the National Drug Code number of the relevant drug sold at a price below the price subject to the appeal and the name of the national or regional pharmaceutical wholesalers operating in this state that currently stock the drug at the lower price; and

(B) if the lower price described by Paragraph (A) is more than the appealing pharmacist's or pharmacy's pharmacy acquisition cost of the relevant drug bought from a pharmaceutical wholesaler from which the pharmacist or pharmacy regularly purchases the majority of the pharmacist's or pharmacy's drugs for resale:

(i) adjust the Maximum Allowable Cost List price to an amount above the pharmacist's or pharmacy's pharmacy acquisition cost; and

(ii) permit the pharmacist or pharmacy to reverse and rebill each claim affected by the pharmacist's or pharmacy's inability to purchase the drug at a cost that is equal to or less than the price subject to the appeal.

(b) In prescribing the procedure under this section, the commissioner shall consider:

(1) input from any interested party;

(2) any appeal procedure that is widely used commercially in this state or by the department or the Centers for Medicare and Medicaid Services; and

(3) any national standard or draft standard relating to the appeal of a pharmacy benefit manager's pricing decision.

(c) The commissioner shall establish penalties for failure to use the procedure prescribed under this section in accordance with this subchapter.

(d) A pharmacy benefit manager that violates this subchapter or a rule adopted under this subchapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions under Chapter 82.

Sec. 1369.3583. COMPLAINT PROGRAM. (a) The department shall establish a program to facilitate resolution of complaints against a pharmacy benefit manger relating to the pharmacy benefit manager's reimbursement practices.

(b) A pharmacist or pharmacy may file a complaint with the department under the program established under Subsection (a) if the complaint includes credible evidence that a pharmacy benefit manager engaged in an intentional course of conduct exhibited through a pattern or practice that:

(1) violates this chapter; or

(2) constitutes improper, fraudulent, or dishonest contract performance with the pharmacist or pharmacy.

(c) The commissioner shall determine by rule the threshold for filing a complaint under Subsection (b).

(d) After receipt of a complaint satisfying the threshold established under Subsection (c), the commissioner shall provide notice to the pharmacy benefit manager that is the subject of the complaint and conduct a hearing to determine if the pharmacy benefit manager engaged in a course of conduct described by Subsection (b). The commissioner shall consider:

(1) the contract between the pharmacist or pharmacy and the pharmacy benefit manager;

(2) one or more independent nationwide drug pricing databases or reference materials, including National Average Drug Acquisition Cost reference data developed by the Centers for Medicare and Medicaid Services; and

(3) any other relevant information.

(e) The commissioner shall take appropriate disciplinary action against the pharmacy benefit manager as provided by this code if the commissioner finds that the pharmacy benefit manager engaged in a course of conduct described by Subsection (b).

SECTION 3. The heading to Subchapter I, Chapter 1369, Insurance Code, is amended to read as follows:

SUBCHAPTER I. PHARMACY BENEFIT CLAIM ADJUDICATION AND DISPUTE RESOLUTION

SECTION 4. Subchapter I, Chapter 1369, Insurance Code, is amended by adding Sections 1369.403, 1369.404, 1369.405, 1369.406, 1369.407, 1369.408, 1369.409, 1369.410, and 1369.411 to read as follows:

Sec. 1369.403. REQUEST AND PRELIMINARY PROCEDURES FOR MANDATORY MEDIATION. (a) A pharmacist or pharmacy may request

mandatory mediation under this subchapter.

(b) A request for mandatory mediation must be provided to the department on a form prescribed by the commissioner and must include:

(1) the name of the pharmacist or pharmacy requesting mediation;

(2) a brief description of the claim to be mediated;

(3) contact information, including a telephone number, for the requesting pharmacist or pharmacy and the pharmacist's or pharmacy's counsel, if the pharmacist or pharmacy retains counsel;

(4) the name of the pharmacy benefit manager and name of the applicable health benefit plan issuer; and

(5) any other information the commissioner may require by rule.

(c) On receipt of a request for mediation, the department shall notify the pharmacy benefit manager and applicable health benefit plan issuer of the request.

(d) In an effort to settle the claim before mediation, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the pharmacist or pharmacy submits a request for mediation under this section.

(e) A dispute to be mediated under this subchapter that does not settle as a result of a teleconference conducted under Subsection (d) must be conducted in the county in which the pharmacist or pharmacy is located.

Sec. 1369.404. MEDIATOR QUALIFICATIONS. (a) Except as

provided by Subsection (b), to qualify for an appointment as a mediator under this subchapter a person must have completed at least 40 classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the chief administrative law judge.

(b) A person not qualified under Subsection (a) may be appointed as a mediator on agreement of the parties.

(c) A person may not act as mediator for a claim adjudication dispute if the person has been employed by, consulted for, or otherwise had a business relationship with a pharmacist, pharmacy, or pharmacy benefit manager during the three years immediately preceding the request for mediation.

Sec. 1369.405. APPOINTMENT OF MEDIATOR; FEES. (a) A mediation shall be conducted by one mediator.

(b) The chief administrative law judge shall appoint the mediator through a random assignment from a list of qualified mediators maintained by the State Office of Administrative Hearings.

(c) Notwithstanding Subsection (b), a person other than a mediator appointed by the chief administrative law judge may conduct the mediation on agreement of all of the parties and notice to the chief administrative law judge.

(d) The mediator's fees shall be split evenly and paid by the pharmacist or pharmacy and the pharmacy benefit manager.

Sec. 1369.406. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a) A mediator may not impose the mediator's judgment on a party about

an issue that is a subject of the mediation.

(b) A mediation session is under the control of the mediator.

(c) Except as provided by this subchapter, the mediator must hold in strict confidence all information provided to the mediator by a party and all communications of the mediator with a party.

(d) A party must have an opportunity during the mediation to speak and state the party's position.

(e) Except on the agreement of the participating parties, a mediation may not last more than four hours.

(f) Except at the request of a pharmacist or pharmacy, a mediation shall be held not later than the 180th day after the date of the request for mediation.

Sec. 1369.407. MATTERS CONSIDERED IN MEDIATION; AGREED RESOLUTION. (a) In a mediation under this subchapter, the parties shall evaluate the adjudicated claim amount and whether the amount is in accordance with this chapter and the pharmacy benefit contract between the pharmacist or pharmacy and the pharmacy benefit manager.

(b) The parties shall consider one or more independent nationwide drug pricing databases or reference materials, including National Average Drug Acquisition Cost reference data developed by the Centers for Medicare and Medicaid Services.

(c) Nothing in this subchapter prohibits mediation of more than one adjudicated claim between the parties at a mediation.

(d) The goal of the mediation is to reach an agreement among the pharmacist or pharmacy, the pharmacy benefit manager, and the

health benefit plan issuer as to the amount paid to the pharmacist or pharmacy.

Sec. 1369.408. NO AGREED RESOLUTION. (a) The mediator of an unsuccessful mediation under this subchapter shall report the outcome of the mediation to the department and the chief administrative law judge.

(b) The chief administrative law judge shall enter an order of referral of a matter reported under Subsection (a) to a special judge under Chapter 151, Civil Practice and Remedies Code, that:

(1) names the special judge on whom the parties agreed or appoints the special judge if the parties did not agree on a judge;

(2) states the issues to be referred and the time and place on which the parties agree for the trial;

(3) requires each party to pay the party's proportionate share of the special judge's fee; and

(4) certifies that the parties have waived the right to trial by jury.

(c) A trial by the special judge selected or appointed as described by Subsection (b) must proceed under Chapter 151, Civil Practice and Remedies Code, except that the special judge's verdict is not relevant or material to any other adjudicated claim and has no precedential value.

(d) Notwithstanding any other provision of this section, Section 151.012, Civil Practice and Remedies Code, does not apply to a mediation under this subchapter.

Sec. 1369.409. REPORT OF MEDIATOR. The mediator shall

report to the commissioner:

(1) the names of the parties to the mediation; and

(2) whether the parties reached an agreement or the mediator made a referral under Section 1369.408.

Sec. 1369.410. BAD FAITH. (a) The following conduct constitutes bad faith mediation for purposes of this subchapter:

(1) failing to participate in the mediation;

(2) failing to provide information the mediator believes is necessary to facilitate an agreement; or

(3) failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

(b) Failure to reach an agreement is not conclusive proof of bad faith mediation.

Sec. 1369.411. PENALTIES. (a) Bad faith mediation by a pharmacy benefit manager is grounds for imposition of an administrative penalty under Chapter 4151.

(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, the commissioner shall impose an administrative penalty.

SECTION 5. Chapter 1369, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. PHARMACY BENEFIT MANAGERS

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) "Health benefit plan" means an individual, group,

blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group subscriber contract or evidence of coverage or similar coverage document issued by a health maintenance organization, that provides health insurance or health benefits.

(3) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits through a health benefit plan in this state.

(4) "Pharmacist service" means the provision of a product or good, patient care, or other clinical, professional, or administrative services in the practice of pharmacy.

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

(6) "Pharmacy benefit network" means a system for the delivery of pharmacy benefits and pharmacist services established by contract between a pharmacy benefit manager and a pharmacist or pharmacy.

(7) "Rebate" means a discount or other concession, including an incentive, related to dispensing a prescription drug that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager.

Sec. 1369.502. CONTRACT REQUIREMENTS; CONTRACT ACCESS. (a) A pharmacy benefit manager may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of a pharmacy benefit network contract without the express authority of and prior adequate notification to the pharmacists or

pharmacies in the pharmacy benefit network. The prior adequate notification must be provided in the written format specified by the pharmacy benefit network contract.

(b) A pharmacy benefit manager may not provide a person access to pharmacy services or contractual discounts under a pharmacy benefit network contract unless the contract specifically:

(1) allows the pharmacy benefit manager to provide to the person access to the pharmacy benefit manager's rights and responsibilities under the pharmacy benefit network contract; and

(2) makes the person's access contingent on the person complying with all applicable terms, limitations, and conditions of the pharmacy benefit network contract.

(c) A pharmacy benefit network contract must require that, on the request of a pharmacist or pharmacy, the pharmacy benefit manager will timely provide information necessary for the pharmacist or pharmacy to determine whether a person is authorized to access the pharmacist's or pharmacy's services and contractual discounts.

(d) A pharmacy benefit network contract must specify or reference a separate fee schedule. The fee schedule may be provided by any reasonable method, including electronically. The fee schedule may describe:

(1) specific services or procedures that the pharmacist or pharmacy may deliver and the amount of the corresponding payment;

(2) a methodology for calculating the amount of the

payment based on a published fee schedule; or

(3) any other reasonable manner that provides an ascertainable amount for payment for services.

(e) For the purposes of this section, a pharmacy benefit manager shall permit a pharmacist or pharmacy participating in a pharmacy benefit network reasonable access, including electronic access, during business hours to review the pharmacy benefit network contract. The information obtained during the review may be used or disclosed only for the purposes of complying with the terms of the contract, this subchapter, or other state or federal law.

Sec. 1369.503. FIDUCIARY DUTIES. (a) A pharmacy benefit manager of a health benefit plan issuer is a fiduciary of the health benefit plan issuer.

(b) The pharmacy benefit manager shall:

(1) act in accordance with the standards of conduct applicable to a fiduciary in an enterprise of like character and with like aims;

(2) perform its duties with care, skill, prudence, and diligence; and

(3) comply with the fiduciary requirements of this section.

(c) The pharmacy benefit manager shall notify the health benefit plan issuer in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest between the pharmacy benefit manager and the health benefit plan issuer.

(d) The pharmacy benefit manager shall provide to a health benefit plan issuer all financial and utilization information requested by the health benefit plan issuer relating to the provision of benefits to the relevant enrollees and any financial and utilization information relating to the pharmacy benefit manager's services to the health benefit plan issuer.

(e) If a pharmacy benefit manager substitutes a more expensive drug for a prescribed drug, the pharmacy benefit manager shall disclose to the health benefit plan issuer the cost of the prescribed drug and the substitute drug and the amount of any rebate the pharmacy benefit manager may receive, directly or indirectly, as a result of the substitution.

(f) A pharmacy benefit manager shall transfer to the health benefit plan issuer the entire amount of any rebate that the pharmacy benefit manager receives, directly or indirectly, for any reason, including as the result of:

(1) a substitution described by Subsection (e);

(2) a substitution by the pharmacy benefit manager of a lower-priced generic and therapeutically equivalent drug for a higher-priced prescribed drug; or

(3) volume of sales of a drug or a class or brand of drug.

(g) A pharmacy benefit manager shall disclose to a health benefit plan issuer all financial terms and arrangements for remuneration of any kind, including rebates, that the pharmacy benefit manager has with each drug manufacturer or relabeler, as defined by 21 C.F.R. Section 207.1, including formulary management

and drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from pharmacists and pharmacies, and data sales fees.

Sec. 1369.504. PHARMACY BENEFIT NETWORK STANDARDS. (a) The commissioner shall by rule adopt pharmacy benefit network adequacy standards that:

(1) are adapted to local markets in which a pharmacy benefit manager operates;

(2) ensure availability of, and accessibility to, a full range of contracted pharmacists and pharmacies to provide pharmacy services to enrollees; and

(3) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's Internet website the name of the pharmacy benefit manager, the health benefit plan issuer, and the affected local market.

(b) The commissioner may not consider mail-order pharmacies in the determination of the pharmacy benefit network adequacy standards adopted by rule under Subsection (a).

Sec. 1369.505. ANY WILLING PROVIDER. (a) A pharmacy benefit manager may not exclude a pharmacist or pharmacy from participation in a pharmacy benefit network if the pharmacist or pharmacy:

(1) accepts the terms, conditions, and reimbursement rates of the pharmacy benefit manager;

(2) meets all applicable federal and state licensure and permit requirements; and

(3) has not been terminated for cause as a provider in any federal or state program.

(b) Except as required by the commissioner in coordination with the Texas State Board of Pharmacy, a pharmacy benefit manager may not require, as a condition of participating in a pharmacy benefit network, that a pharmacist or pharmacy obtain:

(1) accreditation, credentialing, or certification inconsistent with, more stringent than, or in addition to the requirements imposed by the Texas State Board of Pharmacy or state or federal law; or

(2) a performance or surety bond or other financial guarantee in excess of the requirements imposed by the Texas State Board of Pharmacy or state or federal law.

Sec. 1369.506. PROTECTED COMMUNICATION AND OTHER PRACTICES BY PHARMACISTS AND PHARMACIES. (a) In a participation contract between a pharmacy benefit manager and a pharmacist or pharmacy providing prescription drug coverage for a health benefit plan, a pharmacist or pharmacy may not be prohibited or restricted from or penalized in any way for disclosing to an enrollee any health care information that the pharmacist or pharmacy considers appropriate regarding:

(1) the nature of treatment, risks, or alternative therapies;

(2) the availability of alternate therapies, consultations, or tests;

(3) the decision of utilization reviewers or similar persons to authorize or deny services;

(4) the process used to authorize or deny health care services or benefits; or

(5) financial incentives and structures used by the relevant health benefit plan.

(b) A pharmacist or pharmacy may provide to an enrollee information regarding the enrollee's total cost for a pharmacist service for a prescription drug.

(c) A pharmacy benefit manager may not prohibit a pharmacist or pharmacy from:

(1) discussing information regarding the total cost for a pharmacist service for a prescription drug; or

(2) selling a more affordable alternative to the enrollee if a more affordable alternative is available.

(d) A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement, or state or federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements of this subchapter.

Sec. 1369.507. RECOUPMENT LIMITATION. (a) A reimbursement made to a pharmacist or pharmacy by a pharmacy benefit manager may not be denied or reduced after adjudication of the claim, unless:

(1) the original claim was submitted fraudulently;

(2) the original claim payment was incorrect because the pharmacist or pharmacy had already been paid for the pharmacist service; or

(3) the pharmacist service was not properly rendered by the pharmacist or pharmacy.

(b) A pharmacy benefit manager entitled to a recoupment on the basis of a discrepancy found during an audit related to a drug that was properly dispensed may only recover fees paid by the pharmacy benefit manager to the pharmacist or pharmacy associated with the audited claim and may not recoup the cost of the drug or other ingredient or any other amount related to the claim.

SECTION 6. The heading to Subchapter D, Chapter 4151, Insurance Code, is amended to read as follows:

SUBCHAPTER D. PHARMACY BENEFITS [~~BENEFIT PLANS~~]

SECTION 7. Subchapter D, Chapter 4151, Insurance Code, is amended by adding Section 4151.155 to read as follows:

Sec. 4151.155. BOARD OF PHARMACY REQUESTS. The commissioner shall provide to the Texas State Board of Pharmacy, on the board's request, a copy of any document related to an action taken under Subchapter G against a pharmacy benefit manager, including:

(1) a document or information or data submitted by a pharmacy benefit manager to the commissioner;

(2) correspondence between the pharmacy benefit manager and the commissioner; and

(3) a written notice, finding, or determination, or other document sent by the commissioner to the pharmacy benefit manager.

SECTION 8. Section 1369.357, Insurance Code, is repealed.

SECTION 9. Chapter 1369, Insurance Code, as amended by this

Act, applies only to a contract between a pharmacy benefit manager and a pharmacist or pharmacy entered into or renewed on or after January 1, 2020. A contract entered into 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 10. This Act takes effect September 1, 2019.