By: Raymond H.B. No. 3401

A BILL TO BE ENTITLED

AN ACT

relating to delivery of outpatient prescription drug benefits under certain public benefit programs, including Medicaid and the child health plan program.

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

ARTICLE 1. DELIVERY OF OUTPATIENT PRESCRIPTION DRUG BENEFITS USING FEE-FOR-SERVICE DELIVERY MODEL UNDER CERTAIN PUBLIC BENEFIT PROGRAMS

SECTION 1.01. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.068 to read as follows:

Sec. 531.068. DELIVERY OF OUTPATIENT PRESCRIPTION DRUG BENEFITS UNDER CERTAIN PROGRAMS. (a) In this section, "recipient" means a person receiving benefits under a program described by Subsection (b).

(b) Notwithstanding any other law, beginning January 1, 2020, the commission shall provide outpatient prescription drug benefits through the vendor drug program using a transparent fee-for-service delivery model to persons, including persons enrolled in a managed care program, receiving benefits under:

(1) Medicaid;

(2) the child health plan program;

(3) the kidney health care program; and

(4) any other benefits program administered by the commission that provides an outpatient prescription drug benefit.

(c) In providing outpatient prescription drug benefits under this section, the commission shall:

(1) eliminate any obligation to pay fees included in the capitation rate or other amounts paid to managed care organizations that are associated with the provision of outpatient prescription drug benefits, including:

(A) the guaranteed risk margin; and

(B) the health insurance providers fee imposed under Section 9010 of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), and the associated effects of that fee on federal income taxes;

(2) pay claims in accordance with the deadlines imposed by Section 843.339, Insurance Code;

(3) if the commission contracts with a prescription drug benefits administrator for purposes of this section, pay the administrator only for reimbursement of any prescribed drug and a contracted administrative fee; and

(4) in accordance with the findings of the study conducted by the commission in response to Section 60 following the Article II appropriations to the commission in Chapter 605 (S.B. 1), Acts of the 85th Legislature, Regular Session, 2017 (the General Appropriations Act):

(A) consistently apply clinical prior authorization requirements statewide and use prior authorizations to control unnecessary utilization;

(B) ensure the preferred drug list is not

disadvantaged;

(C) maintain drug utilization review; and

(D) coordinate data exchange under existing data warehouse and enterprise data resources.

(d) In providing outpatient prescription drug benefits under this section, the commission may not:

(1) prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services by imposing different copayments associated with a pharmacy or pharmacist; and

(2) prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms of the program and any contract required under the program.

(e) In providing outpatient prescription drug benefits under this section, the commission may include mail-order pharmacies in the commission's network of pharmacy providers, except the commission may not:

(1) require recipients to use a mail-order pharmacy; or

(2) charge a recipient who elects to use a mail-order pharmacy a fee for using the mail order service, including a postage or handling fee.

(f) Notwithstanding any other law, a managed care organization providing health care services under a benefit program described by Subsection (b) may not develop, implement, or maintain an outpatient pharmacy benefit plan for recipients

beginning on the 180th day after the date the commission begins providing outpatient prescription drug benefits under this section.

SECTION 1.02. As soon as practicable after the effective date of this article, but not later than December 31, 2019, the Health and Human Services Commission shall amend each contract with a managed care organization entered into before the effective date of this article to prohibit the organization from providing outpatient prescription drug benefits to recipients under a public benefits program subject to Section 531.068, Government Code, as added by this Act, beginning on the 180th day after the date the commission begins providing outpatient prescription drug benefits in the manner required by that section.

ARTICLE 2. CESSATION OF DELIVERY OF OUTPATIENT PRESCRIPTION DRUG BENEFITS BY MANAGED CARE ORGANIZATIONS

SECTION 2.01. Section 533.012(a), Government Code, is amended to read as follows:

(a) Each managed care organization contracting with the commission under this chapter shall submit the following, at no cost, to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, [~~pharmacy benefit manager,~~] and exclusive provider organization, necessary for the commission to determine the actual cost of administering the managed care plan.

SECTION 2.02. Section 32.046(a), Human Resources Code, is amended to read as follows:

(a) The executive commissioner shall adopt rules governing sanctions and penalties that apply to a provider [~~who participates~~] in the vendor drug program [~~or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 533, Government Code, or its subcontractor and~~] who submits an improper claim for reimbursement under the program.

SECTION 2.03. The following provisions are repealed:

(1) Sections 531.0697, 533.003(b), and 533.056, Government Code; and

(2) Section 32.073(c), Human Resources Code.

SECTION 2.04. The changes in law made by this article apply beginning on the 180th day after the date the Health and Human Services Commission begins providing outpatient prescription drug benefits in the manner required by Section 531.068, Government Code, as added by this Act. Until the changes in law made by this article apply, the law as it existed on the day immediately before

the effective date of this article governs and the former law is continued in effect for that purpose.

ARTICLE 3. INSURANCE PREMIUM AND REVENUE TAX

SECTION 3.01. Section 222.001, Insurance Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as follows:

(a) This chapter applies to any of the following entities that receives gross premiums or revenues subject to taxation under Section 222.002:

(1) an [~~any~~] insurer, including a group hospital service corporation;

(2) a[~~, any~~] health maintenance organization;

(3) a[~~, and any~~] managed care organization; and

(4) a prescription drug benefit administrator that enters into a contract with the Health and Human Services Commission under Section 531.068, Government Code, to administer prescription drug benefits.

(a-1) Entities described by Subsection (a) include [~~that receives gross premiums or revenues subject to taxation under Section 222.002, including~~] companies operating under Chapter 841, 842, 843, 861, 881, 882, 883, 884, 941, 942, 982, or 984, Insurance Code, Chapter 533, Government Code, or Title XIX of the federal Social Security Act.

SECTION 3.02. Section 222.002, Insurance Code, is amended by amending Subsections (a) and (c) and adding Subsection (b-1) to read as follows:

(a) An annual tax is imposed on:

(1) each insurer that receives gross premiums subject to taxation under this section; [~~and~~]

(2) each health maintenance organization that receives gross revenues from the sale of health maintenance certificates or contracts; and

(3) the prescription drug benefit administrator that receives gross revenues from the administration of prescription drug benefits under Section 531.068, Government Code.

(b-1) Except as otherwise provided by this section, a prescription drug benefit administrator's taxable gross revenues are equal to the total gross amount of administrative fees and other consideration received by the prescription drug benefit administrator in a calendar year from the contract entered into under Section 531.068, Government Code.

(c) The following are not included in determining an insurer's taxable gross premiums or a health maintenance organization's or prescription drug benefit administrator's taxable gross revenues:

(1) returned premiums or revenues;

(2) dividends applied to purchase paid-up additions to insurance or to shorten the endowment or premium payment period;

(3) premiums received from an insurer for reinsurance;

(4) premiums or revenues received from the treasury of the United States for insurance or benefits contracted for by the federal government in accordance with or in furtherance of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) and its subsequent amendments;

(5) premiums or revenues paid on group health, accident, and life policies or contracts in which the group covered by the policy or contract consists of a single nonprofit trust established to provide coverage primarily for employees of:

(A) a municipality, county, or hospital district in this state; or

(B) a county or municipal hospital, without regard to whether the employees are employees of the county or municipality or of an entity operating the hospital on behalf of the county or municipality; or

(6) premiums or revenues excluded by another law of this state.

SECTION 3.03. Section 222.003, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) The rate of the tax imposed by this chapter on a prescription drug benefit administrator is:

(1) 0.875 percent of the first $450,000 of taxable gross revenues received during a calendar year; and

(2) 1.75 percent of the remaining taxable gross revenues received during that calendar year.

SECTION 3.04. Section 222.004(b), Insurance Code, is amended to read as follows:

(b) An insurer, [~~or~~] health maintenance organization, or prescription drug benefit administrator that had a net tax liability for the previous calendar year of more than $1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of

tax the insurer, [or] health maintenance organization, or prescription drug benefit administrator paid under this chapter for the previous calendar year. If the insurer, [or] health maintenance organization, or prescription drug benefit administrator did not pay a tax under this chapter during the previous calendar year, the tax paid on each date must be equal to the tax that would be owed on the aggregate of the taxable gross premiums or taxable gross revenues for the two previous calendar quarters.

SECTION 3.05. Sections 222.005(a) and (c), Insurance Code, are amended to read as follows:

(a) An insurer, [or] health maintenance organization, or prescription drug benefit administrator liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(c) The comptroller may require the insurer, [or] health maintenance organization, or prescription drug benefit administrator to file any additional relevant information that is reasonably necessary to verify the amount of tax due.

SECTION 3.06. Section 222.007(a), Insurance Code, is amended to read as follows:

(a) Except as otherwise provided by this subsection, an insurer, [or] health maintenance organization, or prescription drug benefit administrator is entitled to a credit on the amount of tax due under this chapter for all examination and evaluation fees paid to this state during the calendar year for which the tax is due. An insurer is not entitled to a credit on the amount of tax

due under this chapter for fees paid for valuing life insurance policies. The limitations provided by Sections 803.007(1) and (2)(B) for a domestic insurance company apply to a foreign insurance company.

SECTION 3.07. Section 222.008, Insurance Code, is amended to read as follows:

Sec. 222.008. FAILURE TO PAY TAXES. An insurer, [~~or~~] health maintenance organization, or prescription drug benefit administrator that fails to pay all taxes imposed by this chapter is subject to Section 203.002.

ARTICLE 4. FEDERAL AUTHORIZATION AND EFFECTIVE DATE

SECTION 4.01. 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 4.02. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2019.

(b) Article 3 of this Act takes effect January 1, 2020.