BILL ANALYSIS

Senate Research Center
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C.S.H.B. 1919
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Health & Human Services
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Consolidation in the pharmacy benefits and health insurance industries has concentrated control of pharmacy benefits in the hands of a few huge conglomerates. These benefit managers collectively manage roughly three-quarters of the pharmacy benefits market and their control continues to increase due to recent mergers with insurers. A recent survey suggests a significant number of pharmacies reported their patients having prescriptions transferred to a benefit manager, with the steering of patients to certain retail and specialty pharmacies increasing as these new conglomerates use both their pharmacy benefit manager (PBM) and health insurance arms to "refer" patients to their own mail-order, retail, and specialty pharmacies. There are concerns that these "referral" practices represent a conflict of interest and decrease both transparency and competition in the health services market. As engrossed, H.B. 1919 seeks to remedy this situation by protecting the right of pharmacy patients to use their pharmacy of choice.

The committee substitute to H.B. 1919 includes additional language to further reign in PBMs and promote patient choice, specifically for cancer patients receiving clinician-administered drugs. These provisions will preserve a physician's ability to obtain and administer oncology drugs through the medical benefit or the patient's pharmacy of choice, as is current practice.

C.S.H.B. 1919 amends current law relating to certain prohibited practices for certain health benefit plan issuers and certain required and prohibited practices for pharmacy benefit managers.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1369, Insurance Code, by adding Subchapters L and M, as follows:

SUBCHAPTER L. AFFILIATED PROVIDERS

Sec. 1369.551. DEFINITIONS. Defines "affiliated provider," "health benefit plan," and "pharmacy benefit manager."

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Provides that, notwithstanding the definition of "health benefit plan" provided by Section 1369.551, this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program, including the Medicaid managed care program operated under Chapter 553 (Medicaid Managed Care Program), Government Code;

(2) the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code;

(3) the TRICARE military health system;

(4) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(5) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(6) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(7) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and The Texas A&M University System); or

(8) a workers' compensation insurance policy or other form of providing medical benefits under Title 5 (Workers' Compensation), Labor Code.

Sec. 1369.553. TRANSFER OR ACCEPTANCE OF CERTAIN RECORDS PROHIBITED. (a) Provides that, in this section, "commercial purpose" does not include pharmacy reimbursement, formulary compliance, pharmaceutical care, utilization review by a health care provider, or a public health activity authorized by law.

(b) Prohibits a health benefit plan (HBP) issuer or a pharmacy benefit manager (PBM) from transferring to or receiving from an affiliated provider a record containing patient- or prescriber-identifiable prescription information for a commercial purpose.

Sec. 1369.554. PROHIBITION ON CERTAIN COMMUNICATIONS. (a) Prohibits an HBP issuer or PBM from steering or directing a patient to use the issuer's or manager's affiliated provider through any oral or written communication, including:

(1) online messaging regarding the provider; or

(2) patient- or prospective patient-specific advertising, marketing, or promotion of the pharmacy.

(b) Provides that this section does not prohibit an HBP issuer or PBM from including the issuer's or manager's affiliated provider in a patient or prospective patient communication, if the communication:

(1) is regarding information about the cost or service provided by pharmacies or durable medical equipment providers in the network of an HBP in which a patient is enrolled; and

(2) includes accurate comparable information regarding pharmacies or durable medical equipment providers in the network that are not the issuer's or manager's affiliated providers.

Sec. 1369.555. PROHIBITION ON CERTAIN REFERRALS AND SOLICITATIONS. (a) Prohibits an HBP issuer or PBM from requiring a patient to use the issuer's or manager's affiliated provider in order for the patient to receive the maximum benefit for the service under the patient's HBP.

(b) Prohibits an HBP issuer or PBM from offering or implementing an HBP that requires or induces a patient to use the issuer's or manager's affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider.

(c) Prohibits an HBP issuer or PBM from soliciting a patient or prescriber to transfer a patient prescription to the issuer's or manager's affiliated provider.

(d) Prohibits an HBP issuer or PBM from requiring a pharmacy or durable medical equipment provider that is not the issuer's or manager's affiliated provider to transfer a patient's prescription to the issuer's or manager's affiliated provider without the prior written consent of the patient.

SUBCHAPTER M. CLINICIAN-ADMINISTERED DRUGS

Sec. 1369.601. DEFINITIONS. Defines "affiliated provider," "clinician-administered drug," "health care provider," "pharmacy benefit manager," and "physician."

Sec. 1369.602. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to an HBP 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 by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

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

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations);

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

(6) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

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

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

(9) an exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges).

(b) Provides that, notwithstanding any other law, this subchapter applies to:

(1) a small employer HBP subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter;

(2) a standard HBP issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) health benefits provided by or through a church benefits board under Subchapter I (Church Benefits Boards), Chapter 22 (Nonprofit Corporations), Business Organizations Code;

(4) a regional or local health care program operating under Section 75.104 (Health Care Services), Health and Safety Code; and

(5) a self-funded HBP sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

(c) Provides that this subchapter does not apply to an issuer or provider of health benefits under or a PBM administering pharmacy benefits under a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Sec. 1369.603. CERTAIN LIMITATIONS RELATED TO CLINICIAN-ADMINISTERED DRUGS PROHIBITED. (a) Prohibits an HBP issuer or PBM, for a patient with a caner or cancer-related diagnosis, from:

(1) requiring a clinician-administered drug to be dispensed by a pharmacy, including by an affiliated provider; or

(2) requiring that a clinician-administered drug or the administration of a clinician-administered drug be covered as a pharmacy benefit rather than a medical benefit.

(b) Prohibits anything in this section from being construed to:

(1) authorize a person to administer a drug when otherwise prohibited under the laws of this state or federal law; or

(2) modify drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

SECTION 2. Provides that Sections 1369.555(a) and (b), Insurance Code, as added by this Act, apply only to an HBP delivered, issued for delivery, or renewed on or after the effective date of this Act.

SECTION 3. Provides that Subchapter M, 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, 2022.

SECTION 4. Effective date: September 1, 2021.