By: Harris, et al. H.B. No. 1919

(Senate Sponsor - Schwertner, et al.)

(In the Senate - Received from the House May 3, 2021; May 13, 2021, read first time and referred to Committee on Health & Human Services; May 21, 2021, reported adversely, with favorable Committee Substitute by the following vote: Yeas 8, Nays 0; May 21, 2021, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Kolkhorst	X			
Perry	X			
Blanco	X			
Buckingham	X			
Campbell	X			
Hall			X	
Miles	X			
Powell	X			
Seliger	X			

COMMITTEE SUBSTITUTE FOR H.B. No. 1919 By: Perry

A BILL TO BE ENTITLED
AN ACT

relating to certain prohibited practices for certain health benefit plan issuers and certain required and prohibited practices for certain pharmacy benefit managers.

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

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapters L and M to read as follows:

SUBCHAPTER L. AFFILIATED PROVIDERS

Sec. 1369.551. DEFINITIONS. In this subchapter:

(1) "Affiliated provider" means a pharmacy or durable medical equipment provider that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a health benefit plan issuer or pharmacy benefit manager.

(2) "Health benefit plan" has the meaning assigned by Section 1369.251.

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

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. 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 533, Government Code;

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

(3) the TRICARE military health system;

(4) a basic coverage plan under Chapter 1551;

(5) a basic plan under Chapter 1575;

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

(7) a plan providing basic coverage under Chapter 1601; or

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

Sec. 1369.553. TRANSFER OR ACCEPTANCE OF CERTAIN RECORDS PROHIBITED. (a) 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) A health benefit plan issuer or pharmacy benefit manager may not transfer to or receive from the issuer's or manager's affiliated provider a record containing patient- or prescriber-identifiable prescription information for a commercial purpose.

Sec. 1369.554. PROHIBITION ON CERTAIN COMMUNICATIONS. (a) A health benefit plan issuer or pharmacy benefit manager may not steer or direct 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 provider.

(b) This section does not prohibit a health benefit plan issuer or pharmacy benefit manager 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 a health benefit plan in which the patient or prospective 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) A health benefit plan issuer or pharmacy benefit manager may not require 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 health benefit plan.

(b) A health benefit plan issuer or pharmacy benefit manager may not offer or implement a health benefit plan 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) A health benefit plan issuer or pharmacy benefit manager may not solicit a patient or prescriber to transfer a patient prescription to the issuer's or manager's affiliated provider.

(d) A health benefit plan issuer or pharmacy benefit manager may not require 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. In this subchapter:

(1) "Affiliated provider" means a pharmacy or durable medical equipment provider that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a health benefit plan issuer or pharmacy benefit manager.

(2) "Clinician-administered drug" means an outpatient prescription drug other than a vaccine that:

(A) cannot reasonably be:

(i) self-administered by the patient to whom the drug is prescribed; or

(ii) administered by an individual assisting the patient with the self-administration; and

(B) is typically administered:

(i) by a physician or other health care provider authorized under the laws of this state to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

(3) "Health care provider" means an individual who is licensed, certified, or otherwise authorized to provide health care services in this state.

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

(5) "Physician" means an individual licensed to practice medicine in this state.

Sec. 1369.602. 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 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 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) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

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

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

(c) This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager 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) A health benefit plan issuer or pharmacy benefit manager may not, for a patient with a cancer or cancer-related diagnosis:

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

(2) require 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) Nothing in this section may be 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. Sections 1369.555(a) and (b), Insurance Code, as added by this Act, apply only to a health benefit plan delivered, issued for delivery, or renewed on or after the effective date of this Act.

SECTION 3. 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. This Act takes effect September 1, 2021.

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