House Bill 1919
Senate Amendments
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter L 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.	SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter L to read as follows: [FA2(1)] 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 coverage plan under Chapter 1579; [FA1] (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. 1369.552. TRANSFER OR ACCEPTANCE OF	Sec. 1369.553. TRANSFER OR ACCEPTANCE OF	

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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. 1369.553. 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. 1369.554. PROHIBITION ON CERTAIN REFERRALS AND SOLICITATIONS. (a) A health benefit plan issuer or	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	

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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.	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 [Deleted by FA2(2)]	
SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0695 to read as follows: Sec. 531.0695. REQUIRED FEE SCHEDULE FOR CERTAIN PHARMACY BENEFITS PROVIDED UNDER MEDICAID OR CHILD HEALTH PLAN PROGRAM. (a) In this section, "pharmacy benefit manager" has the meaning assigned by Section 4151.151, Insurance Code. (b) A contract between a pharmacy benefit manager and a managed care organization that contracts with the commission	No equivalent provision.	

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to provide pharmacy benefits under Medicaid or the child health plan program must contain a requirement that the pharmacy benefit manager have a fee schedule that applies to each pharmacy or pharmacist with which the pharmacy benefit manager contracts. The contract between the pharmacy benefit manager and the pharmacy or pharmacist must refer to the fee schedule and the pharmacy benefit manager shall provide the fee schedule: (1) in the contract; or (2) separately in an easy-to-access, electronic spreadsheet format and, on request by the pharmacy or pharmacist, in writing. (c) A fee schedule provided under Subsection (b) must describe: (1) specific pharmacy benefits that the pharmacy or pharmacist may deliver and the amount of the corresponding reimbursement for those benefits; (2) the methodology used to calculate the reimbursement for specific pharmacy benefits; or (3) another reasonable method that a pharmacy or pharmacist may use to ascertain the corresponding reimbursement amount for a specific pharmacy benefit.		
SECTION 3. Sections 1369.554(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 2. Substantially the same as House version.	
No equivalent provision.	Same as House version. SECTION 3. [Deleted by FA2(3)]	

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SECTION 4. Section 531.0695, Government Code, as added by this Act, applies only to a contract entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act 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.	No equivalent provision.	
SECTION 5. 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.	No equivalent provision.	
SECTION 6. This Act takes effect September 1, 2021.	SECTION 4. Same as House version.	