BILL ANALYSIS

C.S.H.B. 3317
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Current state law regulates the activities of pharmacy benefit managers (PBM) that operate in Texas. The bill author has informed the committee that, because of market consolidation, a small number of PBMs control the vast majority of prescription drug reimbursements in the country, and many contend that PBMs have used their market power to force pharmacies into accepting contracts with predatory terms. C.S.H.B. 3317 seeks to address this issue by providing contract protections for pharmacies and pharmacists who contract with PBMs.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3317 amends the Insurance Code to establish that a group number on an identification card provided to an enrollee in a health benefit plan to which statutory provisions relating to pharmacy benefit cards apply may only be assigned to enrollees in a health benefit plan to which those provisions apply. This provision applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2026. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2026, is governed by the law as it existed immediately before the bill's effective date, and that law is continued in effect for that purpose.

C.S.H.B. 3317 prohibits a health benefit plan issuer or pharmacy benefit manager, as the result of an audit of a pharmacist or pharmacy, from denying or reducing a claim payment made to the pharmacist or pharmacy after adjudication of the claim. The bill authorizes a health benefit plan issuer or pharmacy benefit manager to recoup from a pharmacist or pharmacy the cost of a prescription drug and the dispensing fee for the drug if:

- the original claim was submitted fraudulently;
- the original claim payment was incorrect because the pharmacist or pharmacy had already been paid for the pharmacist service; or
- the pharmacist or pharmacy made a substantive nonclerical or non-recordkeeping error that led to the patient receiving the wrong prescription drug or dosage.

The bill limits a health benefit plan issuer or pharmacy benefit manager to recouping only the dispensing fee from a pharmacist or pharmacy if the pharmacist or pharmacy made a clerical error that led to an overpayment and repeals a provision which sets out the criteria that must be met before a health benefit plan issuer or pharmacy benefit manager is permitted to include a dispensing fee amount in the calculation of an overpayment.

C.S.H.B. 3317 requires a health benefit plan issuer or pharmacy benefit manager to make available to any pharmacist or pharmacy in the issuer's or manager's pharmacy benefit network access to a secure, online portal through which the pharmacist or pharmacy may access all pharmacy benefit network contracts between that issuer or manager and the pharmacist or pharmacy, including any contract addendums.

C.S.H.B. 3317 authorizes a health benefit plan issuer or pharmacy benefit manager to make an adverse material change to a pharmacy benefit network contract during the term of the contract only with the mutual agreement of the parties. A provision in the contract that allows a health benefit plan issuer or pharmacy benefit manager to unilaterally make an adverse material change during the term of the contract is void and unenforceable. The bill prohibits an adverse material change to a pharmacy benefit network contract from going into effect until the 120th day after the date the pharmacist or pharmacy affirmatively agrees to the adverse material change in writing. The bill requires an adverse material change to a pharmacy benefit network contract proposed by a health benefit plan issuer or pharmacy benefit manager to include notice that clearly and conspicuously states that a pharmacist or pharmacy may choose to not agree to the adverse material change and that the decision to not agree to that change does not affect the following:

- the terms of the pharmacist's or pharmacy's existing contract with the health benefit plan issuer or pharmacy benefit manager; or
- the pharmacist's or pharmacy's participation in another pharmacy benefit network.

The bill establishes the following with respect to adverse material changes:

- a pharmacist's or pharmacy's decision to not agree to an adverse material change to a pharmacy benefit network contract does not affect the terms of the pharmacist's or pharmacy's existing contract or the pharmacist's or pharmacy's participation in another pharmacy benefit network; and
- a health benefit plan issuer's or pharmacy benefit manager's failure to include the required notice described by these provisions with the proposed adverse material change makes an otherwise agreed-to adverse material change void and unenforceable.

These provisions do not apply to:

- a pharmacy benefit network contract:
    - with an unspecified and indefinite duration;
    - with no stated or automatic renewal period or event; and
    - that may only be terminated by notice from one party to the other; or
- a proposed modification or addendum to a pharmacy benefit network contract that is required by state or federal law or rule.

For these purposes, the bill defines "adverse material change" as a modification or addendum to a pharmacy benefit network contract that would decrease a pharmacist's or pharmacy's payment or compensation, change the pharmacist's or pharmacy's tier to a less preferred tier, or change the administrative procedures in a way that may reasonably be expected to increase the pharmacist's or pharmacy's administrative expenses or decrease the pharmacist's or pharmacy's payment or compensation, excluding:

- a decrease in payment or compensation resulting solely from a change in a published governmental fee schedule on which the payment or compensation is based if the applicability of the schedule is clearly identified in the contract;
- a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;
- an administrative change that may increase the pharmacist's or pharmacy's administrative expenses, the specific applicability of which is clearly identified in the contract;
- a change that is required by federal or state law;
- a termination for cause; or
- a termination without cause at the end of the term of the contract.

C.S.H.B. 3317 requires a health benefit plan issuer or pharmacy benefit manager, not later than the 90th day before the date a proposed modification or addendum to a pharmacy benefit network contract, other than an adverse material change as defined by the bill's provisions, is to take effect, to do the following:

- post the proposed modification or addendum to the online portal described by the bill's provisions; and
- provide to the pharmacist or pharmacy notice of the proposed modification or addendum by email, including:
    - a link to the online portal;
    - the National Council for Prescription Drug Programs number or other identifier approved by the commissioner of insurance for the pharmacist or pharmacy to which the proposed modification or addendum applies; and
    - a description of the proposed modification or addendum in a manner that allows the pharmacist or pharmacy to compare the proposed modification or addendum to the current contract.

The bill authorizes a health benefit plan issuer or pharmacy benefit manager, if a pharmacist or pharmacy does not respond before the 31st day after the date the pharmacist or pharmacy receives notice of a proposed modification or addendum under these provisions, to consider the proposed modification or addendum approved by the pharmacist or pharmacy and establishes that such a modification or addendum takes effect on the date described by the bill's provisions. The bill prohibits a pharmacy benefit network contract from incorporating by reference a document not included in a contract or contract attachment, including a provider manual described by the bill's provisions. The bill requires all financial terms, including reimbursement rates and methodology, to be set forth in the contract. These provisions do not apply to:

- a pharmacy benefit network contract:
    - with an unspecified and indefinite duration;
    - with no stated or automatic renewal period or event; and
    - that may only be terminated by notice from one party to the other; or
- a proposed modification or addendum to a pharmacy benefit network contract that is required by state or federal law or rule.

C.S.H.B. 3317 requires a pharmacy benefit network contract to state that the contract is subject to statutory provisions relating to the benefits related to prescription drugs and devices and related services and any rules adopted by the commissioner of insurance under those provisions.

C.S.H.B. 3317 requires a health benefit plan issuer or pharmacy benefit plan manager to do the following:

- make a provider manual readily available on the online portal described by the bill's provisions; and
- post a modification or addendum to the provider manual to the online portal in the same manner as a contract modification or addendum under the bill's provisions.

C.S.H.B. 3317 prohibits a health benefit plan issuer or pharmacy benefit manager from doing the following:

- charging a fee, including an application or participation fee, before providing a pharmacist or pharmacy with the full proposed pharmacy benefit network contract, including any financial terms applicable to the contract and corresponding pharmacy benefit network;
- requiring a pharmacist or pharmacy to participate in a pharmacy benefit network;
- conditioning a pharmacist's or pharmacy's participation in a pharmacy benefit network on participation in any other pharmacy benefit network; or
- penalizing a pharmacist or pharmacy for refusing to participate in a pharmacy benefit network.

C.S.H.B. 3317 replaces the requirement for a pharmacy benefit network contract to specify or reference a separate fee schedule with a requirement for that contract to include a fee schedule.

The bill removes a requirement that the fee schedule, unless otherwise available in the contract, be provided electronically in an easily accessible and complete spreadsheet format and, on request, in writing to each contracted pharmacist and pharmacy. The bill's provisions relating to contracts between health benefit plan issuers or pharmacy benefit managers and pharmacists or pharmacies apply only to a contract entered into or renewed on or after the bill's effective date. A contract entered into or renewed before the bill's effective date is governed by the law as it existed immediately before the bill's effective date, and that law is continued in effect for that purpose.

C.S.H.B. 3317 repeals Section 1369.259(d), Insurance Code.

EFFECTIVE DATE

September 1, 2025.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3317 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute omits the following from the introduced:

- a requirement for the commissioner of insurance by rule to require a health benefit plan that provides pharmacy benefits to enrollees to include on the front of the identification card of each enrollee a unique identifier that enables a pharmacist or pharmacy to determine when submitting a claim that the enrollee's health benefit plan or pharmacy benefit plan is subject to regulation by the Texas Department of Insurance; and
- an authorization for the commissioner, for these purposes, to require a unique bank identification number, processor control number, or group number.

The substitute includes a provision absent from the introduced establishing that a group number on an identification card provided to an enrollee in a health benefit plan to which statutory provisions relating to pharmacy benefit cards apply may only be assigned to enrollees in a health benefit plan to which those provisions apply.

The substitute omits a provision from the introduced that removed an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under a self-funded health benefit plan as defined by the federal Employee Retirement Income Security Act of 1974 from the exception from statutory provisions relating to audits of pharmacists and pharmacies.

With respect to the calculation of recoupment after an audit of a pharmacist or a pharmacy, both the introduced and the substitute prohibit a health benefit plan issuer or pharmacy benefit manager, as the result of an audit, from denying or reducing a claim payment made to a pharmacist or pharmacy after adjudication of the claim. However, the introduced created an exception to that prohibition and authorized a health benefit plan issuer or pharmacy benefit manager to do so if any of the following conditions are met, whereas the substitute does not:

- the original claim was submitted fraudulently;
- the original claim payment was incorrect because the pharmacist or pharmacy had already been paid for the pharmacist service; or
- the pharmacist or pharmacy made a substantive non-clerical or non-recordkeeping error that led to the patient receiving the wrong prescription drug or dosage.

Whereas the introduced, except for a claim that meets one of those conditions, limited a health benefit plan issuer or pharmacy benefit manager to only recouping the dispensing fee paid by that issuer or manager to the pharmacist or pharmacy associated with the audited claim and prohibited that issuer or manager from recouping from the pharmacist or pharmacy the cost of the drug or any other amount related to the claim, the substitute authorizes a health benefit plan

issuer or pharmacy benefit manager to recoup from a pharmacist or pharmacy the cost of a prescription drug and the dispensing fee for the drug if the related claim meets one of those conditions and limits that issuer or manager to recouping only the dispensing fee from a pharmacist or pharmacy if the pharmacist or pharmacy made a clerical error that led to an overpayment.

The substitute includes provisions absent from the introduced that do the following:

- authorize a health benefit plan issuer or pharmacy benefit manager to make an adverse material change to a pharmacy benefit network contract during the term of the contract only with the mutual agreement of the parties;
- establish that a provision in the contract that allows a health benefit plan issuer or pharmacy benefit manager to unilaterally make an adverse material change during the term of the contract is void and unenforceable;
- prohibit an adverse material change to a pharmacy benefit network contract from going into effect until the 120th day after the date the pharmacist or pharmacy affirmatively agrees to the adverse material change in writing;
- require an adverse material change to a pharmacy benefit network contract proposed by a health benefit plan issuer or pharmacy benefit manager to include notice that clearly and conspicuously states that a pharmacist or pharmacy may choose to not agree to the adverse material change and that the decision to not agree to the adverse material change does not affect the terms of the applicable contract or the pharmacist's or pharmacy's participation in another health benefit network;
- establish that a pharmacist's or pharmacy's decision to not agree to an adverse material change to a pharmacy benefit network contract does not affect the terms of the applicable contract or the pharmacists' or pharmacy's participation in another health benefit network;
- establish that a health benefit plan issuer's or pharmacy benefit manager's failure to include the notice with the proposed adverse material change makes an otherwise agreed-to adverse material change void and unenforceable; and
- exempt certain pharmacy benefit network contracts and a proposed modification or addendum to a pharmacy benefit network contract that is required by state or federal law or rule from the application of these provisions; and
- define the term "adverse material change."

The substitute omits the following from the introduced:

- a requirement for a pharmacist or pharmacy to have an opportunity to refuse a proposed modification or addendum to a pharmacy benefit network contract; and
- a prohibition against a proposed modification or addendum taking effect without the signed approval of the pharmacist or pharmacy.

Both the introduced and the substitute require a health benefit plan issuer or pharmacy benefit manager, not later than the 90th day before the date a proposed modification or addendum to a pharmacy benefit network contract is to take effect, to take certain actions with respect to that modification or addendum. However, the substitute establishes that the requirement applies with respect to a proposed modification or addendum to a pharmacy benefit network contract other than an adverse material change, whereas the introduced did not. The substitute also includes provisions absent from the introduced that do the following with respect to proposed modifications or addendums:

- authorize a health benefit plan issuer or pharmacy benefit manager, if a pharmacist or pharmacy does not respond before the 31st day after the date the pharmacist or pharmacy receives notice of a proposed modification or addendum, to consider the proposed modification or addendum approved by the pharmacist or pharmacy and establish that such a modification or addendum takes effect on the date described by the bill's provisions; and

- exempt certain pharmacy benefit network contracts and a proposed modification or addendum to a pharmacy benefit network contract that is required by state or federal law or rule from the application of these provisions.

Both the introduced and the substitute prohibit a pharmacy benefit network contract from incorporating by reference a document not included in a contract or contract attachment, including a provider manual. However, the substitute specifies that an applicable provider manual is a provider manual described by the bill's provisions, whereas the introduced did not.

The substitute includes a requirement absent from the introduced for a health benefit plan issuer or pharmacy benefit manager to make a provider manual readily available on the online portal described by the bill's provisions and post a modification or addendum to the provider manual to the online portal in the same manner as a contract modification or addendum under the bill's provisions.

The substitute omits a prohibition from the introduced against a health benefit plan issuer or pharmacy benefit manager charging a pharmacist or pharmacy already participating in the pharmacy benefit network a fee related to re-credentialing or re-enrollment or a similar fee.