

BILL ANALYSIS

C.S.H.B. 1161
By: Davis, Sarah
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties suggest that women should have greater access to contraception and that such access would have the effect of lowering state Medicaid costs. C.S.H.B. 1161 seeks to address this issue by establishing certain requirements for health benefit plan coverage of prescription contraceptive drugs.

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. 1161 amends the Insurance Code to require certain health benefit plans that provide benefits for a prescription contraceptive drug to provide for an enrollee to obtain up to a three-month supply of the covered prescription contraceptive drug at one time the first time the enrollee obtains the drug and up to a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health benefit plan the first time the enrollee obtained the drug. The bill limits to one the number of 12-month supplies of a covered prescription contraceptive drug an enrollee may obtain during each 12-month period. The bill establishes the applicability of its provisions and requires, to the extent allowed by federal law, the child health plan program, the health benefits plan for certain children who are qualified aliens, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to recipients through a managed care plan to provide the coverage required by the bill to a recipient. The bill applies to an applicable health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2018.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1161 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED

SECTION 1. Section 1369.102, Insurance Code, is amended.

SECTION 2. Subchapter C, Chapter 1369, Insurance Code, is amended by adding Section 1369.1031 to read as follows:

Sec. 1369.1031. CERTAIN COVERAGE REQUIRED. (a) This section applies to a health benefit plan described by Section 1369.102.

(b) This section applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this section applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this section applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(e) Notwithstanding Sections 1507.004 and 1507.053, or any other law, this section applies to a consumer choice of benefits plan issued under Chapter 1507.

(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to recipients through a managed care plan shall provide the coverage required under this section to a recipient.

(g) A health benefit plan that provides benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to a 12-month supply of the covered prescription contraceptive drug at one time.

HOUSE COMMITTEE SUBSTITUTE

SECTION 1. Same as introduced version.

SECTION 2. Subchapter C, Chapter 1369, Insurance Code, is amended by adding Section 1369.1031 to read as follows:

Sec. 1369.1031. CERTAIN COVERAGE REQUIRED. (a) This section applies to a health benefit plan described by Section 1369.102.

(b) This section applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this section applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(d) Notwithstanding Sections 1507.004 and 1507.053, or any other law, this section applies to a consumer choice of benefits plan issued under Chapter 1507.

(e) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to recipients through a managed care plan shall provide the coverage required under this section to a recipient.

(f) A health benefit plan that provides benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to:

(1) a 3-month supply of the covered prescription contraceptive drug at one time

the first time the enrollee obtains the drug;
and

(2) a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health benefit plan the first time the enrollee obtained the drug.

(g) An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

SECTION 3. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2018, 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.

SECTION 3. Same as introduced version.

SECTION 4. This Act takes effect September 1, 2017.

SECTION 4. Same as introduced version.