SUBJECT: Consistent drug formularies for health plan enrollment periods

COMMITTEE: Insurance — favorable, without amendment

VOTE: 5 ayes — Burnam, G. Lewis, J. Moreno, Olivo, Thompson

1 nay — Seaman

2 present, not voting — Smithee, Eiland

1 absent — Wise

SENATE VOTE: On final passage, May 3 — voice vote (Fraser recorded nay)

WITNESSES: *(On House companion bill, HB 2495:)*
For — Lisa McGiffert, Consumers Union; Kim McPherson, The Mental Health Association in Texas; Jefferson E. Nelson, Texas Society of Psychiatric Physicians

Against — Jeff Kloster, Texas Association of Health Plans

BACKGROUND: Drug formularies are lists of drugs for which a health-benefit plan provides coverage, approves payment, or encourages or offers incentives for physicians to prescribe. Drugs that are not on a drug formulary usually are not covered by the plan.

The Administrative Code (28 TAC 11.506, subsection 25) requires health-benefit plans to mention in their contracts that a drug formulary is subject to change. The Texas Department of Insurance (TDI) has adopted a rule that health-benefit plans must notify enrollees 90 days before changing a drug formulary. This notice may be provided in the plan's newsletter or in a separate letter. Once notice is given, enrollees may appeal adverse determinations of drug coverage to an independent review organization. An adverse determination is the denial of coverage for a treatment because a plan has determined that the treatment is not medically necessary. Insurance Code, art. 21.58A establishes standards for the independent review of adverse determinations.

DIGEST:

SB 1030 would require a group health-benefit plan to make a prescription drug that was approved or covered for a medical condition or mental illness available to each enrollee at the contracted benefit level until the enrollee's renewal date, regardless of whether the prescribed drug had been removed from the plan's formulary. The bill would not prevent a health-care provider from prescribing another drug that was covered by the plan and was medically appropriate for the enrollee.

Under the bill, a plan's refusal to cover a drug that was not included in the drug formulary and the drug had been determined by the physician to be medically necessary would constitute an adverse determination. The enrollee could appeal this determination to an independent review organization under Insurance Code, art. 21.58A.

Health-benefit plans that use drug formularies would have to provide the following documentation in plain language to enrollees:

- notice that the plan uses one or more drug formularies;
- an explanation of what a drug formulary is;
- a statement regarding the method the plan uses to determine which prescription drugs are included or excluded from a drug formulary;
- a statement of how often the plan reviews each drug formulary; and
- notice that an enrollee may ask the plan if a specific drug is on a particular drug formulary.

If anyone asked whether a formulary included a particular drug, the plan would have to disclose that information within three business days of the request. The plan would have to notify the person requesting the information that the presence of the drug on the formulary did not guarantee that a health-care provider would prescribe that drug.

The insurance commissioner could adopt rules to implement these provisions.

Health-benefit plans that would be covered by SB 1030 include those offered by insurance companies, health-maintenance organizations, group hospital benefit corporations, stipulated premium insurance companies, reciprocal exchanges, certified multiple-employer welfare arrangements, and certified nonprofit health corporations. SB 1030 would *not* apply to:

- health-benefit plans that offer coverage only for a specified disease or limited benefit, for accidental death or dismemberment, for lost wages, as supplemental liability insurance, for credit insurance, for dental or vision care, for hospital expenses, or for indemnity for hospital confinement;
- small-employer health-benefit plans;
- Medicare supplemental policies;
- workers' compensation insurance coverage;
- medical payment insurance coverage issued as part of an automobile insurance policy; or
- a long-term care policy, including a nursing-home fixed indemnity policy, unless the insurance commissioner determined that the policy was so comprehensive that it belonged within the scope of this bill.

The bill would take effect September 1, 1999, and would apply only to a group health-benefit plan delivered, issued for delivery, or renewed on or after January 1, 2000.

SUPPORTERS SAY:

SB 1030 would require a group health-benefit plan to honor the drug formulary that was in effect when an enrollee chose the plan. Plans should not be allowed to breach their contract and drop drugs from the formulary when the enrollee is trapped in the plan until the next enrollment period. This bill would respond to many complaints by enrollees and health-care providers about drug formularies.

Formulary changes unfairly affect enrollees with chronic conditions. It sometimes takes six months to two years for a physician and patient to find the appropriate combination of drugs to treat certain illnesses. Months and years of work spent finding this combination can be lost if the plan drops the drug from the formulary.

Many people select a plan because a drug that they need is on the plan's formulary. It is a form of false advertising for a plan to drop coverage for a drug once someone has selected the plan because it covers that drug.

TDI's current notice rule does not offer enough protection for the enrollee. Notice of the changes to a drug formulary can be hidden in a newsletter and never seen by an enrollee until the 90 days has passed. Even if the enrollee sees the notice and initiates the review process, the burden is on the enrollee to prove that the drug is medically necessary. Enactment of SB 1030 would

guarantee the availability of drugs until the renewal period. Enrollees who might be fighting life-threatening illnesses would not have to fight their health-benefit plans as well.

This bill would apply only to drug coverage and would not require a physician to prescribe any particular drug, including one no longer approved by the federal Food and Drug Administration (FDA) or one that was not medically necessary. The bill would not hinder a physician from changing a prescription if another drug on the formulary was medically appropriate and could be substituted.

OPPONENTS SAY:

SB 1030 would be a nightmare for physicians and providers because health-care contracts roll over constantly. A physician can see employees from three or four different companies that are covered by the same health plan, but the companies may have signed or renewed their contracts at different times. Under SB 1030, the drug formularies for enrollees in the different companies would vary depending on when the company signed or renewed its contract with the health plan. The physician would have to know which employees were covered by the February drug formulary, the March drug formulary, the April drug formulary, and so on.

TDI responded to enrollee and provider complaints by adopting its 90-day notice rule. This rule has been in effect only since February 1999 and has not been given enough time to work. The 90-day notice rule is a more practical answer that will allow all enrollees to have the same drug formulary. If notice through a newsletter is insufficient, the Legislature should correct that problem by codifying an amended version of the TDI rule, rather than by enacting SB 1030.

The independent review process is not an added burden for enrollees who have been denied drug coverage. Rather, it is the basic protection that the Legislature has required for an adverse determination of any treatment.

OTHER OPPONENTS SAY:

The bill should include provisions that would allow a plan to drop a drug from the formulary for safety reasons. The FDA may revoke approval for a drug that has been found to be unsafe, but SB 1030 would force the plan to cover the drug for the entire enrollment period.

In its current form, SB 1030 would not go far enough. Drug formularies should be consistent for as long as an enrollee is with a plan so that enrollees do not have to change plans constantly to get the drug coverage they need.

NOTES:

HB 2495 by Farabee et al., identical to SB 1030, passed the House on the Local, Consent, and Resolutions Calendar on May 11. HB 2495 was reported favorably by the Senate Economic Development Committee on May 14 and sent to the Senate Local and Uncontested Calendar.