SUBJECT: Requiring notice of change in prescription drug benefits coverage

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Lucio, Oliverson, S. Davis, Julie Johnson, Lambert, Paul, C. Turner, Vo

0 nays

1 absent — G. Bonnen

WITNESSES: For — Joshua Stolow, Coalition of State Rheumatology Organizations; Chase Bearden, Coalition of Texans with Disabilities; Greg Hansch, National Alliance on Mental Illness Texas; Kevin Finkel; (*Registered, but did not testify*: Audra Conwell, Alliance of Independent Pharmacists; Denise Rose, AstraZeneca; Jo DePrang, Children's Defense Fund-Texas; James Mathis, Houston Methodist Hospital; Christine Yanas, Methodist Healthcare Ministries of South Texas, Inc.; Marilyn Hartman and Tesia Krzeminski, National Alliance on Mental Illness Austin; Kaska Watson, Nation Infusion Center Association; Will Francis, National Association of Social Workers-Texas Chapter; Simone Nichols-Segers, National MS Society; Marshall Kenderdine, Texas Academy of Family Physicians; Jessica Boston, Texas Association of Business; Cheri Huddleston, Texas Central Hemophilia; Tom Kowalski, Texas Healthcare and Bioscience Institute; Cameron Duncan, Texas Hospital Association; Duane Galligher, Texas Independent Pharmacies Association; Doug Curran, Texas Medical Association; Clayton Travis, Texas Pediatric Society; Michael Muniz, Texas Pharmacy Association; John Henderson, Texas Organization of Rural and Community Hospitals; Lee Ann Hampton; Charles Weaver)

Against — Melodie Shrader, PCMA; LuGina Mendez-Harper, Prime Therapeutics; Jamie Dudensing, Texas Association of Health Plans; (*Registered, but did not testify*: Billy Phenix, America's Health Insurance Plans; Bill Kelly, City of Houston Mayor’s Office)

On — Robin Vincent, Harris County Human Resources and Risk

Management; (*Registered, but did not testify*: Rachel Bowden, Texas Department of Insurance)

BACKGROUND:

Insurance Code sec. 1369.0541(a) allows a health benefit plan issuer to modify its prescription drug coverage if:

- the modification occurs at the time of coverage renewal;
- the modification is effective uniformly among all group health benefit plan sponsors or individuals covered by identical or substantially identical plans; and
- by the 60th day before the modification is effective, the issuer provides written notice of the change to the Texas Department of Insurance commissioner and each affected plan sponsor, enrollee, and individual plan holder.

Sec. 1369.0541(b) requires a health plan to provide notice of modifications affecting drug coverage if it:

- removes a drug from a formulary;
- adds a preauthorization requirement;
- imposes or alters a quantity limit;
- imposes a step-therapy restriction; or
- moves a drug to a higher cost-sharing tier unless a generic drug alternative is available.

Sec. 1369.055 requires an issuer to offer each enrollee at the contracted benefit level any prescription drug that was approved or covered under the plan for a medical condition or mental illness until the enrollee's plan renewal date, regardless of whether the drug has been removed from the plan's drug formulary before that date.

DIGEST:

CSHB 2099 would require a health benefit plan issuer to provide notice of modifications affecting prescription drug coverage if the modification:

- increased a coinsurance, copayment, deductible, or other out-of-pocket expense; or

- reduced the maximum drug coverage amount.

The bill would require the notice to include a statement explaining the type of modification and indicating that on renewal of the health benefit plan, the plan issuer could not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year.

Exceptions. Under the bill, modifications affecting drug coverage that were more favorable to enrollees could be made at any time, and notice would not be required if the modification:

- added a drug to a formulary;
- reduced an enrollee's coinsurance, copayment, deductible, or other out-of-pocket expense; or
- removed a utilization review requirement.

Renewal. On renewal of a health benefit plan, the plan issuer could not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year and prescribed during that year for an enrollee's medical condition or mental illness if:

- the enrollee was covered by the plan on the date immediately preceding the renewal date;
- a physician or other prescribing provider prescribed the drug for the medical condition or mental illness; and
- the physician or other prescribing provider in consultation with the enrollee determined that the drug was the most appropriate course of treatment.

The bill would require a health plan to provide coverage to an enrollee under the circumstances described above.

The bill would prohibit certain modifications regarding a health plan issuer's drug coverage during the renewal period, including:

- removing a drug from a formulary;
- adding a preauthorization requirement;
- imposing or altering a quantity limit;
- imposing a step-therapy restriction;
- moving a drug to a higher cost-sharing tier;
- increasing a coinsurance, copayment, deductible, or other out-of-pocket expense; and
- reducing the maximum drug coverage amount.

The bill would not prohibit:

- a health benefit plan issuer from requiring a pharmacist to provide a substitution for a prescription drug in accordance with statute under which the pharmacist could substitute an interchangeable biological product or therapeutically equivalent generic product as determined by the U.S. Food and Drug Administration (FDA);
- a physician or other prescribing provider from prescribing another medication; or
- the health plan issuer from adding a new drug to a formulary.

The bill also would not prohibit a health plan issuer from removing a drug from its formulary or denying an enrollee drug coverage if:

- the FDA issued a statement questioning the drug's clinical safety;
- the manufacturer notified the FDA of the drug's manufacturing discontinuance or potential discontinuance; or
- the drug manufacturer removed the drug from the market.

The bill would take effect September 1, 2019, and would apply only to a health benefit plan issued or renewed on or after January 1, 2020.

SUPPORTERS SAY:

CSHB 2099 would address gaps in existing protections against non-medical switching, which occurs when health plans force patients off medications for financial reasons instead of medical ones. When patients

lose access to treatment, they often experience recurring symptoms, further disease progression, missed work, and even hospitalization. The bill would ensure patients continued receiving prescribed medications, as long as a patient remained on the same health plan and was previously approved by the plan for that medication.

The bill would help prevent unnecessary health care costs, including increased doctor and ER visits and hospitalizations. The bill also would not change the way health plans negotiate prices with drug manufacturers. Health plans could continue updating their formularies as needed or incentivize one medication over another by offering less expensive drugs, but they could not reduce coverage for patients' preexisting prescriptions.

OPPONENTS SAY:

CSHB 2099 could cause health plans to freeze their drug formularies, resulting in significantly increased costs for the health care system. The bill would be unnecessary because existing step therapy provisions protect patients from drug formulary and plan changes.