SUBJECT: Requiring notice of change in prescription drug benefits coverage

COMMITTEE: Insurance — favorable, without amendment

VOTE: 7 ayes — Oliverson, Vo, J. González, Israel, Middleton, Romero, Sanford

2 nays — Hull, Paul

WITNESSES: For — Chase Bearden, Coalition of Texans with Disabilities; Greg Hansch, National Alliance on Mental Illness-Texas; Kevin Finkel; (*Registered, but did not testify*: Michael Wright, American Pharmacies; Denise Rose, AstraZeneca; Christine Bryan, Clarity Child Guidance Center; Dennis Borel, Coalition of Texans with Disabilities; Alison Mohr Boleware, National Association of Social Workers-Texas Chapter; Rebecca Galinsky, Protect TX Fragile Kids; Josette Saxton, Texans Care for Children; Marshall Kenderdine, Texas Academy of Family Physicians; Melissa Compton, Texas Bleeding Disorders Coalition; David Reynolds, Texas Chapter of the American College of Physicians; Janis Carter, Texas Federation of Drug Stores; Cameron Duncan, Texas Hospital Association; Clayton Stewart, Texas Medical Association; Kevin Stewart, Texas Nurses Association; Duane Galligher, Texas Pharmacy Association; Khrystal Davis, Texas Rare Alliance; Thomas Parkinson)

Against — Melodie Shrader, Pharmaceutical Care Management Association; Jamie Dudensing, Texas Association of Health Plans; Bill Hammond, Texas Employers for Insurance Reform; (*Registered, but did not testify*: Billy Phenix, America's Health Insurance Plans; Patricia Kolodzey, Blue Cross Blue Shield of Texas; Eric Glenn, Superior Health Plan)

On — Libby Elliott, Texas Department of Insurance; (*Registered, but did not testify*: Jenny Blakey, Office of Public Insurance Counsel)

BACKGROUND: Insurance Code ch. 1369, subch. B governs certain health benefit plans that provide coverage of prescription drugs specified by a drug formulary. The subchapter does not apply to certain health plans, including:

- a Medicare supplemental policy;
- a workers' compensation insurance policy;
- the Children's Health Insurance Program (CHIP) or the health benefits plan for certain other children; and
- the state Medicaid program, including Medicaid managed care.

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. 1369.055 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:

HB 1646 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 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.

The bill would not apply to a self-funded health benefit plan as defined by the Employee Retirement Income Security Act.

**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 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 not require a health plan to provide coverage to an enrollee excluded by the above circumstances during the renewal period.

The bill would prohibit certain modifications regarding a health plan'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 plan 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 from adding a new drug to a formulary.

The bill also would not prohibit a health plan 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, 2021, and would apply only to a health benefit plan issued or renewed on or after January 1, 2022.

SUPPORTERS SAY:

HB 1646 would address gaps in existing protections against nonmedical 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.

CRITICS SAY:

HB 1646 could cause health plans to freeze their drug formularies, resulting in significantly increased costs for the health care system. Freezing drug formularies inhibits the ability of health plans to negotiate lower drug prices. The bill is unnecessary because existing step therapy provisions protect patients from drug formulary and plan changes.