BILL ANALYSIS

Senate Research Center

H.B. 2495
By: Farabee (Madla)
Economic Development
5/13/1999
Engrossed

DIGEST

Currently, if a health plan changes the formulary in the middle of a contract period, during which time a consumer is unable to change coverage, the consumer is left with a health plan that lacks the drug needed for the consumer's medical condition or mental illness. A formulary is a list of prescription drugs that a health plan will pay for. Health plans have increasingly relied on formularies to control the rising cost of prescription medicines. Consumers with specific prescription drug needs often choose a health plan based on whether the prescription drug they require is part of the health plan's formulary. H.B. 2495 would require group health plans to continue covering a medication previously on its formulary list for the remainder of a contract period.

PURPOSE

As proposed, H.B. 2495 requires group health plans to continue covering a medication previously on its formulary list for the remainder of a contract period.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance in SECTION 1 (Article 21.52J, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter E, Chapter 21, Insurance Code, by adding Article 21.52J, as follows:

Article 21.52J. USE OF PRESCRIPTION DRUG FORMULARY
BY GROUP HEALTH BENEFIT PLAN

Sec. 1. DEFINITIONS. Defines "drug formulary," "enrollee," "group health benefit plan," "physician," and "prescription drug."

Sec. 2. SCOPE OF ARTICLE. Sets forth the scope of this article, specifying the group health benefit plans (plans) that are applicable and the plans that are not applicable.

Sec. 3. DISCLOSURE OF DRUG FORMULARY REQUIRED. Requires a plan that covers prescription drugs and that uses one or more drug formularies to specify which prescription drugs the plan will cover to provide the specified information to each enrollee in plain language in the coverage documentation provided to the enrollee; disclose to any individual on request, within three businesses days, whether a specific drug is on a particular drug formulary; and notify an enrollee or any other individual who requests information about a drug formulary that the presence of a drug on a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness.

Sec. 4. CHANGES TO PRESCRIPTION DRUG FORMULARY; CONTINUATION OF BENEFITS REQUIRED. Requires a group health benefit plan that offers prescription drug benefits to make a prescription drug that was approved or covered fora medical condition or mental illness available to each enrollee at the contracted benefit level until the enrollee's plan renewal date, regardless of whether the prescribed drug has been removed from the health benefit plan's drug formulary. Provides that this section does not preclude a physician or other health professional authorized to prescribe a drug from prescribing another drug covered by the group health benefit plan that is medically appropriate for the enrollee.

Sec. 5. NONFORMULARY PRESCRIPTION DRUGS; ADVERSE DETERMINATION. Provides that if a plan, through any of its employees or agents, refuses to provide benefits to an enrollee for a drug that is not included in a drug formulary and that the enrollee's physician has determined is medically necessary, the refusal constitutes an adverse determination for purposes of Section 2, Article 21.58A. Authorizes an enrollee to appeal the adverse determination under Sections 6 and 6a, Article 21.58A, of this code.

Sec. 6. RULES. Authorizes the commissioner of insurance to adopt rules to implement this article.

SECTION 2. Effective date: September 1, 1999.
Makes application of this Act prospective to January 1, 2000.

SECTION 3. Emergency clause.