BILL ANALYSIS

Senate Research Center
76R10367 DLF-F

C.S.S.B. 1030
By: Madla
Economic Development
4/28/1999
Committee Report (Substituted)

DIGEST

Currently, the Texas Department of Insurance rules require insurers to give enrollees 90 days notice of any drug formulary changes, allowing insurers to change drug formularies within the enrollees' contract period. This bill would permit enrollees to continue to use prescribed formulary drugs until their insurance contract ends, even if a prescribed drug has been removed from the formulary, and if a physician prescribes a nonformulary drug, the enrollee could appeal, using the independent review process, to have the prescribed drug covered.

PURPOSE

As proposed, C.S.S.B. 1030 regulates the use of a prescription drug formulary by a group health benefit plan.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the insurance commissioner in SECTION 1 (Section 6, Article 21.52J, Chapter 21E, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

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

Art. 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 certain group health benefit plans to which this article applies. Provides that this article does not apply to certain health benefit plans and insurance.

Sec. 3. DISCLOSURE OF DRUG FORMULARY REQUIRED. Requires a group health benefit plan that covers prescription drugs and that uses one or more drug formularies to specify which prescription drugs the plan will cover to provide to each enrollee notice that the plan uses drug formularies and certain information about the drug formulary.

Sec. 4. CHANGES TO PRESCRIPTION DRUG FORMULARY; CONTINUATION OF BENEFITS REQUIRED. Requires a group health benefit plan that offers prescription drug benefits to make an approved or covered prescription drug 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 group health benefit plan, through any of its employees or agents, refuses to provide benefits to an enrollee for a nonformulary drug and that the enrollee's physician has determined is medically necessary, the refusal shall constitute an adverse determination within the meaning of Section 2, Article 21.58A of this code. Authorizes an enrollee to appeal the adverse

determination under Sections 6 and 6A, Article 21.58A of this code.

Sec. 6. RULES. Authorizes the insurance commissioner 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.

SUMMARY OF COMMITTEE CHANGES

Relating clause.

Adds text regarding the use of a prescription drug formulary by a group health benefit plan.

SECTION 1.

Amends Chapter 21E, Insurance Code, by adding Article 21.52J, rather than adding Article 21.53L, to provide a new heading.

Sec. 1. DEFINITIONS. Defines "group health benefit plan" and redefines "enrollee." Deletes the definition of a "health benefit plan."

Sec. 2. SCOPE OF ARTICLE. Revises the group health benefit plans to which this article applies. Revises which health benefit plans and insurance to which this article does not apply. Deletes text providing that this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code.

Sec. 3. DISCLOSURE OF DRUG FORMULARY REQUIRED. Requires a group health benefit plan that covers prescription drugs and that uses one or more drug formularies to specify which prescription drugs the plan will cover to provide to each enrollee notice that the plan uses drug formularies and certain information about the drug formulary.

Sec. 4. New heading: CHANGES TO PRESCRIPTION DRUG FORMULARY; CONTINUATION OF BENEFITS REQUIRED. Redesignates proposed Section 3 as Section 4. Makes conforming and nonsubstantive changes.

Sec. 5. New heading: NONFORMULARY PRESCRIPTION DRUGS; ADVERSE DETERMINATION. Makes conforming and nonsubstantive changes.

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