BILL ANALYSIS

Senate Research Center

H.B. 1405
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State Affairs
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

For policyholders employed by small businesses or covered by individual plans, insurance companies can move a medication from a lower tier to a more costly tier at any time during the enrollee's contract year. This can unexpectedly increase costs for prescriptions drugs and place a heavy financial burden on those dependent upon this medication. For those with financial limitations, this increase in an individual's share of the prescription drug payment can lead to a choice between life-saving medicine or daily necessities such as food.

Current law prevents an issuer of a health plan that covers prescription drugs for a large employer from changing the cost of the medication before the renewal date. However, this does not extend to small businesses and individual plans. Enrollees must adhere to the contracts that are made whereas policy issuers are not held to those same requirements.

H.B. 1405 requires disclosure to enrollees of what a drug formulary is, whether a certain drug is included, and the method used to determine which drugs are included. It requires informing enrollees that being included does not necessarily mean the physician will prescribe it. In addition, a drug approved under the enrollee's plan will be offered to the patient until the plan renewal date regardless if it is removed from the drug formulary before that time. These provisions do not apply to the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or a Medicaid managed care program operated under Chapter 533 (Public Disclosrue), Government Code. A health benefit plan issuer may modify the drug coverage if the changes take place at the time of renewal, changes are uniform throughout all sponsors covered by identical plans, and are made not later than the 60th day before they are effective. Notice of the changes is required if a drug is removed from the formulary, if a requirement for receiving drug is added, if a quantity limit is imposed, or if the drug is moved to a more costly tier. The notifications may be sent via email.

H.B. 1405 amends current law relating to provision by a health benefit plan of prescription drug coverage specified by formulary.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1369.051(2), Insurance Code, to define "enrollee" as an individual who is covered under a health benefit plan, including a covered dependent, rather than an individual who is covered under a group health benefit plan.

SECTION 2. Amends Section 1369.052, Insurance Code, as follows:

> Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group

hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

(3) a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies);

(4) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(5) a reciprocal exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges);

(6) a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements); or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations).

SECTION 3. Amends Section 1369.053, Insurance Code, as follows:

Sec. 1369.053. EXCEPTION. Provides that this subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended, rather than a small employer health benefit plan written under Chapter 1501;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner of insurance determines that the policy provides

benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.052;

(6) the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 533 (Public Disclosure), Government Code, or a Medicaid program operated under Chapter 32 (Medical Assistance Program), Human Resources Code.

SECTION 4. Amends Section 1369.054, Insurance Code, to make a conforming change.

SECTION 5. Amends Section 1369.055, Insurance Code, to make conforming changes.

SECTION 6. Amends Section 1369.056(a), Insurance Code, to make conforming changes.

SECTION 7. Makes application of this Act prospective to January 1, 2012.

SECTION 8. Effective date: September 1, 2011.