BILL ANALYSIS

Senate Research Center
86R13008 SMT-F

H.B. 2099
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Business & Commerce
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

H.B. 2099 amends current law relating to modification of certain prescription drug benefits and coverage offered by certain health benefit plans.

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 1369.0541, Insurance Code, by amending Subsections (a) and (b) and adding Subsections (a-1) and (b-1), as follows:

(a) Creates an exception under Section 1369.055(a-1) and Subsection (b-1) to the authorization of a health benefit plan issuer to modify drug coverage provided under a health benefit plan if:

(1)–(3) makes no changes to these subdivisions.

(a-1) Requires the notice described by Subsection (a)(3) to include a statement:

(1) indicating that the health benefit plan issuer is modifying drug coverage provided under the health benefit plan;

(2) explaining the type of modification; and

(3) indicating that, on renewal of the health benefit plan, the health benefit plan issuer is prohibited from modifying an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year as provided by Section 1369.055(a-1).

(b) Provides that modifications affecting drug coverage that require notice under Subsection (a) include:

(1)–(3) makes no changes to these subdivisions;

(4) makes a nonsubstantive change;

(5) moving a drug to a higher cost-sharing tier, rather than moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available;

(6) increasing a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and

(7) reducing the maximum drug coverage amount.

(b-1) Authorizes modifications affecting drug coverage that are more favorable to enrollees to be made at any time and provides that they do not require notice under Subsection (a), including:

(1) the addition of a drug to a formulary;

(2) the reduction of a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and

(3) the removal of a utilization review requirement.

SECTION 2. Amends Section 1369.055, Insurance Code, by adding Subsections (a-1), (a-2), and (c), as follows:

(a-1) Prohibits the plan issuer, on renewal of a health benefit plan, from modifying 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 a medical condition or mental illness of the enrollee if:

(1) the enrollee was covered by the health benefit plan on the date immediately preceding the renewal date;

(2) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness; and

(3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment.

(a-2) Provides that modifications prohibited under Subsection (a-1) include:

(1) removing a drug from a formulary;

(2) adding a requirement that an enrollee receive prior authorization for a drug;

(3) imposing or altering a quantity limit for a drug;

(4) imposing a step-therapy restriction for a drug;

(5) moving a drug to a higher cost-sharing tier;

(6) increasing a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and

(7) reducing the maximum drug coverage amount.

(c) Provides that Subsections (a-1) and (a-2) do not:

(1) prohibit a health benefit plan issuer from requiring, by contract, written policy or procedure, or other agreement or course of conduct, a pharmacist to provide a substitution for a prescription drug in accordance with Subchapter A (Prescription and Substitution Requirements), Chapter 562, Occupations Code, under which the pharmacist may substitute an interchangeable biologic product or therapeutically equivalent generic product as determined by the United States Food and Drug Administration (FDA);

(2) prohibit a physician or other prescribing provider from prescribing another medication;

(3) prohibit the health benefit plan issuer from adding a new drug to a formulary;

(4) require a health benefit plan to provide coverage to an enrollee under circumstances not described by Subsection (a-1); or

(5) prohibit a health benefit plan issuer from removing a drug from its formulary or denying an enrollee coverage for the drug if:

(A) the FDA has issued a statement about the drug that calls into question the clinical safety of the drug;

(B) the drug manufacturer has notified the FDA of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C, Federal Food, Drug, and Cosmetic Act (21 U.S.C. Section 356c); or

(C) the drug manufacturer has removed the drug from the market.

SECTION 3. Makes application of this Act prospective to January 1, 2020.

SECTION 4. Effective date: September 1, 2019.