

BILL ANALYSIS

Senate Research Center
88R20842 RDS-F

H.B. 999
By: Price et al. (Schwertner)
Health & Human Services
5/12/2023
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Patients may receive copay assistance coupons from a drug manufacturer or other types of copay assistance from other organizations to help with payment for medications. However, according to the Texas All Copays Count Coalition, this assistance is not necessarily being recognized by health benefit plans or pharmacy benefit managers and therefore is not counted toward an enrollee's insurance deductible or annual out-of-pocket maximum.

H.B. 999 seeks to address this issue by requiring a health benefit plan that covers prescription drugs or a pharmacy benefit manager to apply any coupon or other reduction in out-of-pocket expenses made by or on behalf of an enrollee to the enrollee's deductible copayment, cost sharing responsibility, or out-of-pocket maximum applicable to prescription drug benefits.

H.B. 999 amends current law relating to the effect of certain reductions in a health benefit plan enrollee's out-of-pocket expenses for certain prescription drugs on enrollee cost-sharing requirements.

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 the heading to Subchapter B, Chapter 1369, Insurance Code, to read as follows:

SUBCHAPTER B. REQUIREMENTS AFFECTING COVERAGE OF SPECIFIC PRESCRIPTION DRUGS OR COST SHARING

SECTION 2. Amends Subchapter B, Chapter 1369, Insurance Code, by adding Section 1369.0542, as follows:

Sec. 1369.0542. EFFECT OF REDUCTIONS IN OUT-OF-POCKET EXPENSES ON COST SHARING. (a) Provides that this section applies only to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which:

- (1) a generic equivalent does not exist;
- (2) a generic equivalent does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:
 - (A) a prior authorization process;
 - (B) a step therapy protocol; or
 - (C) the health benefit plan issuer's exceptions and appeals process;

(3) an interchangeable biological product does not exist; or

(4) an interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:

(A) a prior authorization process;

(B) a step therapy protocol; or

(C) the health benefit plan issuer's exceptions and appeals process.

(b) Requires an issuer of a health benefit plan that covers prescription drugs or a pharmacy benefit manager to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan.

SECTION 3. Makes application of Section 1369.0542, Insurance Code, as added by this Act, prospective to January 1, 2024.

SECTION 4. Effective date: September 1, 2023.