

By: Johnson of Dallas, Lalani, Harless,
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H.B. No. 755

Substitute the following for H.B. No. 755:

By: Oliverson

C.S.H.B. No. 755

A BILL TO BE ENTITLED

AN ACT

1
2 relating to prior authorization for prescription drug benefits
3 related to the treatment of autoimmune diseases and certain blood
4 disorders.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

6 SECTION 1. Chapter 1369, Insurance Code, is amended by
7 adding Subchapter N to read as follows:

8 SUBCHAPTER N. COVERAGE OF PRESCRIPTION DRUGS FOR AUTOIMMUNE
9 DISEASES AND CERTAIN BLOOD DISORDERS

10 Sec. 1369.651. DEFINITION. In this subchapter,
11 "prescription drug" has the meaning assigned by Section 551.003,
12 Occupations Code.

13 Sec. 1369.652. APPLICABILITY OF SUBCHAPTER. (a) This
14 subchapter applies only to a health benefit plan that provides
15 benefits for medical, surgical, or prescription drug expenses
16 incurred as a result of a health condition, accident, or sickness,
17 including an individual, group, blanket, or franchise insurance
18 policy or insurance agreement, a group hospital service contract,
19 or an individual or group evidence of coverage or similar coverage
20 document that is issued by:

21 (1) an insurance company;

22 (2) a group hospital service corporation operating
23 under Chapter 842;

24 (3) a health maintenance organization operating under

- 1 Chapter 843;
2 (4) an approved nonprofit health corporation that
3 holds a certificate of authority under Chapter 844;
4 (5) a multiple employer welfare arrangement that holds
5 a certificate of authority under Chapter 846;
6 (6) a stipulated premium company operating under
7 Chapter 884;
8 (7) a fraternal benefit society operating under
9 Chapter 885;
10 (8) a Lloyd's plan operating under Chapter 941; or
11 (9) an exchange operating under Chapter 942.
12 (b) Notwithstanding any other law, this subchapter applies
13 to:
14 (1) a small employer health benefit plan subject to
15 Chapter 1501, including coverage provided through a health group
16 cooperative under Subchapter B of that chapter;
17 (2) a standard health benefit plan issued under
18 Chapter 1507;
19 (3) a basic coverage plan under Chapter 1551;
20 (4) a basic plan under Chapter 1575;
21 (5) a primary care coverage plan under Chapter 1579;
22 (6) a plan providing basic coverage under Chapter
23 1601;
24 (7) group health coverage made available by a school
25 district in accordance with Section 22.004, Education Code; and
26 (8) a self-funded health benefit plan sponsored by a
27 professional employer organization under Chapter 91, Labor Code.

1 (c) This subchapter applies to coverage under a group health
2 benefit plan provided to a resident of this state regardless of
3 whether the group policy, agreement, or contract is delivered,
4 issued for delivery, or renewed in this state.

5 Sec. 1369.653. EXCEPTIONS. (a) This subchapter does not
6 apply to:

7 (1) a plan that provides coverage:

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

11 (B) only for hospital expenses;

12 (2) the state Medicaid program, including the Medicaid
13 managed care program operated under Chapter 533, Government Code;
14 or

15 (3) the child health plan program under Chapter 62,
16 Health and Safety Code.

17 (b) This subchapter does not apply to an individual health
18 benefit plan issued on or before March 23, 2010, that has not had
19 any significant changes since that date that reduce benefits or
20 increase costs to the individual.

21 Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR
22 AUTHORIZATIONS. (a) A health benefit plan issuer that provides
23 prescription drug benefits may not require an enrollee to receive
24 more than one prior authorization annually of the prescription drug
25 benefit for a prescription drug prescribed to treat an autoimmune
26 disease, hemophilia, or Von Willebrand disease.

27 (b) This section does not apply to:

- 1 (1) opioids, benzodiazepines, barbiturates, or
2 carisoprodol;
3 (2) prescription drugs that have a typical treatment
4 period of less than 12 months;
5 (3) drugs that:
6 (A) have a boxed warning assigned by the United
7 States Food and Drug Administration for use; and
8 (B) must have specific provider assessment; or
9 (4) the use of a drug approved for use by the United
10 States Food and Drug Administration in a manner other than the
11 approved use.

12 SECTION 2. The change in law made by this Act applies only
13 to a health benefit plan that is delivered, issued for delivery, or
14 renewed on or after January 1, 2024.

15 SECTION 3. This Act takes effect September 1, 2023.