BILL ANALYSIS

C.S.H.B. 3025
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Many Americans live with at least one chronic disease, such as high blood pressure, diabetes, high cholesterol, or heart disease. Medication is often a primary source of medical treatment for these conditions and patients with multiple chronic conditions can have difficulty juggling the refills on their medication. This can lead to missed doses and interrupted treatment plans, which can result in avoidable and costly health complications, worsening of disease progression, and increased emergency room visits and hospital stays. Concerned parties observe that under a medicine synchronization plan, the patient, health care insurer, and pharmacist work together to determine which of the patient's prescriptions should be synchronized, allowing for the alignment of refill dates for prescription drugs. C.S.H.B. 3025 seeks to encourage the use of prescription drug synchronization plans.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3025 amends the Insurance Code to require a health benefit plan that provides benefits for prescription drugs to prorate any cost-sharing amount charged for a prescription drug dispensed in a quantity that is less than a 30 days' supply if the pharmacy or the covered person's prescribing physician or health care provider notifies the health benefit plan that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the covered person's prescription drugs and the synchronization is in the covered person's best interest and the covered person agrees to the synchronization. The bill requires the proration to be based on the number of days' supply of the drug actually dispensed. The bill prohibits a health benefit plan that prorates a cost-sharing amount from prorating the fee paid to the pharmacy for dispensing the drug for which the cost-sharing amount was prorated.

C.S.H.B. 3025 requires a health benefit plan to establish a process through which the health benefit plan, the covered person, the prescribing physician or health care provider, and a pharmacist may jointly approve a medication synchronization plan for medication to treat a covered person's chronic illness. The bill requires a health benefit plan to provide coverage for a medication dispensed in accordance with the dates established in the medication synchronization plan and to establish a process that allows a pharmacist or pharmacy to override the health benefit plan's denial of coverage for a medication to treat a person's chronic illness. The bill requires a health benefit plan to allow a pharmacist or pharmacy to override the health benefit

plan's denial of coverage through such a process and requires the health benefit plan to provide coverage for the medication if the prescription for the medication is being refilled in accordance with the medication synchronization plan and the reason for the denial is that the prescription is being refilled before the date established by the plan's general prescription refill guidelines.

C.S.H.B. 3025 applies to health benefit plans that provide benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness and that are offered by specified insurers; group coverage made available by a school district; health benefit plan coverage provided to state employees, public school employees, employees of The University of Texas System and The Texas A&M University System under the applicable programs; coverage under certain small employer health benefit plans; and to a consumer choice of benefits plan. The bill requires, to the extent allowed by federal law, the children's health plan program (CHIP), the health benefits plan for children for certain qualified aliens, the state Medicaid program, and a Medicaid managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients to provide the coverage required under the bill's provisions. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016.

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3025 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter H to read as follows: SUBCHAPTER H. COVERAGE RELATED TO PRESCRIPTION DRUG SYNCHRONIZATION	SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter H to read as follows: SUBCHAPTER H. COVERAGE RELATED TO PRESCRIPTION DRUG SYNCHRONIZATION
Sec. 1369.351. DEFINITIONS.	Sec. 1369.351. DEFINITIONS.
Sec. 1369.352. APPLICABILITY OF SUBCHAPTER. (a) 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 an individual or group evidence of coverage or similar coverage document that is offered by: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a health maintenance organization	Sec. 1369.352. APPLICABILITY OF SUBCHAPTER. (a) 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 an individual or group evidence of coverage or similar coverage document that is offered by: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a health maintenance organization

operating under Chapter 843;
(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
(6) a stipulated premium company operating under Chapter 884;
(7) a fraternal benefit society operating under Chapter 885; or
(8) an exchange operating under Chapter 942.
(b) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.
(c) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to health benefit plan coverage provided under:
(1) Chapter 1551;
(2) Chapter 1575;
(3) Chapter 1579; and
(4) Chapter 1601.
(e) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.
(f) This subchapter applies to a consumer choice of benefits plan issued under Chapter 1507.
(g) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients through a managed care plan shall provide the coverage required under this subchapter to a recipient.

Sec. 1369.353. PRORATION OF COST-SHARING AMOUNT REQUIRED.

operating under Chapter 843;
(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
(6) a stipulated premium company operating under Chapter 884;
(7) a fraternal benefit society operating under Chapter 885; or
(8) an exchange operating under Chapter 942.
(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to health benefit plan coverage provided under:
(1) Chapter 1551;
(2) Chapter 1575;
(3) Chapter 1579; and
(4) Chapter 1601.
(d) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.
(e) This subchapter applies to a consumer choice of benefits plan issued under Chapter 1507.
(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients through a managed care plan shall provide the coverage required under this subchapter to a recipient.

Sec. 1369.353. PRORATION OF COST-SHARING AMOUNT REQUIRED.

Sec. 1369.354. PRORATION OF DISPENSING FEE PROHIBITED.

Sec. 1369.355. IMPLEMENTATION OF PLAN.

No individual or group health insurance policy providing prescription drug coverage shall deny coverage for the dispensing of a chronic medication that is made in accordance with a plan among the health plan, individual beneficiary or group plan, a practitioner and a pharmacist for the purpose of synchronizing the filling or refilling of multiple prescriptions for the insured. The individual or group health plan must allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization.

Sec. 1369.354. PRORATION OF DISPENSING FEE PROHIBITED.

Sec. 1369.355. IMPLEMENTATION OF CERTAIN MEDICATION SYNCHRONIZATION PLANS. (a) For the purposes of this section:

(1) "Chronic illness" means an illness or physical condition that may be:

(A) reasonably expected to continue for an uninterrupted period of at least three months; and

(B) controlled but not cured by medical treatment.

(2) "Medication synchronization plan" means a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

(b) A health benefit plan shall establish a process through which the following parties may jointly approve a medication synchronization plan for medication to treat a covered person's chronic illness:

(1) the health benefit plan;

(2) the covered person;

(3) the prescribing physician or health care provider; and

(4) a pharmacist.

(c) A health benefit plan shall provide coverage for a medication dispensed in accordance with the dates established in the medication synchronization plan described by Subsection (b).

(d) A health benefit plan shall establish a process that allows a pharmacist or pharmacy to override the health benefit plan's denial of coverage for a medication described by Subsection (b).

(e) A health benefit plan shall allow a pharmacist or pharmacy to override the health benefit plan's denial of coverage through the process described by Subsection (d), and the health benefit plan shall provide coverage for the medication if:

(1) the prescription for the medication is being refilled in accordance with the medication synchronization plan described by Subsection (b); and

(2) the reason for the denial is that the prescription is being refilled before the date established by the plan's general prescription

	refill guidelines.
SECTION 2. This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2016. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 2. Same as introduced version.
SECTION 3. This Act takes effect September 1, 2015.	SECTION 3. Same as introduced version.