BILL ANALYSIS

C.S.H.B. 2099
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

There are concerns that changes in an insurance policy can force patients who find the right medication to control their condition to forgo treatments. C.S.H.B. 2099 seeks to address these concerns by helping to ensure that enrollees continue to have access to the medications that are right for them.

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. 2099 amends the Insurance Code to require the required notice provided by a health benefit plan issuer that modifies drug coverage under the plan to include a statement indicating that the health benefit plan issuer is modifying drug coverage provided under the plan, explaining the type of modification, and indicating that, on renewal of the plan, the issuer may not modify 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 certain bill provisions. The bill includes the increase of an out-of-pocket expense that an enrollee must pay for a drug and the reduction of the maximum drug coverage amount among the modifications that require such notice and removes the condition that the movement of a drug to a higher cost-sharing tier only requires notice if a generic drug alternative to the drug is not available. The bill authorizes modifications that are more favorable to enrollees to be made at any time and establishes that such modifications do not require notice. The bill specifies that such favorable modifications include the addition of a drug to a formulary; the reduction of a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and the removal of a utilization review requirement.

C.S.H.B. 2099 prohibits a health benefit plan issuer, on renewal of a 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:

- the enrollee was covered by the plan on the date immediately preceding the renewal date;
- a physician or other prescribing provider prescribes the drug for the medical condition or mental illness; and
- the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment.

The bill specifies that such prohibited modifications include:

- removing a drug from a formulary;
- adding a requirement that an enrollee receive prior authorization for a drug;
- imposing or altering a quantity limit for a drug;
- imposing a step-therapy restriction for a drug;
- moving a drug to a higher cost-sharing tier;
- increasing a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and
- reducing the maximum drug coverage amount.

C.S.H.B. 2099 establishes that the bill's provisions regarding prohibited modifications do not:

- 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 certain statutory provisions under which the pharmacist may substitute an interchangeable biologic product or therapeutically equivalent generic product as determined by the U.S. Food and Drug Administration (FDA);
- prohibit a physician or other prescribing provider from prescribing another medication;
- prohibit the health benefit plan issuer from adding a new drug to a formulary;
- require a health benefit plan to provide coverage to an enrollee under circumstances not described by the bill's provisions; or
- prohibit a health benefit plan issuer from removing a drug from its formulary or denying an enrollee coverage for the drug under the following conditions:
    - the FDA has issued a statement about the drug that calls into question the clinical safety of the drug;
    - the drug manufacturer has notified the FDA of a manufacturing discontinuance or potential discontinuance of the drug; or
    - the drug manufacturer has removed the drug from the market.

C.S.H.B. 2099 applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020.

EFFECTIVE DATE

September 1, 2019

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2099 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute revises provisions relating to the prohibition against a health benefit plan issuer modifying an enrollee's contracted benefit level for applicable covered prescription drugs under certain conditions by:

- removing the condition that the drug is considered safe and effective for treating the enrollee's medical condition or mental illness;

- including among the prohibited modifications the increase of an out-of-pocket expense that an enrollee must pay for a drug and the reduction of the maximum drug coverage amount; and
- including provisions establishing certain exceptions to and clarifications of the prohibited modifications.