By: Campbell S.B. No. 580

A BILL TO BE ENTITLED

AN ACT

relating to modification of certain prescription drug benefits and coverage offered by certain health benefit plans.

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

SECTION 1. Section 1369.0541, Insurance Code, is amended by amending Subsections (a) and (b) and adding Subsections (a-1) and (b-1) to read as follows:

(a) Except as provided by Section 1369.055(a-1) and Subsection (b-1) of this section, a [~~A~~] health benefit plan issuer may modify drug coverage provided under a health benefit plan if:

(1) the modification occurs at the time of coverage renewal;

(2) the modification is effective uniformly among all group health benefit plan sponsors covered by identical or substantially identical health benefit plans or all individuals covered by identical or substantially identical individual health benefit plans, as applicable; and

(3) not later than the 60th day before the date the modification is effective, the issuer provides written notice of the modification to the commissioner, each affected group health benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each affected individual health benefit plan holder.

(a-1) The notice described by Subsection (a)(3) must

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 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 Section 1369.055(a-1).

(b) Modifications affecting drug coverage that require notice under Subsection (a) 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; [~~and~~]

(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 [~~unless a generic drug alternative to the drug is available~~].

(b-1) Modifications affecting drug coverage that are more favorable to enrollees may be made at any time and 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. Section 1369.055, Insurance Code, is amended by adding Subsections (a-1) and (a-2) to read as follows:

(a-1) On renewal of a health benefit plan, the plan 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 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 appropriately prescribes the drug for the medical condition or mental illness;

(3) the prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment; and

(4) the drug is considered safe and effective for treating the enrollee's medical condition or mental illness.

(a-2) 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; and

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

SECTION 3. The changes in law made by this Act apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2020, 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 4. This Act takes effect September 1, 2019.