BILL ANALYSIS

H.B. 1646
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Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

When an insurer changes its drug formulary, increases out-of-pocket payment amounts, or implements new prior authorization requirements, enrollees may be forced to forgo obtaining necessary prescription drugs. For many Texans with chronic conditions, an established and stable treatment regimen may be disrupted by these arbitrary changes at the beginning of a new plan year. H.B. 1646 seeks to ensure that Texans retain reliable access to needed prescription drugs by prohibiting 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 under certain conditions.

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

H.B. 1646 amends the Insurance Code to prohibit an applicable 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 the enrollee's medical condition or mental illness under the following conditions:

- 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.

That prohibition applies with respect to the following modifications:

- removing a drug from a formulary;
- adding a prior authorization requirement;
- imposing or altering a quantity limit;
- imposing a step-therapy restriction;
- 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.

H.B. 1646 establishes that the bill's provisions regarding prohibited modifications of benefit levels do not do the following:

- prohibit a health benefit plan issuer from requiring, by agreement or course of conduct, a pharmacist to provide a substitution for a prescription drug in accordance with applicable state law under which the pharmacist may substitute an interchangeable biologic product or therapeutically equivalent generic product as determined by the FDA;
- prohibit a physician or other prescribing provider from prescribing another medication;
- prohibit the plan issuer from adding a new drug to a formulary;
- require a plan to provide coverage to an enrollee under circumstances not described by the bill; or
- prohibit a plan issuer from removing a drug from its formulary or denying an enrollee coverage for the drug under certain circumstances relating to the safety or availability of the drug.

H.B. 1646 requires the written notice that an applicable health benefit plan issuer is required to provide when modifying prescription drug coverage provided under a health benefit plan to include a statement that does the following:

- indicates that the plan issuer is modifying drug coverage provided under the plan;
- explains the type of modification; and
- indicates that, on renewal of the 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 as provided by the bill.

The bill includes among the modifications that require such notice reducing the maximum drug coverage amount and increasing a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug. The bill removes availability of a generic drug alternative as a condition that triggers an exception to the requirement for notice to be provided when the plan issuer moves a drug to a higher cost-sharing tier. The bill specifies that modifications affecting drug coverage that are more favorable to enrollees may be made at any time and do not require notice.

H.B. 1646 exempts a self-funded health benefit plan as defined by the federal Employee Retirement Income Security Act of 1974 from provisions governing the coverage of prescription drugs specified by a drug formulary. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2022.

EFFECTIVE DATE

September 1, 2021.