BILL ANALYSIS

C.S.H.B. 2668
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Concern has been raised regarding the adoption by health insurers and pharmacy benefit managers of policies in relation to medications with no alternative medicines, called copay accumulator adjustment programs. Under these copay accumulator adjustment programs, patients may use manufacturer or nonprofit foundation support but the payments are prohibited from applying toward a patient's deductible or annual out-of-pocket maximum. This practice permits double dipping because out-of-pocket costs are paid twice. C.S.H.B. 2668 seeks to address this issue by requiring for coverage to reduce certain out-of-pocket expenses.

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. 2668 amends the Insurance Code to require an issuer of a health benefit plan that covers prescription drugs or a pharmacy benefit manager to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan. The bill applies only to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug for which:

- a generic equivalent does not exist;
- a generic equivalent does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:
    - a prior authorization process;
    - a step therapy protocol; or
    - the health benefit plan issuer's exceptions and appeals process;
- an interchangeable biological product does not exist; or
- an interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:
    - a prior authorization process;
    - a step therapy protocol; or
    - the health benefit plan issuer's exceptions and appeals process.

C.S.H.B. 2668 applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2022.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2668 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 original required an issuer of a health benefit plan that covers prescription drugs or a pharmacy benefit manager to apply any reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to prescription drug benefits under the enrollee's plan. The substitute requires the issuer or pharmacy benefit manager instead to apply the reduction to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan.

The substitute includes a provision absent from the original limiting the applicability of the bill's requirement to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for certain prescription drugs.