87R5962 SMT-D

By:  Price H.B. No. 1701

A BILL TO BE ENTITLED

AN ACT

relating to pricing of and health benefit plan cost-sharing requirements for prescription insulin.

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

SECTION 1.  Section 1358.054(b), Insurance Code, is amended to read as follows:

(b)  Except as provided by Section 1358.103(c), a [~~A~~] health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

SECTION 2.  Chapter 1358, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. COST-SHARING LIMIT

Sec. 1358.101.  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 a small or large employer group contract or similar coverage document that is offered by:

(1)  an insurance company;

(2)  a group hospital service corporation operating under Chapter 842;

(3)  a fraternal benefit society operating under Chapter 885;

(4)  a stipulated premium company operating under Chapter 884;

(5)  a reciprocal exchange operating under Chapter 942;

(6)  a health maintenance organization operating under Chapter 843;

(7)  a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8)  an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(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:

(1)  a basic coverage plan under Chapter 1551;

(2)  a basic plan under Chapter 1575;

(3)  a primary care coverage plan under Chapter 1579; and

(4)  basic coverage under Chapter 1601.

Sec. 1358.102.  EXCEPTION. This subchapter does not apply to:

(1)  a health benefit plan that provides coverage:

(A)  only for a specified disease or for another single benefit;

(B)  only for accidental death or dismemberment;

(C)  for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D)  as a supplement to a liability insurance policy;

(E)  for credit insurance;

(F)  only for dental or vision care;

(G)  only for hospital expenses; or

(H)  only for indemnity for hospital confinement;

(2)  a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3)  medical payment insurance coverage provided under a motor vehicle insurance policy;

(4)  a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.101;

(5)  health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or

(6)  a workers' compensation insurance policy.

Sec. 1358.103.  LIMIT ON COST-SHARING REQUIREMENT. (a) In this section, "insulin" means a prescription drug that contains insulin, is used to treat diabetes, and is prescribed as medically necessary by a physician.

(b)  A health benefit plan that provides coverage for insulin may not impose a cost-sharing provision for insulin if the total amount the enrollee is required to pay exceeds $30 for a 30-day supply, regardless of the amounts, types, or brands of insulin needed to treat the enrollee's diabetes.

(c)  A health benefit plan that provides coverage for insulin may not impose a deductible applicable to insulin.

SECTION 3.  (a) In this section, "commission" means the Health and Human Services Commission.

(b)  The commission shall conduct a study evaluating pricing of prescription insulin drugs to ensure adequate consumer protections in pricing of prescription insulin drugs and consider whether additional consumer protections are necessary.

(c)  The commission shall request from health benefit plan issuers and prescription drug manufacturers information concerning the organization, business practices, pricing information, data, reports, or other information the commission determines is necessary to conduct the study. The commission shall also consider any publicly available information related to prescription insulin pricing.

(d)  A health benefit plan issuer or prescription drug manufacturer who receives a request from the commission under Subsection (c) of this section shall furnish the commission with the information as soon as practicable after the date the issuer or manufacturer receives the request.

(e)  The commission may not require a health benefit plan issuer or prescription drug manufacturer to disclose trade secrets in information provided to the commission under Subsection (d) of this section.

(f)  Not later than September 1, 2022, the commission shall prepare and submit to the governor, the lieutenant governor, and the speaker of the house of representatives a written report containing the results of the study. The report must include:

(1)  a summary of insulin pricing practices and variables that contribute to pricing of health benefit plans;

(2)  policy recommendations to control and prevent overpricing of prescription insulin; and

(3)  any other information the commission determines is necessary.

(g)  The commission shall publish the report described by Subsection (f) of this section on its Internet website.

(h)  This section expires September 1, 2023.

SECTION 4.  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, 2022. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2022, 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 5.  This Act takes effect September 1, 2021.