BILL ANALYSIS

C.S.H.B. 999
By: Price
Health Care Reform, Select
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Patients may receive copay assistance coupons from a drug manufacturer or other types of copay assistance from other organizations to help with payment for medications. However, according to the Texas All Copays Count Coalition, this assistance is not necessarily being recognized by health benefit plans or pharmacy benefit managers and therefore is not counted toward an enrollee's insurance deductible or annual out-of-pocket maximum. C.S.H.B. 999 seeks to address this issue by requiring a health benefit plan that covers prescription drugs or a pharmacy benefit manager to apply any coupon or other reduction in out-of-pocket expenses made by or on behalf of an enrollee to the enrollee's deductible copayment, cost sharing responsibility, or out-of-pocket maximum applicable to prescription drug benefits.

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. 999 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, as follows, only to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which:

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

C.S.H.B. 999 applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 999 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes a specification absent from the introduced that the bill's reduction in out-of-pocket expenses made by or on behalf of an enrollee for certain prescription drugs applies only to prescription drugs that are covered by the enrollee's health benefit plan.