BILL ANALYSIS

S.B. 622
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Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

When prescribing medication to a patient, a health care provider may not have information regarding the financial impact that filling the prescription might have on the patient. Some patients may not purchase their prescription because the cost is much higher than expected or because the pharmacy may need to contact the provider to prescribe an alternative that may be less expensive for the patient. These outcomes may have the potential to delay care and cause unnecessary administrative burden for both the pharmacy and possibly the provider. Providing more information to the prescribing provider and patient when the prescription is written would help the provider understand the financial impact to their patient and potentially cause the provider to prescribe a product that the patient is more likely to fill. S.B. 622 seeks to address this issue by requiring certain health benefit plan issuers to provide specific information regarding prescription drugs to an enrollee or the enrollee's prescribing provider upon request.

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

S.B. 622 amends the Insurance Code to require a health benefit plan issuer that covers prescription drugs under a plan's pharmacy benefit to provide information regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. The information provided must include the issuer's drug formulary and, for the prescription drug and any formulary alternative, the enrollee's eligibility, applicable utilization management requirements, and cost-sharing information, including any deductible, copayment, or coinsurance. The bill requires the cost-sharing information to be consistent with cost-sharing requirements under the enrollee's plan, to be accurate at the time the information is provided, and to include any variance in cost-sharing based on the patient's preferred dispensing retail or mail-order pharmacy or the prescribing provider. The bill defines "cost-sharing information" as the actual out-of-pocket amount an enrollee is required to pay a dispensing pharmacy or prescribing provider for a prescription drug under the enrollee's health benefit plan.

S.B. 622 requires the health plan issuer, in providing that information, to do the following:

- respond in real time to a request made through a standard application interface (API);
- allow the use of an integrated technology or service as necessary to provide the required information;

- ensure that the information provided is current no later than one business day after the date a change is made; and
- provide the information if the request is made using the drug's unique billing code and National Drug Code.

The bill defines "Standard API" as an application interface that meets the requirements of an applicable American National Standards Institute (ANSI) accredited standard to conform to standards adopted under federal regulations.

S.B. 622 prohibits a health plan issuer from taking the following actions with respect to the disclosure of prescription drug information:

- denying or delaying a response to a request for information under the bill's provisions for the purpose of blocking the release of the information;
- restricting a prescribing provider from communicating to the enrollee any of the information the bill requires plan issuers to provide, information about the cash price of the drug, or any additional information on any lower cost or clinically appropriate alternative drug, whether or not the drug is covered under the enrollee's plan;
- except as required by law, interfering with, preventing, or materially discouraging access to or the exchange or use of prescription drug information, including by charging an access fee, not responding to a request within the required time, or instituting a consent requirement for access; or
- penalizing, including by taking any action intended to punish or discourage future similar behavior, a prescribing provider for disclosing any of the information the bill requires plan issuers to provide or prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

S.B. 622 authorizes a health plan issuer with fewer than 10,000 enrollees to register with the Texas Department of Insurance (TDI) to receive an additional 12 months after the bill's effective date to comply with the bill's requirements and, after those additional 12 months, to request from TDI a temporary exception from one or more requirements of the bill's provisions by submitting a report to TDI that demonstrates that compliance would impose an unreasonable cost relative to the public value that would be gained from full compliance. The bill specifies the types of plans to which its provisions apply and establishes exceptions to that applicability with respect to Medicaid, CHIP, TRICARE, and workers' compensation. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2025.

EFFECTIVE DATE

September 1, 2023.