BILL ANALYSIS

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C.S.S.B. 622
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Health & Human Services
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Patients, even those with health coverage, continue to face an affordability crisis. High-deductible health plans and increased cost sharing has led to a high degree of patient sensitivity to out-of-pocket costs. Patient decisions are often based on affordability—and too often patients and their care teams lack meaningful and actionable coverage and cost information to help inform decisions. As a result, patients abandon filling their prescription, leading to poor medical outcomes and increased disease progression. IQVIA reports, for example, that a $50 out-of-pocket patient cost results in a prescription abandonment rate of 31.2 percent for commercial payers nationwide.

Patients, clinicians, and pharmacies, including specialty pharmacies, are challenged by not being able to accurately identify the appropriate patient-specific benefit coverage (medical or pharmacy benefit) or patient's out-of-pocket cost at the time of care for a specific medication being ordered or prescribed.

This information gap increases the likelihood of duplicative and unnecessary health care spending as a result of patient abandonment of a prescription, then additional clinician visits as the condition worsens, and/or clinician phone time working through the bureaucracy of coverage and spending decisions, robbing them of time with patients.

Fortunately, the data to help patients and clinicians make these decisions is currently available. The problem is that it is not appropriately shared in the patient workflow, which is generally an electronic health record, clinical decision support tool, electronic prescribing or other healthcare platform. Current rules on data sharing inhibit the free flow of patient data to better empower patients and the providers on the appropriate range of clinical and financial options.

S.B. 622 is a common sense, patient-friendly policy change that has become law to date in Ohio, Tennessee, Colorado, California, Maine, and soon in New York. It will better empower patient decision-making, increase the depth of discussions between clinicians and patients to arrive at the best clinical and financial outcome, and ease the bureaucratic burden of clinicians seeking to spend more time with patients and less time with paperwork.

S.B. 622 requires disclosure of an issuer's list of generic and brand-name prescription drugs covered by a specific health insurance plan, the enrollee's eligibility, cost-sharing information, and applicable utilization management requirements. The bill also specifies that the health benefit plan issuer must respond to requests in real time and cannot restrict a prescribing provider from communicating information about the drug or penalize a provider for disclosing or prescribing lower cost alternative drugs.

(Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 622 amends current law relating to the disclosure of certain prescription drug information by a health benefit plan.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1369, Insurance Code, by adding Subchapter B-2, as follows:

SUBCHAPTER B-2. DISCLOSURE OF CERTAIN PRESCRIPTION DRUG INFORMATION SPECIFIED BY DRUG FORMULARY

Sec. 1369.091. DEFINITIONS. Defines "cost-sharing information," "drug formulary," "enrollee," "prescription drug," and "standard API."

Sec. 1369.092. APPLICABILITY OF SUBCHAPTER. (a) Provides that 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 an individual or group evidence of coverage or similar coverage document that is offered by certain entities.

(b) Provides that this subchapter, notwithstanding any other law, applies to certain health plans.

Sec. 1369.093. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Provides that this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under certain programs.

Sec. 1369.094. DISCLOSURE OF PRESCRIPTION DRUG INFORMATION. (a) Provides that this section applies only with respect to a prescription drug covered under a health benefit plan's pharmacy benefit.

(b) Requires a health benefit plan issuer that covers prescription drugs to provide information regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. Requires that the information provided include the issuer's drug formulary and, for the prescription drug and any formulary alternative:

(1) the enrollee's eligibility;

(2) cost-sharing information, including any deductible, copayment, or coinsurance, which is required to:

(A) be consistent with cost-sharing requirements under the enrollee's plan;

(B) be accurate at the time the cost-sharing information is provided; and

(C) include any variance in cost-sharing based on the patient's preferred dispensing retail or mail-order pharmacy or the prescribing provider; and

(3) applicable utilization management requirements.

(c) Requires a health benefit plan issuer, in providing the information required under Subsection (b), to:

(1) respond in real time to a request made through a standard API;

(2) allow the use of an integrated technology or service as necessary to provide the required information;

(3) ensure that the information provided is current no later than one business day after the date a change is made; and

(4) provide the information if the request is made using the drug's unique billing code and National Drug Code.

(d) Prohibits a health benefit plan issuer from:

(1) denying or delaying a response to a request for information under Subsection (b) for the purpose of blocking the release of the information;

(2) restricting a prescribing provider from communicating to the enrollee the information provided under Subsection (b), 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;

(3) interfering with, preventing, or materially discouraging access to or the exchange or use of the information provided under Subsection (b), except as required by law, including by:

(A) charging a fee to access the information;

(B) not responding to a request within the time required by this section; or

(C) instituting a consent requirement for an enrollee to access the information; or

(4) penalizing, including by taking any action intended to punish or discourage future similar behavior by the prescribing provider, a prescribing provider for:

(A) disclosing the information provided under Subsection (b); or

(B) prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

(e) Authorizes a health benefit plan issuer with fewer than 10,000 enrollees to:

(1) register with the Texas Department of Insurance (TDI) to receive an additional 12 months after the effective date of this subchapter to comply with the requirements of this subchapter; and

(2) after the additional 12 months provided for in Subdivision (1), request from TDI a temporary exception from one or more requirements of this section 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.

SECTION 2. Makes application of this Act prospective to January 1, 2025.

SECTION 3. Effective date: September 1, 2023.