

By: Lambert

H.B. No. 826

A BILL TO BE ENTITLED

1 AN ACT
2 relating to modification of certain prescription drug benefits and
3 coverage offered by certain health benefit plans.

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

5 SECTION 1. Section 1369.053, Insurance Code, is amended to
6 read as follows:

7 Sec. 1369.053. EXCEPTION. This subchapter does not apply
8 to:

9 (1) a health benefit plan that provides coverage:

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

12 (B) only for accidental death or dismemberment;

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

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

18 (E) for credit insurance;

19 (F) only for dental or vision care;

20 (G) only for hospital expenses; or

21 (H) only for indemnity for hospital confinement;

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

1 (3) a workers' compensation insurance policy;

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

4 (5) a long-term care insurance policy, including a
5 nursing home fixed indemnity policy, unless the commissioner
6 determines that the policy provides benefit coverage so
7 comprehensive that the policy is a health benefit plan as described
8 by Section 1369.052;

9 (6) the child health plan program under Chapter 62,
10 Health and Safety Code, or the health benefits plan for children
11 under Chapter 63, Health and Safety Code; ~~or~~

12 (7) a Medicaid managed care program operated under
13 Chapter 533, Government Code, or a Medicaid program operated under
14 Chapter 32, Human Resources Code; or

15 (8) a self-funded health benefit plan as defined by
16 the Employee Retirement Income Security Act of 1974 (29 U.S.C.
17 Section 1001 et seq.).

18 SECTION 2. Section 1369.0541, Insurance Code, is amended by
19 amending Subsections (a) and (b) and adding Subsections (a-1) and
20 (b-1) to read as follows:

21 (a) Except as provided by Section 1369.055(a-1) and
22 Subsection (b-1) of this section, a [A] health benefit plan issuer
23 may modify drug coverage provided under a health benefit plan if:

24 (1) the modification occurs at the time of coverage
25 renewal;

26 (2) the modification is effective uniformly among all
27 group health benefit plan sponsors covered by identical or

1 substantially identical health benefit plans or all individuals
2 covered by identical or substantially identical individual health
3 benefit plans, as applicable; and

4 (3) not later than the 60th day before the date the
5 modification is effective, the issuer provides written notice of
6 the modification to the commissioner, each affected group health
7 benefit plan sponsor, each affected enrollee in an affected group
8 health benefit plan, and each affected individual health benefit
9 plan holder.

10 (a-1) The notice described by Subsection (a)(3) must
11 include a statement:

12 (1) indicating that the health benefit plan issuer is
13 modifying drug coverage provided under the health benefit plan;

14 (2) explaining the type of modification; and

15 (3) indicating that, on renewal of the health benefit
16 plan, the health benefit plan issuer may not modify an enrollee's
17 contracted benefit level for any prescription drug that was
18 approved or covered under the plan in the immediately preceding
19 plan year as provided by Section 1369.055(a-1).

20 (b) Modifications affecting drug coverage that require
21 notice under Subsection (a) include:

22 (1) removing a drug from a formulary;

23 (2) adding a requirement that an enrollee receive
24 prior authorization for a drug;

25 (3) imposing or altering a quantity limit for a drug;

26 (4) imposing a step-therapy restriction for a drug;

27 [~~and~~]

1 (5) moving a drug to a higher cost-sharing tier;

2 (6) increasing a coinsurance, copayment, deductible,
3 or other out-of-pocket expense that an enrollee must pay for a drug;
4 and

5 (7) reducing the maximum drug coverage amount [~~unless~~
6 ~~a generic drug alternative to the drug is available~~].

7 (b-1) Modifications affecting drug coverage that are more
8 favorable to enrollees may be made at any time and do not require
9 notice under Subsection (a), including:

10 (1) the addition of a drug to a formulary;

11 (2) the reduction of a coinsurance, copayment,
12 deductible, or other out-of-pocket expense that an enrollee must
13 pay for a drug; and

14 (3) the removal of a utilization review requirement.

15 SECTION 3. Section 1369.055, Insurance Code, is amended by
16 adding Subsections (a-1), (a-2), and (c) to read as follows:

17 (a-1) On renewal of a health benefit plan, the plan issuer
18 may not modify an enrollee's contracted benefit level for any
19 prescription drug that was approved or covered under the plan in the
20 immediately preceding plan year and prescribed during that year for
21 a medical condition or mental illness of the enrollee if:

22 (1) the enrollee was covered by the health benefit
23 plan on the date immediately preceding the renewal date;

24 (2) a physician or other prescribing provider
25 prescribes the drug for the medical condition or mental illness;
26 and

27 (3) the physician or other prescribing provider in

1 consultation with the enrollee determines that the drug is the most
2 appropriate course of treatment.

3 (a-2) Modifications prohibited under Subsection (a-1)
4 include:

5 (1) removing a drug from a formulary;

6 (2) adding a requirement that an enrollee receive
7 prior authorization for a drug;

8 (3) imposing or altering a quantity limit for a drug;

9 (4) imposing a step-therapy restriction for a drug;

10 (5) moving a drug to a higher cost-sharing tier;

11 (6) increasing a coinsurance, copayment, deductible,
12 or other out-of-pocket expense that an enrollee must pay for a drug;

13 and

14 (7) reducing the maximum drug coverage amount.

15 (c) Subsections (a-1) and (a-2) do not:

16 (1) prohibit a health benefit plan issuer from
17 requiring, by contract, written policy or procedure, or other
18 agreement or course of conduct, a pharmacist to provide a
19 substitution for a prescription drug in accordance with Subchapter
20 A, Chapter 562, Occupations Code, under which the pharmacist may
21 substitute an interchangeable biologic product or therapeutically
22 equivalent generic product as determined by the United States Food
23 and Drug Administration;

24 (2) prohibit a physician or other prescribing provider
25 from prescribing another medication;

26 (3) prohibit the health benefit plan issuer from
27 adding a new drug to a formulary;

1 (4) require a health benefit plan to provide coverage
2 to an enrollee under circumstances not described by Subsection
3 (a-1); or

4 (5) prohibit a health benefit plan issuer from
5 removing a drug from its formulary or denying an enrollee coverage
6 for the drug if:

7 (A) the United States Food and Drug
8 Administration has issued a statement about the drug that calls
9 into question the clinical safety of the drug;

10 (B) the drug manufacturer has notified the United
11 States Food and Drug Administration of a manufacturing
12 discontinuance or potential discontinuance of the drug as required
13 by Section 506C, Federal Food, Drug, and Cosmetic Act (21 U.S.C.
14 Section 356c); or

15 (C) the drug manufacturer has removed the drug
16 from the market.

17 SECTION 4. The changes in law made by this Act apply only to
18 a health benefit plan that is delivered, issued for delivery, or
19 renewed on or after January 1, 2024. A health benefit plan
20 delivered, issued for delivery, or renewed before January 1, 2024,
21 is governed by the law as it existed immediately before the
22 effective date of this Act, and that law is continued in effect for
23 that purpose.

24 SECTION 5. This Act takes effect September 1, 2023.