By: Parker, et al. S.B. No. 622
(Smithee)

A BILL TO BE ENTITLED

AN ACT

relating to the disclosure of certain prescription drug information by a health benefit plan.

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

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter B-2 to read as follows:

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

Sec. 1369.091. DEFINITIONS. In this subchapter:

(1) "Cost-sharing information" means 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.

(2) "Drug formulary," "enrollee," and "prescription drug" have the meanings assigned by Section 1369.051.

(3) "Standard API" means an application interface that meets the requirements of an applicable American National Standards Institute (ANSI) accredited standard to conform to standards adopted under 45 C.F.R. Section 170.215.

Sec. 1369.092. 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 an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

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

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

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

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) nonprofit agricultural organization health benefits offered by a nonprofit agricultural organization under Chapter 1682;

(8) alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company under Subchapter M, Chapter 2054;

(9) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(10) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Sec. 1369.093. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(2) the child health plan program under Chapter 62, Health and Safety Code;

(3) the TRICARE military health system; or

(4) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

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

benefit.

(b) A health benefit plan issuer that covers prescription drugs shall 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:

(1) the enrollee's eligibility;

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

(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) In providing the information required under Subsection (b), a health benefit plan issuer shall:

(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) A health benefit plan issuer may not:

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

(2) restrict 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) except as required by law, interfere with, prevent, or materially discourage access to or the exchange or use of the information provided under Subsection (b), 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) penalize, 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) A health benefit plan issuer with fewer than 10,000

enrollees may:

(1) register with the department 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 the department a temporary exception from one or more requirements of this section by submitting a report to the department that demonstrates that compliance would impose an unreasonable cost relative to the public value that would be gained from full compliance.

SECTION 2. The changes in law made by this Act apply only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2025.

SECTION 3. This Act takes effect September 1, 2023.