By: Jones of Dallas H.B. No. 1023

A BILL TO BE ENTITLED

AN ACT

relating to modification of certain prescription drug benefits and coverage offered by certain health benefit plans.

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

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

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

(1) a health benefit plan that provides coverage:

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

(B) only for accidental death or dismemberment;

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

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

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

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

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

(7) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code; or

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

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

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

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

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

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

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

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

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

(2) explaining the type of modification; and

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

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

(1) removing a drug from a formulary;

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

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

(4) imposing a step-therapy restriction for a drug; [~~and~~]

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

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

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

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

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

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

(3) the removal of a utilization review requirement.

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

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

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

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

(3) the physician or other prescribing provider in

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

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

(1) removing a drug from a formulary;

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

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

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

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

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

(7) reducing the maximum drug coverage amount.

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

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

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

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

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

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

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

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

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

SECTION 4. The changes in law made by this Act apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2028. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2028, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2027.