AN ACT

relating to provision by a health benefit plan of prescription drug coverage specified by formulary and to modifications of that coverage.

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

SECTION 1. Section 1369.051(2), Insurance Code, is amended to read as follows:

(2) "Enrollee" means an individual who is covered under a [~~group~~] health benefit plan, including a covered dependent.

SECTION 2. Section 1369.052, Insurance Code, is amended to read as follows:

Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a [~~group~~] 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, [~~a~~] group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

(5) a reciprocal exchange operating under Chapter 942;

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

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

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

SECTION 3. 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 small employer health benefit plan written~~

~~under Chapter 1501;~~

[~~(3)~~] a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) [~~(4)~~] a workers' compensation insurance policy;

(4) [~~(5)~~] medical payment insurance coverage provided under a motor vehicle insurance policy; [~~or~~]

(5) [~~(6)~~] 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 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 4. Section 1369.054, Insurance Code, is amended to read as follows:

Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION REQUIRED. An issuer of a [~~group~~] health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) provide in plain language in the coverage documentation provided to each enrollee:

(A) notice that the plan uses one or more drug

formularies;

(B) an explanation of what a drug formulary is;

(C) a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

(D) a statement of how often the issuer reviews the contents of each drug formulary; and

(E) notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

(2) disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and

(3) notify an enrollee and any other individual who requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness.

SECTION 5. Subchapter B, Chapter 1369, Insurance Code, is amended by adding Section 1369.0541 to read as follows:

Sec. 1369.0541. MODIFICATION OF DRUG COVERAGE UNDER PLAN. (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.

(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 unless a generic drug alternative to the drug is available.

(c) A health benefit plan issuer may elect to offer an enrollee in the plan the option of receiving notifications required by this section by e-mail.

SECTION 6. Section 1369.055, Insurance Code, is amended to read as follows:

Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER DRUGS NOT PRECLUDED. (a) An issuer of a [~~group~~] health benefit plan that covers prescription drugs shall offer to each enrollee at the

contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

(b) This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under Subsection (a) if the alternative drug is:

(1) covered under the [~~group~~] health benefit plan; and

(2) medically appropriate for the enrollee.

SECTION 7. Section 1369.056(a), Insurance Code, is amended to read as follows:

(a) The refusal of a [~~group~~] health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Section 4201.002 if:

(1) the drug is not included in a drug formulary used by the [~~group~~] health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

SECTION 8. Section 1501.108(d), Insurance Code, is amended to read as follows:

(d) Notwithstanding Subsection (a), a small or large employer health benefit plan issuer may modify a small or large employer health benefit plan in accordance with Section 1369.0541 or if:

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

(2) the modification is effective uniformly among all small or large employers covered by that health benefit plan; and

(3) the issuer notifies the commissioner and each affected covered small or large employer of the modification not later than the 60th day before the date the modification is effective.

SECTION 9. The change in law made by this Act applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 10. This Act takes effect September 1, 2011.

President of the Senate

Speaker of the House

I certify that H.B. No. 1405 was passed by the House on April 6, 2011, by the following vote: Yeas 143, Nays 0, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 1405 on May 16, 2011, by the following vote: Yeas 142, Nays 0, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 1405 was passed by the Senate, with amendments, on May 10, 2011, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor