BILL ANALYSIS

Senate Research Center

S.B. 1030
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Economic Development
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As Filed

DIGEST

Currently, the Texas Department of Insurance rules require insurers to give enrollees 90 days notice of any drug formulary changes, allowing insurers to change drug formularies within the enrollees' contract period. This bill would permit enrollees to continue to use prescribed formulary drugs until their insurance contract ends, even if a prescribed drug has been removed from the formulary, and if a physician prescribes a nonformulary drug, the enrollee could appeal, using the independent review process, to have the prescribed drug covered.

PURPOSE

As proposed, S.B. 1030 regulates prescription drug benefits available to enrollees of certain health benefit plans.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 21E, Insurance Code, by adding Article 21.53L, as follows:

Art. 21.53L. PRESCRIPTION DRUG BENEFITS

Sec. 1. DEFINITIONS. Defines "drug formulary," "enrollee," "health benefit plan," "physician," and "prescription drug."

Sec. 2. SCOPE OF ARTICLE. Sets forth certain health benefit plans to which this article applies. Provides that this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code. Provides that this article does not apply to certain health benefit plans and insurance.

Sec. 3. CONTINUED ACCESS TO FORMULARY DRUGS. Requires a health benefit plan that offers prescription drug benefits to make an approved or covered prescription drug available to each enrollee at the contracted benefit level until the enrollee's contract with the health benefit plan expires, regardless of whether the prescribed drug has been removed from the health benefit plan's drug formulary. Provides that nothing in this section shall preclude a physician from prescribing another drug covered by the health benefit plan that is medically appropriate for the enrollee.

Sec. 4. NOTICE. Requires a health benefit plan that provides prescription drug benefits to disclose to enrollees in the evidence of coverage and by separate written notice that the health benefit plan does or does not use a drug formulary. Requires the notice to include an explanation of what a drug formulary is, how the health benefit plan determines which prescription drugs are included on or excluded from the formulary, and how often the plan reviews the composition of the formulary, if the health benefit plan uses a drug formulary. Requires a health benefit plan that provides prescription drug benefits and maintains one or more drug formularies to provide to enrollees and prospective enrollees, upon request, a copy of the most current list of prescription drugs on the formulary, by major therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. Requires the health benefit plan to also provide

any prior drug formularies that were in effect at any time during the term of the enrollee's contract with the health benefit plan, if the request is from an enrollee. Requires the health benefit plan to send a copy of each drug formulary to the requester, if the health benefit plan maintains more than one formulary.

Sec. 5. NONFORMULARY PRESCRIPTION DRUGS. Provides that if a health benefit plan, through any of its employees or agents, refuses to provide a nonformulary drug which an enrollee's physician has determined is medically necessary, such denial shall constitute an "adverse determination" within the meaning of Section 2(3), Article 21.58A of this code. Authorizes an enrollee to appeal the adverse determination under Sections 6 and 6A, Article 21.58A of this code.

SECTION 2. Effective date: September 1, 1999.
Makes application of this Act prospective to January 1, 2000.

SECTION 3. Emergency clause.