BILL ANALYSIS

Senate Research Center
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C.S.S.B. 804
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Business & Commerce
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Committee Report (Substituted)

DIGEST AND PURPOSE

Current Texas law requires health benefit plans to provide enrollees with continuous access to prescribed formulary drugs at the same benefit level until the enrollee's plan renewal date, even if the drug has been removed from the formulary. C.S.S.B. 804 narrows the scope of current law and requires health plans to provide enrollees with access to prescription drugs that were prescribed for an enrollee during the plan year. Such prescriptions would have to be available at the contracted benefit level until the enrollee's plan renewal date, whether or not the prescribed drug has been removed from the health benefit plan's drug formulary.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 3, Article 21.52J, Insurance Code, to require a group health benefit plan that covers prescription drugs and that uses one or more drug formularies to specify which prescription drugs the plan will cover to provide a statement of the enrollee's right to complain in a circumstance in which benefits for a drug are denied because the drug is not included in the plan's drug formulary, including the enrollee's rights under Section 4(c) of this article.

SECTION 2. Amends Section 4, Article 21.52J, Insurance Code, by amending Subsection (a) and adding Subsections (c) and (d), as follows:

> (a) Requires, except as provided by Subsection (d), a group health benefit plan that offers prescription drug benefits to make a prescription drug that, at the beginning of the plan year, was included on the health benefit plan's drug formulary available to an enrollee at the contracted benefit level for that prescription drug until the enrollee's plan renewal date, regardless of whether the prescribed drug has been removed from the health benefit plan's drug formulary, if the drug was at any time previously prescribed to the enrollee and provided under the plan, regardless of whether the drug was prescribed during the plan year or the enrollee can demonstrate, in accordance with Subsection (c) of this section, that the drug was at any time previously prescribed to the enrollee.
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> (c) Authorizes an enrollee who is denied benefits for a prescription drug because the drug has been removed from the group health benefit plan's drug formulary during a plan year and who believes the benefits are required under Subsection (a)(2) of this section to file a complaint in accordance with the complaint procedures of the group health benefit plan. Requires, that on an initial showing by the enrollee that the drug was previously prescribed at any time to the enrollee, the group health benefit plan to provide the benefits at the contracted benefit level from the date the benefits were initially requested until the enrollee's plan renewal date. Provides that an initial showing under this subsection may be made by any means that demonstrates that a prescription drug was previously prescribed to an enrollee, including a

copy of a prescription or a letter or other appropriate documentation from the physician who prescribed the drug or pharmacist who distributed the drug.

(d) Provides that Subsection (a) of this section does not require a group health benefit plan to continue to provide prescription drug benefits for a prescription drug if certain requirements are met.

SECTION 3. Amends Section 6, Article 21.52J, Insurance Code, as follows:

Sec. 6. RULES. Authorizes the commissioner to adopt rules to implement this article, including rules governing documents or other evidence that must be accepted under Section 4 (c) of this article by a group health benefit plan as an initial showing that a drug was at any time previously prescribed to an enrollee.

SECTION 4. Effective date: September 1, 2001.
Makes application of this Act prospective.

SUMMARY OF COMMITTEE CHANGES

SECTION 1. Amends the As Filed S.B. 804 by amending Section 3, rather than Section 4, of Article 21.52J, Insurance Code, the As Filed version proposed language that is now included in SECTION 2(Section 4(d), Aricle 21.52J, Insurance Code) of the substitute.

SECTION 2. Amends the As Filed S.B. 804 by adding language regarding the plan's year and provisions allowing an enrollee to obtain a prescription drug that is not on the company's formulary and provisions for an enrollee to file a complaint.

SECTION 3. Amends the As Filed S.B. 804 by amending Section 6, Article 2152J, Insurance Code, implementing rules governing documents.