PRELIMINARY

HB 4156 -2 STAFF MEASURE SUMMARY

House Committee On Health Care

Prepared By: Oliver Droppers, LPRO Analyst
Meeting Dates: 2/7, 2/9

WHAT THE MEASURE DOES:
Prohibits health insurers from removing prescription drugs from a formulary during a plan year with one exception. Prevents health insurers from modifying consumer cost sharing for prescription drugs during a plan year unless a generic drug is added to a formulary. Forbids health plans from enacting new utilization management controls on prescription drugs during a plan year.

ISSUES DISCUSSED:
- Formularies, co-insurance, patient co-pays, and affordability of prescription drugs
- Transparency with drug pricing, different prescription drug coverage among health plans, and impacts to consumers from mid-year changes in formularies

EFFECT OF AMENDMENT:
-2 Requires carriers in a geographic region that offer individual, small employer, and group health plans to offer at least 25 percent of plans with no deductible or other cost-sharing requirements except a flat dollar co-payment. Specifies criteria for flat dollar co-payment. Exempts carriers from requirement if a plan qualifies as a health savings account that requires a deductible or is a catastrophic plan.

REVENUE: *No revenue impact.*
FISCAL: *Fiscal impact issued.*

BACKGROUND:
A formulary is a list of medications available in a health plan and is used by health care insurers as a method to manage utilization of prescription drugs. States have enacted consumer-related laws to create transparency and coverage notification requirements among health insurers for prescription drug benefits including changes to formularies. State regulations are designed to help individuals compare covered benefits among health plans and require insurers to notify affected members when changes are made to a prescription drug formulary in a specified period. Several states such as Louisiana, Nevada, New Mexico, and Texas enacted laws either limiting formulary changes during a plan year or requiring insurers notify consumers at least 60 days before a formulary changes.

Commercial health insurers may add, remove, or replace a prescription drug from their lists of approved medications as part of their formulary management, resulting in mid-year changes to health plans. Health plans may also exclude certain prescription drugs from a formulary, including medications without generic alternatives, or move covered drugs to different cost tiers to encourage consumers to select lower cost drugs when available. Health insurers use these strategies to reduce prescription drug costs. Such changes can result in patients having to switch medications for treatment of a health condition.

House Bill 4156 limits formulary changes and prohibits health insurers from increasing cost-sharing for prescription drugs or creating new utilization management requirements during a plan year.