BILL ANALYSIS

C.S.H.B. 907
By: Johnson, Julie
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health plans utilize prior authorizations to require a physician to obtain approval of the medical necessity and appropriateness of a health care service before it is provided. This process can lead to a delay of much-needed care and, at times, may result in a denial of a particular course of treatment altogether. Prior authorizations are being used to slow or even stop the use of high-cost medications, particularly for patients with autoimmune diseases. In some instances, patients have reported having to undergo the prior authorization process every time they need to refill their medication even though their disease requires consistent, lifelong treatment. This current structure has led to patients running out of their medication while waiting for the prior authorization request to be approved, thus disrupting treatment and causing increased health risks. C.S.H.B. 907 seeks to address this issue and improve patient outcomes by prohibiting an insurer from requiring prior authorization for drugs prescribed to treat an autoimmune disease more than once annually.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 907 amends the Insurance Code to prohibit a health benefit plan issuer that provides prescription drug benefits from requiring an enrollee to receive more than one prior authorization annually of the prescription drug benefit for a prescription drug prescribed to treat an autoimmune disease. The bill establishes, and provides certain exceptions to, the applicability of its provisions. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2022.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 907 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute does not prohibit an issuer from requiring any prior authorization for a prescription drug prescribed to treat a chronic or autoimmune disease. The substitute prohibits an issuer instead from requiring an enrollee to receive more than one prior authorization annually for a drug prescribed to treat an autoimmune disease.

The substitute does not apply to county employee group health benefits or to health and accident coverage provided by a risk pool created under the Texas Political Subdivision Employees Uniform Group Benefits Act.