SUBJECT: Creating a standard request form for prior authorization of health care

COMMITTEE: Insurance — favorable, without amendment

VOTE: 8 ayes — Smithee, Eiland, G. Bonnen, Morrison, Muñoz, Sheets, Taylor, C. Turner

0 nays

1 absent — Creighton

SENATE VOTE: On final passage, May 2— 31-1 (Estes)

WITNESSES: For — Patricia Kolodzey, Texas Medical Association; (*Registered, but did not testify:* B.J. Avery, Texas Optometric Association; Charles Bailey, Texas Hospital Association; Matt Johnson, Takeda Pharmaceuticals USA)

Against — None

On — (*Registered, but did not testify:* Doug Danzeiser, Texas Department of Insurance; Amy Lee, Texas Department of Insurance, Division of Workers' Compensation)

BACKGROUND: Health benefit plan issuers require physicians to fill out a prior authorization form when requesting certain procedures, services, or supplies.

DIGEST: SB 1216 would require certain health benefit plan issuers and their agents to use a single, standard form prescribed by rule of the commissioner of insurance for requesting prior authorization of health care services as required by a plan. The Department of Insurance, the health benefit plan issuers and the agents of health benefit plan issuers would have to make the form available electronically on their websites.

Definition of "health care services." The bill would define "health care services" to include medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment. The

term would not include prescription drugs.

Form development. The commissioner of insurance would have to develop the form with input from the advisory committee on uniform prior authorization forms for health care services benefits and would have to consider prior authorization forms widely used by the state or the Department of Insurance, forms established by the federal Centers for Medicaid and Medicaid Services, and national standards or draft standards for electronic prior authorization.

Advisory committee on uniform prior authorization forms. Under the bill, the commissioner of insurance would appoint an uncompensated advisory committee composed of an equal number of physicians, other health-care providers, hospital representatives, health benefit plan medical representatives, and representatives from the Health and Human Services Commission to advise the commissioner on the technical, operational, and practical aspects of developing the form. A physician could only serve on the committee if he or she had never been an insurance company employee or consultant. The advisory committee would:

- consult with the commissioner of insurance on rules related to the prior authorization form;
- determine the timelines for a health benefit issuer or its agent to acknowledge receipt of the form;
- determine the requirements for acknowledgement of receipt of the form; and
- set the administrative penalties that would be imposed on the health benefit plan issuer or its agent for failure to timely acknowledge receipt of the form or to use or accept the form.

Electronic prior authorization requests. Within two years of adoption of national standards for electronic prior authorization of benefits, a health benefit plan issuer or its agent would have to exchange prior authorization requests electronically with a physician or health care provider who had electronic capability and who initiated a request electronically. A health benefit plan issuer or its agent would have to continue to accept prior authorization requests using the standard paper form for requests initiated on paper.

Exceptions. The bill would not apply to a health benefit plan that provided coverage:

- only for a specified disease or for another single benefit;
- only for accidental death or dismemberment;
- only for wages or payments in lieu of wages for a period during which an employee was absent from work because of sickness or injury;
- as a supplement to a liability insurance policy;
- for credit insurance;
- only for dental or vision care;
- only for hospital expenses; or
- only for indemnity for hospital confinement.

The bill also would not apply to a Medicare supplemental policy, medical payment insurance coverage provided under a motor vehicle insurance policy, or a long-term insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determined that the policy provided benefit coverage so comprehensive that the policy was a health benefit plan affected by the bill.

Effective dates. The commissioner would have to rule to prescribe the standard prior authorization form by January 1, 2015. A change in law made by the bill would apply only to a request for prior authorization of health care services made on or after September 1, 2015. A request for prior authorization of health care services made before September 1, 2015, under a health benefit plan delivered, issued for delivery, or renewed before that date would not be affected by the bill.

The bill would take effect September 1, 2013.

SUPPORTERS SAY:

SB 644 would reduce red tape for health-care providers, cut health care costs, and improve patient safety and access to care by requiring health insurance plans to use one standard prior authorization form for health care services. Currently, each health insurance plan may require providers to use several different prior authorization forms, each of which asks for slightly different information. Inconsistency between prior authorization forms increases the risk of denial of a prior authorization request, increases the time providers need to fill out forms, and makes it harder for providers to know which form to use.

By establishing a prior authorization form advisory committee to develop the standard form, the bill would ensure that all stakeholders, including insurers, physicians, health care providers, HHSC, and hospitals could

decide together about the length and content of the form, administrative penalties assessed for noncompliance, and requirements for acknowledgement of receipt of the form. The bill would not affect how much time plans had to make a decision about a request. The advisory board would simply develop requirements for how and when a health plan had to acknowledge that they had received the form.

The bill would lessen the paperwork burden for providers by requiring use of one basic form, but the bill would not keep providers from attaching an addendum if they needed more room. It would not affect workers' compensation insurance plans or other specific plans that needed to use different forms.

OPPONENTS SAY:

By requiring one standard prior authorization form, the bill might require providers to either provide more information or less than was needed for a certain request. The bill might be burdensome for primary care providers, who typically do not need to fill out more than one page, or inadequate for specialists, who might need more room than the form would allow.