BILL ANALYSIS

Senate Research Center

C.S.S.B. 644
By: Huffman
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Prior authorization is a pre-approval step required by insurance companies, pharmacy benefits managers, and workers' compensation carriers for some medicines before they can be dispensed to patients and paid for by the insurer. Prior authorization often is required for drugs that are expensive and/or not on an insurance plan drug formulary. Each insurer has different prior authorization forms and the number of forms has increased and resulted in a time-consuming process for both physicians and pharmacists and delays in patients receiving their medication.

To save time and streamline the prior authorization process, C.S.S.B. 644 requires the commissioner of the Texas Department of Insurance to develop a single standard form for requesting the prior authorization of prescription drug benefits upon advice of an advisory committee.

C.S.S.B. 644 amends current law relating to the creation of a standard request form for prior authorization of prescription drug benefits.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1369.254 and 1369.256, Insurance Code) and SECTION 2 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1369, Insurance Code, by adding Subchapter F, as follows:

SUBCHAPTER F. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS

Sec. 1369.251. DEFINITION. Defines "prescription drug" in this subchapter.

Sec. 1369.252. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by an insurance company; a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations); a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies); a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies); a reciprocal exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges); a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations); a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements); or an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations).

(b) Provides that this subchapter applies to group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code.

(c) Provides that, notwithstanding Section 172.014 (Application of Certain Laws), Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172 (Texas Political Subdivisions Uniform Group Benefits Program), Local Government Code.

(d) Provides that, notwithstanding any provision in Chapter 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), 1579 (Texas School Employees Uniform Group Health Coverage), or 1601 (Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System) or any other law, this subchapter applies to a basic coverage plan under Chapter 1551, a basic plan under Chapter 1575, a primary care coverage plan under Chapter 1579, and basic coverage under Chapter 1601.

(e) Provides that, notwithstanding any other law, this subchapter applies to coverage under the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code; and the medical assistance program under Chapter 32 (Medical Assistance Program), Human Resources Code.

Sec. 1369.253. EXCEPTION. Provides that this subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) medical payment insurance coverage provided under a motor vehicle insurance policy;

(4) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner of insurance (commissioner) determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.252; or

(5) a workers' compensation insurance policy.

Sec. 1369.254. STANDARD FORM. (a) Requires the commissioner by rule to:

(1) prescribe a single, standard form for requesting prior authorization of prescription drug benefits;

(2) require a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits to use the form for any prior authorization of prescription drug benefits required by the plan;

(3) require that the Texas Department of Insurance (TDI) and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits make the form available electronically on the website of:

(A) TDI;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer; and

(4) establish penalties for failure to accept the form and acknowledge receipt of the form as required by commissioner rule.

(b) Requires a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits, not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, to exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.

(c) Requires the commissioner, in prescribing a form under this section, to:

(1) develop the form with input from the advisory committee on uniform prior authorization forms established under Section 1369.255; and

(2) take into consideration any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by TDI, request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services, and national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Sec. 1369.255. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) Requires the commissioner to appoint a committee to advise the commissioner on the technical, operational, and practical aspects of developing the single, standard prior authorization form required under Section 1369.254 for requesting prior authorization of prescription drug benefits.

(b) Requires the advisory committee to determine the following:

(1) a single standard form for requesting prior authorization of prescription drug benefits;

(2) the length of the standard prior authorization form;

(3) the length of time allowed for acknowledgment of receipt of the form by the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits;

(4) the acceptable methods to acknowledge receipt; and

(5) the penalty imposed on the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits for failure to acknowledge receipt of the form.

(c) Requires the commissioner to consult the committee with respect to any rule relating to a subject described by Section 1369.254 and 1369.255 before adopting the rule and authorizes the commissioner to consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(d) Requires the commissioner, not later than the second anniversary of the final approval of the standard prior authorization form, and every two years subsequently to convene the advisory committee to review the standard prior authorization form and determine if changes are needed.

(e) Requires that the committee be composed of the executive commissioner of the Health and Human Services Commission or designee and an equal number of members from each of the following groups: physicians; other prescribing health care providers; hospitals; pharmacists; specialty pharmacies; pharmacy benefit managers; health benefit plan issuers for the Texas Insurance Pool established under Chapter 1506 (Texas Health Insurance Pool); health benefit plan issuers; and health benefit plan networks of providers.

(f) Provides that a member of the advisory committee serves without compensation.

(g) Provides that Section 39.003(a) (relating to the requirement that at least one-half of the membership of each advisory body appointed by the commissioner, other than certain advisory bodies, represent the general public) of this code and Chapter 2110 (State Agency Advisory Committees), Government Code, do not apply to the advisory committee.

Sec. 1369.256. FAILURE TO USE OR ACKNOWLEDGE STANDARD FORM. Provides that, if a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits fails to use or accept the form prescribed under this subchapter or fails to acknowledge the receipt of a completed form submitted by a prescribing provider, as required by commissioner rule the health benefit plan issuer or the agent of the health benefit plan issuer is subject to the penalties established by the commissioner.

SECTION 2. Requires the commissioner, not later than January 1, 2015, by rule to prescribe a standard form under Section 1369.254, Insurance Code, as added by this Act.

SECTION 3. Makes application of this Act prospective to September 1, 2015.

SECTION 4. Effective date: September 1, 2013.