SUBJECT: Standardizing the prior authorization form for prescription drug benefits

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 — 31-0

WITNESSES: (*On House companion bill, HB 1032*)
For — Sharon Blancarte, Texas Medical Association; John Gill; Greg Hansch, National Association on Mental Illness; Bobby Hillert, Texas Orthopaedic Association; Vaughn Kinosian, ReCept Pharmacy; John McCormick, Texas Optometric Association; C.M. Schade, Texas Pain Society; (*Registered, but did not testify:* Jay Arnold, American Lung Association; Christine Bryan, Clarity Child Guidance Center; Jaime Capelo, Texas Academy of Physician Assistants, Texas Chapter of the American College of Cardiology, and Texas Urological Society; Tracy Casto; Audra Conwell, Alliance of Independent Pharmacists; Krista Crockett, Texas Pain Society; Lenore Depagter; Kristine Donatello, American Cancer Society Cancer Action Network; Steven Hays; John Heal, PBA Health and Texas TrueCare Pharmacies; Greg Herzog, Texas Society of Gastroenterology and Endoscopy; Michelle Ho, Texas Medical Association; Cheri Huddleston, Injured Workers' Pharmacy; Lisa Huges, Texas Dermatological Society; Lee Johnson, Texas Council of Community Centers; Marshall Kenderdine, Texas Pediatric Society and Texas Academy of Family Physicians; Jean Langendorf, Easter Seals Central Texas; John Lee Sang; Katherine Ligon, Center for Public Policy Priorities; Shannon Lucas, March of Dimes; Pete Martinez, Pharmaceutical Research and Manufacturers of America; David A. Marwitz, Texas Pharmacy Association; Mark Newberry, Tarrytown Pharmacy; Amber Pearce, Pfizer, Inc.; Karen Reagan, Walgreen Company; Laurie Reece, Texas Transplantation Society; Michelle Rodriguez, Tricounty Medical; Robert Rogers; Alberto Santos; Bradford

Shields, Texas Society of Health-System Pharmacists and Texas Federation of Drug Stores; Stephanie Simpson, Texas Association of Manufacturers; Dennis Wiesner, HEB; Eric Woomer, Federation of Texas Psychiatry; Michael Wright, Texas Pharmacy Business Council; Sherif Zaafran, Texas Society of Anesthesiologists)

Against — Cathy Dewitt, Texas Association of Business; David Gonzales, Texas Association of Health Plans; Sam McMurry, Texas Self Insurance Association; David Root; Joe Woods, Property Casualty Insurers Association of America; (*Registered, but did not testify:* Kevin Cooper, American Insurance Association; Lucinda Saxon, American Association of Preferred Provider Association)

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

BACKGROUND:

Occupations Code, sec. 551.003, defines "prescription drug" to mean:

- a substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;
- a drug or device that under federal law is required, before being dispensed or delivered, to be labeled with a caution statement or another legend that complies with federal law; or
- a drug or device that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a practitioner only.

Insurance companies and pharmacy benefits managers often require prior authorization to dispense prescription drugs that are expensive or that are not on an insurance plan drug formulary.

DIGEST:

SB 644 would require certain health insurance plans to use a single, standard form prescribed by rule of the commissioner of insurance for requesting prior authorization of prescription drug benefits. 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.

Form development. The commissioner of insurance would have to develop the form with input from the advisory committee on uniform prior

authorization 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. Under the bill, the commissioner of insurance would appoint an uncompensated advisory committee including health care providers, health benefit plan issuers, and a representative from the Health and Human Services Commission to help develop the form. The advisory committee would:

- consult with the commissioner of insurance on rules related to the prior authorization form;
- determine the page length of the standard prior authorization form;
- determine the length of time allowed for a health benefit issuer or its agent to acknowledge receipt of the form;
- determine the acceptable methods for acknowledgement of receipt; and
- set the penalty that would be imposed on the health benefit plan issuer or its agent for failure to acknowledge receipt of the form.

Penalties. Under the bill, a health benefit plan issuer or its agent that managed or administered prescription drug benefits would be subject to penalties established by the commissioner of insurance if they failed to use or accept the standard prior authorization form or failed to acknowledge the receipt of a completed form submitted by a prescribing provider.

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 accept electronic prior authorization requests for a prescribing provider who had e-prescribing capability.

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;
- 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:

- Medicare supplemental policies;
- medical payment insurance under a motor vehicle policy; or
- long-term care insurance, 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.

Effective dates. The commissioner of insurance would prescribe the standard prior authorization form by January 1, 2015.

The bill would take effect September 1, 2013, and would apply only to a request for prior authorization of prescription drug benefits made on or after September 1, 2015.

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 prescription drug benefits. Currently, Texas health insurance plans require providers to use up to 200 different prior authorization forms, many of which ask for 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.

Requiring providers to use several different prior authorization forms is unnecessary. Two Texas Medicaid plans each use only one prior authorization form for their prescription drug authorization requests, so it can be done.

The bill would ensure that a provider knew that a health plan had received its request for authorization by requiring health plans to acknowledge receipt of the request within a certain time frame and by penalizing health plans that did not use the standard form or did not acknowledge receipt of the form. The bill would only require health plans to acknowledge that

they had received the form. It would not affect how much time plans had to make a decision about the request.

By establishing a prior authorization form advisory committee, the bill would ensure that all stakeholders, including insurers, providers, HHSC, hospitals, and pharmacies, could decide the length and content of the form, penalties assessed for noncompliance, and the length of time required for acknowledgement of receipt of the form. Under the bill, providers could add an addendum to the form as needed.

OPPONENTS SAY:

By requiring a certain length for all prior authorization forms, 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 for specialists who might need more room than the form would allow.