BILL ANALYSIS

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S.B. 644
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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, 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.

As proposed, 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 (Section 1369.254, 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 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 (Texas School Employees Uniform Group Health Coverage), and basic coverage under Chapter 1601.

(e) Provides that, notwithstanding any other law, this subchapter applies to medical benefits provided to an injured employee under a workers' compensation insurance policy or otherwise under Title 5 (Workers' Compensation), Labor Code.

(f) 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; or

(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.

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; and

(4) allow a completed form to be submitted electronically by the prescribing provider to the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits.

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

(1) limit the form, as printed, to not more than two pages;

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

(3) 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 commissioner to consult the committee with respect to any rule relating to a subject described by Section 1369.254 before adopting the rule.

(c) Requires that the committee be composed of an equal number of members from each of the following groups: physicians; other prescribing health care providers; hospitals; pharmacists; pharmacy benefit managers; and health benefit plans.

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

(e) 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 RESPOND TO 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 respond within two business days of receipt to a completed form submitted by a prescribing provider, the prior authorization is considered granted by the health benefit plan.

SECTION 2. Requires the commissioner, not later than January 1, 2014, 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 March 1, 2014.

SECTION 4. Effective date: September 1, 2013.