BILL ANALYSIS

C.S.H.B. 1032
By: Zerwas
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Prior authorization is required by insurance companies and pharmacy benefits managers before certain prescriptions may be dispensed. While this process assists health plans in reducing costs and ensuring the medical necessity of certain medications, interested parties report that in the past several years, the number of prior authorization forms in Texas has increased more than fivefold. These parties contend that the process of fulfilling prior authorization requirements is time-consuming and expensive and can cause delays in patient treatment or, worse, result in lack of treatment and that the use of one standardized form for requesting prior authorization of prescription drug benefits could save providers and patients time and resources. C.S.H.B. 1032 seeks to facilitate the prior authorization process by providing for a single, standard form for requesting the prior authorization of prescription drug benefits.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 1 and 2 of this bill.

ANALYSIS

C.S.H.B. 1032 amends the Insurance Code to require the commissioner of insurance by rule, not later than September 1, 2015, to prescribe a single, standard form for requesting prior authorization of prescription drug benefits; to 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; and to require the Texas Department of Insurance (TDI) and a health benefit plan issuer or that issuer's agent to make the form available electronically on the websites of TDI, the health benefit plan issuer, and the agent of the health benefit plan issuer. The bill requires a health benefit plan issuer or the issuer's agent, 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.S.H.B. 1032 requires the commissioner, in prescribing the single, standard prescription drug benefits prior authorization request form, to limit the form, as printed, to not more than two pages; to develop the form with input from the advisory committee on uniform prior authorization forms established by the bill and appointed by the commissioner; and to take into consideration certain other forms and national standards, or draft standards, pertaining to electronic prior authorization of benefits.

C.S.H.B. 1032 requires the commissioner to consult with the advisory committee with respect to any rule relating to the content and implementation of the form before adopting the rule and authorizes the commissioner to consult the committee as needed with respect to a subsequent amendment of an adopted rule. The bill sets out the composition of the committee and specifies that a member of the committee serves without compensation. The bill establishes that Insurance

Code provisions requiring at least one-half of the membership of a commissioner-appointed advisory body to represent the general public and Government Code provisions relating to state agency advisory committees do not apply to the advisory committee on uniform prior authorization forms.

C.S.H.B. 1032 establishes that a health benefit plan issuer or issuer's agent that fails to use or accept the prescription drug benefits prior authorization request form or fails to acknowledge within two business days the receipt of a completed form submitted by a prescribing provider is considered to have granted the prior authorization.

C.S.H.B. 1032 establishes the applicability of its provisions to specified types of insurance providers, coverages, and plans and the inapplicability of those provisions to specified types of health benefit plans, coverages, and related insurance policies and establishes that its provisions apply only to a request for prior authorization of prescription drug benefits made on or after September 1, 2015.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1032 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows: SUBCHAPTER F. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS Sec. 1369.251. DEFINITION. In this subchapter, "prescription drug" has the meaning assigned by Section 551.003, Occupations Code. Sec. 1369.252. APPLICABILITY OF SUBCHAPTER. (a) 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: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a fraternal benefit society operating under Chapter 885;	SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows: SUBCHAPTER F. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS Sec. 1369.251. DEFINITION. In this subchapter, "prescription drug" has the meaning assigned by Section 551.003, Occupations Code. Sec. 1369.252. APPLICABILITY OF SUBCHAPTER. (a) 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: (1) an insurance company; (2) a group hospital service corporation operating under Chapter 842; (3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;
(5) a reciprocal exchange operating under Chapter 942;
(6) a health maintenance organization operating under Chapter 843;
(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.
(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:
(1) a basic coverage plan under Chapter 1551;
(2) a basic plan under Chapter 1575;
(3) a primary care coverage plan under Chapter 1579; and
(4) basic coverage under Chapter 1601.

(f) Notwithstanding any other law, this subchapter applies to coverage under:
(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and
(2) the medical assistance program under Chapter 32, Human Resources Code.
Sec. 1369.253. EXCEPTION. 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;

(4) a stipulated premium company operating under Chapter 884;
(5) a reciprocal exchange operating under Chapter 942;
(6) a health maintenance organization operating under Chapter 843;
(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.
(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:
(1) a basic coverage plan under Chapter 1551;
(2) a basic plan under Chapter 1575;
(3) a primary care coverage plan under Chapter 1579; and
(4) basic coverage under Chapter 1601.

(e) Notwithstanding any other law, this subchapter applies to coverage under:
(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and
(2) the medical assistance program under Chapter 32, Human Resources Code.
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(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 determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.252.	(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 determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.252; or
(e) 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, Labor Code.	(5) a workers' compensation insurance policy.
Sec. 1369.254. STANDARD FORM. (a) The commissioner by rule shall: (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 department 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	Sec. 1369.254. STANDARD FORM. (a) The commissioner by rule shall: (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; and (3) require that the department 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) the department; (B) the health benefit plan issuer; and (C) the agent of the health benefit plan issuer.
(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) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits shall exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.

(b) In prescribing a form under this section, the commissioner shall:
(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:
(A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by the department;
(B) request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services; and
(C) national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Sec. 1369.255. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) The commissioner shall 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) The commissioner shall consult the committee with respect to any rule relating to a subject described by Section 1369.254 before adopting the rule.

(c) The committee shall be composed of an equal number of members from each of the following groups:
(1) physicians;
(2) other prescribing health care providers;
(3) hospitals;
(4) pharmacists;

(5) pharmacy benefit managers; and
(6) health benefit plans.

(d) A member of the advisory committee serves without compensation.
(e) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

(c) In prescribing a form under this section, the commissioner shall:
(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:
(A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by the department;
(B) request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services; and
(C) national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Sec. 1369.255. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) The commissioner shall 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) The commissioner shall consult the committee with respect to any rule relating to a subject described by Section 1369.254 before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an adopted rule.
(c) The committee shall be composed of an equal number of members from each of the following groups:
(1) physicians;
(2) other prescribing health care providers;
(3) hospitals;
(4) pharmacists;
(5) specialty pharmacies;
(6) pharmacy benefit managers;
(7) health benefit plan issuers for the Texas Health Insurance Pool established under Chapter 1506;
(8) health benefit plan issuers; and
(9) health benefit plan networks of providers.
(d) A member of the advisory committee serves without compensation.
(e) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

Sec. 1369.256. FAILURE TO USE OR RESPOND TO STANDARD FORM. 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.	Sec. 1369.256. FAILURE TO USE OR ACKNOWLEDGE STANDARD FORM. 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 within two business days the receipt of a completed form submitted by a prescribing provider, the prior authorization is considered granted by the health benefit plan.
SECTION 2. Not later than January 1, 2014, the commissioner of insurance by rule shall prescribe a standard form under Section 1369.254, Insurance Code, as added by this Act.	SECTION 2. Not later than September 1, 2015, the commissioner of insurance by rule shall prescribe a standard form under Section 1369.254, Insurance Code, as added by this Act.
SECTION 3. The change in law made by this Act applies only to a request for prior authorization of prescription drug benefits made on or after March 1, 2014. A request for prior authorization of prescription drug benefits made before March 1, 2014, under a health benefit plan delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 3. The change in law made by this Act applies only to a request for prior authorization of prescription drug benefits made on or after September 1, 2015. A request for prior authorization of prescription drug benefits made before September 1, 2015, under a health benefit plan delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.
SECTION 4. This Act takes effect September 1, 2013.	SECTION 4. Same as introduced version.