BILL ANALYSIS

Senate Research Center

S.B. 1216
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Health benefit plan issuers require physicians to fill out a prior authorization form when the physician or provider requests a procedure, service, or supply that falls on their required list of items requiring prior authorization. Each health benefit plan issuer can have multiple prior authorization forms for the various services or supplies requested. Processing these various forms can delay and negatively impact patient care.

S.B. 1216 will streamline the prior authorization process and improve access to medical services and procedures. It directs the Texas Department of Insurance with input from an advisory committee to create a single, uniform standardized prior authorization form required to be used by all health benefit plan issuers. "Health benefit plan issuer" is defined and includes commercial insurers, health maintenance organizations, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, Medicaid, Medicaid managed care, the children's health insurance program, and workers' compensation.

S.B. 1216 amends current law relating to the creation of a standard request form for prior authorization of medical care or health care services.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1217.004, Insurance Code) and SECTION 2 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle A, Title 8, Insurance Code, by adding Chapter 1217, as follows:

CHAPTER 1217. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Sec. 1217.001. DEFINITIONS. Defines "health benefit plan issuer" and "health care services" in this chapter.

Sec. 1217.002. APPLICABILITY OF CHAPTER. (a) Provides that this chapter 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 (Group Hospital Service Corporations);

(3) a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies);

(4) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(5) a reciprocal exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges);

(6) a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements); or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations).

(b) Provides that this chapter 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 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 chapter 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.

(d) Provides that, notwithstanding any other law, this chapter applies to coverage under:

(1) 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

(2) a Medicaid managed care program operated under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code, or a Medicaid program operated under Chapter 32 (Medical Assistance Program), Human Resources Code.

Sec. 1217.003. EXCEPTION. Provides that this chapter 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) only 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, 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 1217.002; or

(5) a workers' compensation insurance policy.

Sec. 1217.004. STANDARD FORM. (a) Requires the commissioner by rule to:

(1) prescribe a single, standard form for requesting prior authorization of health care services;

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

(3) require the Texas Department of Insurance (TDI) and a health benefit plan issuer or an agent of a health benefit plan issuer that manages or administers health care services benefits to make the form available in paper form and electronically on the websites of TDI, the health benefit plan issuer, and the agent of the health benefit plan issuer.

(b) Requires a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services 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 physician or health care provider who has electronic capability and who initiates a request electronically. Requires a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits, for requests initiated on paper, to accept prior authorization requests using the standard paper form developed pursuant to this chapter.

(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 for health care services benefits established under Section 1217.005; and

(2) take into consideration:

(A) any form for requesting prior authorization of health care services benefits that is widely used in this state or any form currently used by TDI;

(B) request forms for prior authorization of health care services 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. 1217.005. 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 1217.004 for requesting prior authorization of health care services, including:

(1) requirements for the health benefit plan issuer or agent of the health benefit plan issuer to acknowledge receipt of the standard form;

(2) timelines under which the health benefit plan issuer or agent of the health benefit plan issuer is required to acknowledge receipt of the standard form; and

(3) implications, including administrative penalties, for the failure of a health benefit plan issuer or agent of a health benefit plan issuer to timely acknowledge receipt of the standard form, or use or accept the form.

(b) Requires the commissioner to consult the Advisory Committee on Uniform Prior Authorization Forms (advisory committee) with respect to any rule relating to a subject described by Section 1217.004 before adopting the rule and authorizes the commissioner to consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(c) Requires the advisory committee to be composed of an equal number of members from each of the following groups of stakeholders:

(1) physicians;

(2) health care providers other than physicians;

(3) hospitals; and

(4) representatives of health benefit plans.

(5) Health and Human Services Commission representatives.

(d) Prohibits a physician from serving on the advisory committee as a physician member under Subsection (c)(1) if the physician is or has been employed by or consults or has consulted for an insurance company.

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

(f) Provides that Section 39.003(a) (relating to requiring at least one-half of the membership of each advisory body appointed by the commissioner, other than an advisory body whose membership is determined by this code or by another law relating to the business of insurance in this state, to represent the general public) of this code and Chapter 2110 (State Agency Advisory Committees), Government Code, do not apply to the advisory committee.

Sec. 1217.006. FAILURE TO PRESCRIBE STANDARD FORM. Provides that nothing in this chapter may be construed as authorizing the commissioner to decline to prescribe the form required by Section 1217.004.

Sec. 1217.007. CONSTRUCTION WITH OTHER LAW. Provides that nothing in this chapter may be construed as permitting a health benefit plan issuer or an agent of a health benefit plan issuer to require prior authorization of health care services benefits when otherwise prohibited by law.

SECTION 2. Requires the commissioner, not later than January 1, 2015, by rule to prescribe a standard form under Section 1217.004, Insurance Code, as added by this Act.

SECTION 3. Provides that the change in law made by this Act applies only to a request for prior authorization of health care services made on or after September 1, 2015. Provides that 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 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. Effective date: September 1, 2013.