BILL ANALYSIS

S.B. 1216
By: Eltife
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Health benefit plan issuers require physicians to fill out a prior authorization form when requesting certain procedures, services, or supplies. Interested parties observe that each health benefit plan issuer can have multiple prior authorization forms for the various services or supplies requested, and there is concern that processing these various forms can delay and negatively impact patient care. S.B. 1216 seeks to streamline the prior authorization process and improve access to medical services and procedures through the creation of a single, standard form for requesting prior authorization of health care services.

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

S.B. 1216 amends the Insurance Code to require the commissioner of insurance by rule to prescribe a single, standard form not later than January 1, 2015, for requesting prior authorization of health care services; to require a health benefit plan issuer or the issuer's agent that manages or administers health care services benefits to use the form for any prior authorization required by the plan of health care services; and to require that the Texas Department of Insurance (TDI) and a health benefit plan issuer or the issuer's agent that manages or administers health care services benefits make the form available in paper form and electronically on the website of TDI, the health benefit plan issuer, and the issuer's agent.

S.B. 1216 requires a health benefit plan issuer or the issuer's agent 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. The bill requires a health benefit plan issuer or the issuer's agent that manages or administers health care services benefits to accept prior authorization requests initiated on paper using the standard paper form developed under the bill's provisions.

S.B. 1216 requires the commissioner, in prescribing the standard form, to develop the form with input from the advisory committee on uniform prior authorization forms for health care services benefits established under the bill's provisions and to take into consideration certain other forms regarding prior authorization of health care services benefits and national standards, or draft standards, pertaining to electronic prior authorization of benefits.

S.B. 1216 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, including requirements for the health benefit plan issuer or the issuer's agent to acknowledge receipt of the standard form; timelines under which the health benefit plan issuer or the issuer's agent must acknowledge receipt of the standard form; and implications, including

administrative penalties, for the failure of a health benefit plan issuer or the issuer's agent to timely acknowledge receipt of the standard form or use or accept the form.

S.B. 1216 requires the commissioner to consult the advisory committee with respect to any rule relating to the development and use of the standard form or the electronic exchange of prior authorization requests 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 advisory committee and prohibits a physician from serving on the committee as a physician member if the physician is or has been employed by or consults or has consulted for an insurance company. The bill establishes that a member of the advisory committee serves without compensation. The bill exempts the advisory committee from 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.

S.B. 1216 provides that nothing in the bill's provisions may be construed as authorizing the commissioner to decline to prescribe the standard form or permitting a health benefit plan issuer or an issuer's agent to require prior authorization of health care services benefits when otherwise prohibited by law. The bill applies its provisions to specified health benefit plans, coverages, and programs and excludes certain plans, coverages, and policies from its provisions. The bill's provisions apply only to a request for prior authorization of health care services made on or after September 1, 2015.

EFFECTIVE DATE

September 1, 2013.