By: Eltife S.B. No. 1216

(In the Senate - Filed March 6, 2013; March 13, 2013, read first time and referred to Committee on State Affairs; April 29, 2013, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; April 29, 2013, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Duncan	X			
Deuell	X			
Ellis	X			
Fraser	X			
Huffman	X			
Lucio	X			
Nichols	X			
Van de Putte	X			
Williams	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 1216 By: Deuell

A BILL TO BE ENTITLED
AN ACT

relating to the creation of a standard request form for prior authorization of medical care or health care services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1217 to read as follows:

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

Sec. 1217.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that delivers or issues for delivery a health benefit plan or other coverage that is covered under this chapter as described by Section 1217.002. The term includes:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a reciprocal exchange operating under Chapter 942;

(F) a health maintenance organization operating under Chapter 843;

(G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(2) "Health care services" includes medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment. The term does not include prescription drugs as defined by Section 551.003, Occupations Code.

Sec. 1217.002. APPLICABILITY OF CHAPTER. (a) 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;

(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 chapter 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 chapter 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 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.

(e) Notwithstanding any other law, this chapter 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) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Sec. 1217.003. EXCEPTION. 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; 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 1217.002.

Sec. 1217.004. STANDARD FORM. (a) The commissioner by rule shall:

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

(2) require a health benefit plan issuer or the agent of the health benefit plan issuer 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

(3) require that the department and a health benefit

plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits make the form available in paper form and electronically on the website of:

(A) the department;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer.

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

(c) In prescribing a form under this section, the commissioner shall:

(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 the department;

(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) 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 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 must 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:

(A) timely acknowledge receipt of the standard form; or

(B) use or accept the form.

(b) The commissioner shall consult the advisory committee with respect to any rule relating to a subject described by Section 1217.004 before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(c) The advisory committee shall 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;

(4) medical representatives of health benefit plans; and

(5) Health and Human Services Commission representatives.

(d) A physician may not serve 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) A member of the advisory committee serves without

compensation.

(f) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

Sec. 1217.006. FAILURE TO PRESCRIBE STANDARD FORM. 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. 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. Not later than January 1, 2015, the commissioner of insurance by rule shall prescribe a standard form under Section 1217.004, 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 health care services made on or after September 1, 2015. 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. This Act takes effect September 1, 2013.

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