BILL ANALYSIS

C.S.H.B. 755
By: Johnson, Julie
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health plans utilize prior authorizations to require a physician to obtain approval of the medical necessity and appropriateness of a health care service before it is provided. This process can lead to a delay of much-needed care and, at times, may result in a denial of a particular course of treatment altogether. Prior authorizations are being used to slow or even stop the use of high-cost medications, particularly for patients with an autoimmune disease, hemophilia, or Von Willebrand disease. In some instances, patients have reported having to undergo the prior authorization process every time they need to refill their medication even though their disease requires consistent, lifelong treatment. This current structure has led to patients running out of their medication while waiting for the prior authorization request to be approved, thus disrupting treatment and causing increased health risks.

C.S.H.B. 755 seeks to address this issue and improve patient outcomes by prohibiting an insurer from requiring prior authorization for drugs prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease more than once annually.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 755 amends the Insurance Code to prohibit a health benefit plan issuer that provides prescription drug benefits from requiring an enrollee to receive more than one prior authorization annually of the prescription drug benefit for certain prescription drugs prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. The bill makes that requirement inapplicable to the following:

- opioids, benzodiazepines, barbiturates, or carisoprodol;
- prescription drugs that have a typical treatment period of less than 12 months;
- drugs that have a boxed warning assigned by the FDA for use and must have specific provider assessment; or
- the use of a drug approved for use by the FDA in a manner other than the approved use.

C.S.H.B. 755 establishes the types of plans to which its provisions apply and establishes exceptions to that applicability, including exceptions for Medicaid and CHIP. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 755 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute revises provisions in the introduced regarding the bill's applicability in the following manner:

- changes the medical conditions for which an applicable health benefit plan issuer may not require more than one prior authorization annually for prescription drugs from chronic or autoimmune disease, as provided in the introduced, to autoimmune disease, hemophilia, or Von Willebrand disease, as provided in the substitute;
- includes a provision that was not in the introduced excluding specified prescription drugs from that prohibition;
- includes a provision that was not in the introduced excepting Medicaid and CHIP from the bill's applicability; and
- omits provisions included in the introduced making the bill applicable to health benefits provided by or through a church benefits board and a regional or local health care program.