BILL ANALYSIS

Senate Research Center
88R2329 CJD-D

S.B. 1150
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Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Prior authorization is a decision by health insurers or plans that determine whether a health care service, treatment plan, prescription drug, or durable medical device is medically necessary. Some health insurance plans require preauthorization for certain services, except in the cases of emergencies.

Chronically ill patients in the state of Texas maintain their health, quality of life, and livelihood through medications that allow them to manage their illnesses. Once a patient is stable on medication that must be taken regularly, health benefit plans can still require a prior authorization for that medication, which interrupts the continuity of care and negatively affects a patient's health. Patients stable on their medications should not be subject to prior authorization requirements that interrupt their care and put their health at risk.

This bill would prohibit insurance companies from requiring prior authorization for prescription drugs used to treat chronic or autoimmune conditions more than once annually. This would promote continuity of care and allow patients to lead productive lives while managing their illnesses.

As proposed, S.B. 1150 amends current law relating to prior authorization for prescription drug benefits related to the treatment of chronic and autoimmune diseases.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1369, Insurance Code, by adding Subchapter N, as follows:

SUBCHAPTER N. COVERAGE OF PRESCRIPTION DRUGS FOR CHRONIC AND AUTOIMMUNE DISEASES

Sec. 1369.651. DEFINITION. Defines "prescription drug."

Sec. 1369.652. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to a health benefit plan that provides benefits for medical, surgical, or prescription drug expenses incurred as a result of a health condition, accident, or sickness, including an individual 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 an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

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

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

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

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

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

(8) a Lloyd's plan operating under Chapter 941 (Lloyd's Plan); or

(9) an exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges).

(b) Provides that this subchapter, notwithstanding any other law, applies to:

(1) a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter;

(2) a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(4) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(5) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(6) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System);

(7) health benefits provided by or through a church benefits board under Subchapter I (Church Benefits Boards), Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code;

(9) a regional or local health care program operated under Section 75.104 (Health Care Services), Health and Safety Code; and

(10) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

(c) Provides that this subchapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Sec. 1369.653. EXCEPTIONS. (a) Provides that this subchapter does not apply to a plan that provides coverage:

(1) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(2) only for hospital expenses.

(b) Provides that this subchapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR AUTHORIZATIONS. Prohibits 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 a prescription drug prescribed to treat a chronic or autoimmune disease.

SECTION 2. Makes application of this Act prospective to January 1, 2024.

SECTION 3. Effective date: September 1, 2023.