AN ACT

relating to the creation of a standard request form for prior authorization of prescription drug benefits.

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

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS

Sec. 1369.251. DEFINITION. In this subchapter, "prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

Sec. 1369.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter 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 subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter 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) Notwithstanding any other law, this subchapter 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) the medical assistance program under Chapter 32, Human Resources Code.

Sec. 1369.253. EXCEPTION. This subchapter 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) 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(g)(1), 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 determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.252;

(5) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or

(6) a workers' compensation insurance policy.

Sec. 1369.254. STANDARD FORM. (a) The commissioner by

rule shall:

(1) prescribe a single, standard form for requesting prior authorization of prescription drug benefits;

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

(3) require that the department and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits make the form available electronically on the website of:

(A) the department;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer; and

(4) establish penalties for failure to accept the form and acknowledge receipt of the form as required by commissioner rule.

(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 prescription drug benefits shall exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.

(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 established under Section 1369.255; and

(2) take into consideration:

(A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by the department;

(B) request forms for prior authorization of 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. 1369.255. 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 1369.254 for requesting prior authorization of prescription drug benefits.

(b) The advisory committee shall determine the following:

(1) a single standard form for requesting prior authorization of prescription drug benefits;

(2) the length of the standard prior authorization form;

(3) the length of time allowed for acknowledgement of receipt of the form by the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits;

(4) the acceptable methods to acknowledge receipt; and

(5) the penalty imposed on the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits for failure to acknowledge receipt of the form.

(c) The commissioner shall consult the advisory committee with respect to any rule relating to a subject described by Section 1369.254 or this section before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(d) Not later than the second anniversary of the final approval of the standard prior authorization form, and every two years subsequently, the commissioner shall convene the advisory committee to review the standard prior authorization form, examine the form's effectiveness and impact on patient safety, and determine whether changes are needed.

(e) The advisory committee shall be composed of the commissioner of insurance or the commissioner's designee, the executive commissioner of the Health and Human Services Commission or the executive commissioner's designee, and an equal number of members from each of the following groups:

(1) physicians;

(2) other prescribing health care providers;

(3) consumers experienced with prior authorizations;

(4) hospitals;

(5) pharmacists;

(6) specialty pharmacies;

(7) pharmacy benefit managers;

(8) specialty drug distributors;

(9) health benefit plan issuers for the Texas Health Insurance Pool established under Chapter 1506;

(10) health benefit plan issuers; and

(11) health benefit plan networks of providers.

(f) A member of the advisory committee serves without compensation.

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

Sec. 1369.256. FAILURE TO USE OR ACKNOWLEDGE STANDARD FORM. If a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits fails to use or accept the form prescribed under this subchapter or fails to acknowledge the receipt of a completed form submitted by a prescribing provider, as required by commissioner rule, the health benefit plan issuer or the agent of the health benefit plan issuer is subject to the penalties established by the commissioner.

SECTION 2. Not later than January 1, 2015, the commissioner of insurance by rule shall prescribe a standard form under Section 1369.254, 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 prescription drug benefits made on or after September 1, 2015. A request for prior authorization of prescription drug benefits 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.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 644 passed the Senate on May 2, 2013, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendments on May 24, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 644 passed the House, with amendments, on May 21, 2013, by the following vote: Yeas 132, Nays 15, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor