

1-1 By: Bonnen, Morales Shaw H.B. No. 3459  
 1-2 (Senate Sponsor - Buckingham)  
 1-3 (In the Senate - Received from the House May 10, 2021;  
 1-4 May 11, 2021, read first time and referred to Committee on Finance;  
 1-5 May 19, 2021, reported favorably by the following vote: Yeas 13,  
 1-6 Nays 0; May 19, 2021, sent to printer.)

1-7 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-8				
1-9	X			
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15			X	
1-16	X			
1-17			X	
1-18	X			
1-19	X			
1-20	X			
1-21	X			
1-22	X			
1-23	X			

1-24 A BILL TO BE ENTITLED  
 1-25 AN ACT

1-26 relating to preauthorization requirements for certain medical and  
 1-27 health care services and utilization review for certain health  
 1-28 benefit plans.

1-29 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-30 SECTION 1. Subchapter J, Chapter 843, Insurance Code, is  
 1-31 amended by adding Section 843.3484 to read as follows:

1-32 Sec. 843.3484. EXEMPTION FROM PREAUTHORIZATION  
 1-33 REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH  
 1-34 CARE SERVICES. (a) A health maintenance organization that uses a  
 1-35 preauthorization process for health care services may not require a  
 1-36 physician or provider to obtain preauthorization for a particular  
 1-37 health care service if, in the preceding calendar year:

1-38 (1) the physician or provider submitted not less than  
 1-39 five preauthorization requests for the particular health care  
 1-40 service; and

1-41 (2) the health maintenance organization approved not  
 1-42 less than 80 percent of the preauthorization requests submitted by  
 1-43 the physician or provider for the particular health care service.

1-44 (b) An exemption from preauthorization requirements under  
 1-45 Subsection (a) lasts for one calendar year.

1-46 (c) Not later than January 30 of each calendar year, a  
 1-47 health maintenance organization must provide to a physician or  
 1-48 provider who qualifies for an exemption from preauthorization  
 1-49 requirements under Subsection (a) a notice that includes:

1-50 (1) a statement that the physician or provider  
 1-51 qualifies for an exemption from preauthorization requirements  
 1-52 under Subsection (a);

1-53 (2) a list of the health care services to which the  
 1-54 exemption applies; and

1-55 (3) a statement that the exemption applies only for  
 1-56 the calendar year in which the physician or provider receives the  
 1-57 notice.

1-58 (d) If a physician or provider submits a preauthorization  
 1-59 request for a health care service for which the physician or  
 1-60 provider qualifies for an exemption from preauthorization  
 1-61 requirements under Subsection (a), the health maintenance

2-1 organization must promptly provide a notice to the physician or  
 2-2 provider that includes:

2-3 (1) the information described by Subsection (c); and  
 2-4 (2) a notification of the health maintenance  
 2-5 organization payment requirements described by Subsection (e).

2-6 (e) A health maintenance organization may not deny or reduce  
 2-7 payment to a physician or provider for a health care service to  
 2-8 which the physician or provider qualifies for an exemption from  
 2-9 preauthorization requirements under Subsection (a) based on  
 2-10 medical necessity or appropriateness of care.

2-11 SECTION 2. Subchapter C-1, Chapter 1301, Insurance Code, is  
 2-12 amended by adding Section 1301.1354 to read as follows:

2-13 Sec. 1301.1354. EXEMPTION FROM PREAUTHORIZATION  
 2-14 REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING  
 2-15 CERTAIN HEALTH CARE SERVICES. (a) An insurer that uses a  
 2-16 preauthorization process for medical care or health care services  
 2-17 may not require a physician or health care provider to obtain  
 2-18 preauthorization for a particular medical or health care service  
 2-19 if, in the preceding calendar year:

2-20 (1) the physician or health care provider submitted  
 2-21 not less than five preauthorization requests for the particular  
 2-22 medical or health care service; and

2-23 (2) the insurer approved not less than 80 percent of  
 2-24 the preauthorization requests submitted by the physician or health  
 2-25 care provider for the particular medical or health care service.

2-26 (b) An exemption from preauthorization requirements under  
 2-27 Subsection (a) lasts for one calendar year.

2-28 (c) Not later than January 30 of each calendar year, an  
 2-29 insurer must provide to a physician or health care provider who  
 2-30 qualifies for an exemption from preauthorization requirements  
 2-31 under Subsection (a) a notice that includes:

2-32 (1) a statement that the physician or health care  
 2-33 provider qualifies for an exemption from preauthorization  
 2-34 requirements under Subsection (a);

2-35 (2) a list of the medical or health care services to  
 2-36 which the exemption applies; and

2-37 (3) a statement that the exemption applies only for  
 2-38 the calendar year in which the physician or health care provider  
 2-39 receives the notice.

2-40 (d) If a physician or health care provider submits a  
 2-41 preauthorization request for a medical or health care service for  
 2-42 which the physician or health care provider qualifies for an  
 2-43 exemption from preauthorization requirements under Subsection (a),  
 2-44 the insurer must promptly provide a notice to the physician or  
 2-45 health care provider that includes:

2-46 (1) the information described by Subsection (c); and

2-47 (2) a notification of the insurer payment requirements  
 2-48 described by Subsection (e).

2-49 (e) An insurer may not deny or reduce payment to a physician  
 2-50 or health care provider for a medical or health care service to  
 2-51 which the physician or health care provider qualifies for an  
 2-52 exemption from preauthorization requirements under Subsection (a)  
 2-53 based on medical necessity or appropriateness of care.

2-54 SECTION 3. Section 4201.206, Insurance Code, is amended to  
 2-55 read as follows:

2-56 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE  
 2-57 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the  
 2-58 notice requirements of Subchapter G, before an adverse  
 2-59 determination is issued by a utilization review agent who questions  
 2-60 the medical necessity, the appropriateness, or the experimental or  
 2-61 investigational nature of a health care service, the agent shall  
 2-62 provide the health care provider who ordered, requested, provided,  
 2-63 or is to provide the service a reasonable opportunity to discuss  
 2-64 with a physician licensed to practice medicine in this state the  
 2-65 patient's treatment plan and the clinical basis for the agent's  
 2-66 determination.

2-67 (b) If the health care service described by Subsection (a)  
 2-68 was ordered, requested, or provided, or is to be provided by a  
 2-69 physician, the opportunity described by that subsection must be

3-1 with a physician licensed to practice medicine in this state and who  
3-2 has the same or similar specialty as the physician.

3-3 SECTION 4. The changes in law made by this Act to Chapters  
3-4 843 and 1301, Insurance Code, apply only to a request for  
3-5 preauthorization of medical care or health care services made on or  
3-6 after January 1, 2022. A request for preauthorization of medical  
3-7 care or health care services made before January 1, 2022, is  
3-8 governed by the law as it existed immediately before the effective  
3-9 date of this Act, and that law is continued in effect for that  
3-10 purpose.

3-11 SECTION 5. Section 4201.206, Insurance Code, as amended by  
3-12 this Act, applies only to a utilization review requested on or after  
3-13 the effective date of this Act. A utilization review requested  
3-14 before the effective date of this Act is governed by the law as it  
3-15 existed immediately before the effective date of this Act, and that  
3-16 law is continued in effect for that purpose.

3-17 SECTION 6. This Act takes effect September 1, 2021.

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