BILL ANALYSIS

Senate Research Center

H.B. 4290
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Texas consumers with managed care health plans regulated by the Texas Department of Insurance (TDI), such as health maintenance organizations and preferred provider plans, currently are entitled to an independent review of their carriers' decisions to deny a pre-authorization of treatment based on a carrier's decision that the treatment is not medically necessary, but current law does not require an independent review of a carrier's conclusion that a treatment should be denied because it is experimental or investigational. In addition, current law does not provide for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary.

Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review of the denial. However, such decisions are entitled to independent review both prospectively and retroactively through a process coordinated by TDI. A study by a national association of health plans found that a majority of states currently have independent review programs that cover either all adverse decisions or all adverse decisions involving medical necessity or services deemed to be experimental. Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care.

TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68 percent of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30 percent of the time.

H.B. 4290 requires an independent review of experimental and investigational denials and an independent review of denials based on retrospective reviews when requested by the insured, the provider, or a person acting on behalf of the insured.

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 Sections 1305.004(a)(1), (10), and (23), Insurance Code, to redefine "adverse determination," "independent review," and "screening criteria."

SECTION 2. Amends Section 1305.053, Insurance Code, as follows:

> Sec. 1305.053. CONTENTS OF APPLICATION. Requires that each certificate application include certain information including a description of programs and procedures to be utilized that includes certain information including the utilization review

program described in Subchapter H (Utilization Review; Retrospective Review), rather than the utilization review and retrospective review programs described in Subchapter H.

SECTION 3. Amends Section 1305.154(c), Insurance Code, to create Subdivision (9)(D) from existing text and delete Subdivision (9)(E).

SECTION 4. Amends the heading to Subchapter H, Chapter 1305, Insurance Code, to read as follows:

SUBCHAPTER H. UTILIZATION REVIEW

SECTION 5. Amends Section 1305.351, Insurance Code, as follows:

Sec. 1305.351. New heading: UTILIZATION REVIEW IN NETWORK. (a) Makes no changes to this subsection.

(b) Requires that any screening criteria used for utilization review, rather than utilization review or retrospective review, related to a workers' compensation health care network be consistent with the network's treatment guidelines.

(c) Makes no changes to this subsection.

(d) Makes a conforming change.

SECTION 6. Amends Section 1305.353(a), Insurance Code, to make conforming changes.

SECTION 7. Amends Sections 4201.002(1) and (13), Insurance Code, to redefine "adverse determination" and "utilization review."

SECTION 8. Amends Section 4201.051, Insurance Code, as follows:

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. Provides that this chapter does not apply to a person who provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan and does not determine whether a particular health care service provided or to be provided to an enrollee is medically necessary or appropriate or experimental or investigational.

SECTION 9. Amends Section 4201.206, Insurance Code, as follows:

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Requires that a utilization review agent, subject to the notice requirements of Subchapter G (Notice of Determinations), before an adverse determination is issued by an agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of health care service, provide the healthcare provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination.

SECTION 10. Amends Section 4201.401, Insurance Code, by adding Subsection (c) to require that the utilization review agent comply with the independent review organization's determination regarding the experimental or investigational nature of health care items and services for an enrollee.

SECTION 11. Amends Section 4201.456, Insurance Code, as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Makes conforming changes.

SECTION 12. Amends Section 401.011(38-a), Labor Code to redefine "retrospective review."

SECTION 13. Amends Section 408.0043(a), Labor Code, as follows:

(a) Provides that this section applies to a person, other than a chiropractor or a dentist, who performs health care services under this title as a doctor performing peer review; a doctor performing a utilization review of a health care service provided to an injured employee, rather than a utilization review of a health care service provided to an injured employee, including a retrospective review; a doctor performing an independent review of a health care service provided to an injured employee, rather than an independent review of a health care service provided to an injured employee, including a retrospective review; a designated doctor; a doctor performing a required medical examination; or a doctor serving as a member of the medical quality review panel.

SECTION 14. Amends Section 408.0044(a), Labor Code, to make conforming changes.

SECTION 15. Amends Section 408.0045(a), Labor Code, to make conforming changes.

SECTION 16. Amends Section 408.023(h), Labor Code, to provide that notwithstanding Section 4201.152, Insurance Code, a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, rather than utilization review and retrospective review, may only use doctors licensed to practice in this state.

SECTION 17. Amends Section 413.031(e-3), Labor Code, to make conforming changes.

SECTION 18. Repealers: Section 1305.004(a)(21) (relating to the definition of "retrospective review"), Insurance Code; Section 1305.352 (General Standards for Retrospective Review), Insurance Code; and Subchapter K (Claims Review of Medical Necessity), Chapter 4201 (Utilization Review Agents), Insurance Code.

SECTION 19. Makes application of this Act prospective to January 1, 2010.

SECTION 20. Effective date: September 1, 2009.