BILL ANALYSIS

C.S.H.B. 1621
By: Bonnen, Greg
Business & Industry
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties point out that, by law, a utilization review agent must provide an insured or a person acting on the insured's behalf with notice of an adverse determination made in relation to coverage or benefits under a health insurance policy or health benefit plan. The parties observe that the insured or person acting on the insured's behalf may appeal the adverse determination decision and may request an independent review of a final adverse determination. The parties express concern that during the appeal, the contested treatment is not covered by the insurer, forcing the insured to pay for the treatment out-of-pocket or go without treatment. C.S.H.B. 1621 seeks to address this concern by proposing changes to the law regarding notice, appeal, and independent review of an adverse determination by a utilization review agent.

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. 1621 amends the Insurance Code to require a utilization review agent to provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

C.S.H.B. 1621 requires the procedures for appealing an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions and the procedures for an independent review of such an appeal to do the following:

- provide that coverage or benefits for the contested prescription drugs or intravenous infusions that are the basis of the adverse determination continue under the enrollee's health insurance policy or health benefit plan while the appeal or review, as applicable, is being considered to the same extent and in the same manner as if there had been no adverse determination;
- require the payor, without regard to whether the adverse determination is upheld on appeal or review, as applicable, to cover the contested prescription drugs or intravenous infusions received during the period the appeal or review was considered to the same extent and in the same manner, including the same benefit level, as if there had been no adverse determination; and
- prohibit the payor, without regard to whether the adverse determination is upheld on

appeal or review, as applicable, from recouping, based on an adverse determination, any payment made to a physician or health care provider for the continuation of coverage or benefits for the contested prescription drugs or intravenous infusions.

C.S.H.B. 1621 applies only to an adverse determination made in relation to coverage or benefits under a health insurance policy or health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016, and does not apply to utilization review of a health care service provided to a person eligible for workers' compensation benefits. The bill expands the exemption from statutory provisions relating to utilization review agents for certain state health or mental health programs to include any health or mental health program operated by the state. The bill adds to the list of programs that are specifically included under that exemption.

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1621 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
No equivalent provision.	SECTION 1. Section 4201.053, Insurance Code, is amended to read as follows: Sec. 4201.053. MEDICAID AND [~~CERTAIN~~] OTHER STATE HEALTH OR MENTAL HEALTH PROGRAMS. Except as provided by Section 4201.057, this chapter does not apply to a health or mental health program operated by this state, including: (1) the state Medicaid program; (2) the services program for children with special health care needs under Chapter 35, Health and Safety Code; (3) a program administered under Title 2, Human Resources Code; (4) a program of the Department of State Health Services relating to mental health services; (5) a program of the Department of Aging and Disability Services relating to intellectual disability [~~mental retardation~~] services; [~~or~~] (6) a program of the Texas Department of Criminal Justice; (7) the child health program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; (8) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under

	Chapter 1551; (9) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579; and (10) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601.
No equivalent provision.	SECTION 2. Section 4201.054, Insurance Code, is amended by adding Subsection (b) to read as follows: (b) Sections 4201.304(b), 4201.3555, and 4201.404 do not apply to utilization review of a health care service provided to a person eligible for workers' compensation benefits under Title 5, Labor Code.
SECTION 1. Section 4201.304, Insurance Code, is amended to read as follows: Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Subject to Subsection (b), a [~~A~~] utilization review agent shall provide notice of an adverse determination required by this subchapter as follows: (1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination; (2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or (3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request. (b) A utilization review agent shall provide notice of an adverse determination for a	SECTION 3. Section 4201.304, Insurance Code, is amended to read as follows: Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Subject to Subsection (b), a [~~A~~] utilization review agent shall provide notice of an adverse determination required by this subchapter as follows: (1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination; (2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or (3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request. (b) A utilization review agent shall provide notice of an adverse determination for a

concurrent review of health care services not later than the 30th day before the date on which the health care services will be discontinued.

concurrent review of the provision of prescription drugs or intravenous infusions not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

SECTION 2. Subchapter H, Chapter 4201, Insurance Code, is amended by adding Section 4201.3555 to read as follows:

Sec. 4201.3555. CONTINUATION OF CONCURRENT HEALTH CARE SERVICES.

The procedures for appealing an adverse determination for a concurrent review of health care services must provide that:

(1) coverage or benefits for the contested health care services, including prescription drugs, that are the basis of the adverse determination continues under the enrollee's health insurance policy or health benefit plan while the appeal is being considered; and

(2) without regard to whether the adverse determination is upheld on appeal, the payor may not charge an enrollee for the cost of the contested health care services, including prescription drugs, received during the period the appeal was considered except for an applicable copayment, coinsurance, or deductible under the enrollee's health insurance policy or health benefit plan.

SECTION 4. Subchapter H, Chapter 4201, Insurance Code, is amended by adding Section 4201.3555 to read as follows:

Sec. 4201.3555. CONTINUATION OF CONCURRENT PROVISION OF PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS.

The procedures for appealing an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions must provide that:

(1) coverage or benefits for the contested prescription drugs or intravenous infusions that are the basis of the adverse determination continue under the enrollee's health insurance policy or health benefit plan while the appeal is being considered to the same extent and in the same manner as if there had been no adverse determination;

(2) without regard to whether the adverse determination is upheld on appeal, the payor shall cover the contested prescription drugs or intravenous infusions received during the period the appeal was considered to the same extent and in the same manner, including the same benefit level, as if there had been no adverse determination; and

(3) without regard to whether the adverse determination is upheld on appeal, the payor may not recoup, based on an adverse determination, any payment made to a physician or health care provider for the continuation of coverage or benefits under Subdivision (1) or (2).

SECTION 3. Subchapter I, Chapter 4201, Insurance Code, is amended by adding Section 4201.404 to read as follows:

Sec. 4201.404. CONTINUATION OF CONCURRENT HEALTH CARE SERVICES.

The procedures for an independent review of an appeal of an adverse determination for a concurrent review of health care services must provide that:

(1) coverage or benefits for the contested

SECTION 5. Subchapter I, Chapter 4201, Insurance Code, is amended by adding Section 4201.404 to read as follows:

Sec. 4201.404. CONTINUATION OF CONCURRENT PROVISION OF PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. The procedures for an independent review of an appeal of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions must provide that:

(1) coverage or benefits for the contested

health care services, including prescription drugs, that are the basis of the adverse determination continues under the enrollee's health insurance policy or health benefit plan while the review is being considered; and (2) without regard to whether the adverse determination is upheld on review, the payor may not charge an enrollee for the cost of the contested health care services, including prescription drugs, received during the period the review was considered except for an applicable copayment, coinsurance, or deductible under the enrollee's health insurance policy or health benefit plan.	prescription drugs or intravenous infusions that are the basis of the adverse determination continue under the enrollee's health insurance policy or health benefit plan while the review is being considered to the same extent and in the same manner as if there had been no adverse determination; (2) without regard to whether the adverse determination is upheld on review, the payor shall cover the contested prescription drugs or intravenous infusions received during the period the review was considered to the same extent and in the same manner, including the same benefit level, as if there had been no adverse determination; and (3) without regard to whether the adverse determination is upheld on review, the payor may not recoup, based on an adverse determination, any payment made to a physician or health care provider for the continuation of coverage or benefits under Subdivision (1) or (2).
SECTION 4. This Act applies only to an adverse determination made in relation to coverage or benefits under a health insurance policy or health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016. An adverse determination made in relation to coverage or benefits under a policy or plan delivered, issued for delivery, or renewed before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 6. Same as introduced version.
SECTION 5. This Act takes effect September 1, 2015.	SECTION 7. Same as introduced version.