BILL ANALYSIS

Senate Research Center

C.S.H.B. 1621
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Business & Commerce
5/22/2015
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Under current 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 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. However, 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.

C.S.H.B. 1621 amends current law relating to utilization review and notice and appeal of certain adverse determinations by utilization review agents.

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 Section 4201.053, Insurance Code, as follows:

Sec. 4201.053. New heading: MEDICAID AND OTHER STATE HEALTH OR MENTAL HEALTH PROGRAMS. (a) Creates this subsection from existing text and changes a reference to mental retardation services to intellectual disability services.

(b) Provides that Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

(1) the child health program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code;

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 (Texas Public School Employees Group Benefits Program) or 1579 (Texas School Employees Uniform Group Health Coverage);

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter

1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and The Texas A&M University System); and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code.

SECTION 2. Amends Section 4201.054, Insurance Code, by adding Subsection (b) to provide that Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to utilization review of a health care service provided to a person eligible for workers' compensation benefits under Title 5 (Workers' Compensation), Labor Code.

SECTION 3. Amends Section 4201.303, Insurance Code, by adding Subsection (c), as follows:

(c) Requires that the notice required by Subsection (a)(4) (requiring that notice of an adverse determination include a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review), for an enrollee who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review.

SECTION 4. Amends Section 4201.304, Insurance Code, as follows:

Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Creates this subsection from existing text. Requires a utilization review agent, subject to Subsection (b), to provide notice of an adverse determination required by this subchapter as follows:

(1)-(3) Makes no change to these subdivisions.

(b) Requires 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.

SECTION 5. Amends the heading to Section 4201.357, Insurance Code, to read as follows:

Sec. 4201.357. EXPEDITED APPEAL FOR DENIAL OF EMERGENCY CARE, CONTINUED HOSPITALIZATION, PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS.

SECTION 6. Amends Section 4201.357, Insurance Code, by adding Subsection (a-1), as follows:

(a-1) Requires that the procedures for appealing an adverse determination include, in addition to the written appeal and the appeal described by Subsection (a), a procedure for an expedited appeal of a denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy. Requires that the procedure include a review by a health care provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

SECTION 7. Amends Subchapter H, Chapter 4201, Insurance Code, by adding Section 4201.3601, as follows:

Sec. 4201.3601. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION FOR DENIAL OF PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. Provides that, notwithstanding any other law, in a circumstance involving the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, the enrollee is:

(1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I (Independent Review of Adverse Determination); and

(2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

SECTION 8. Amends Section 4202.003, Insurance Code, as follows:

Sec. 4203.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. Requires that the standards adopted under Section 4202.002 require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by 4201.002 or the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, not later than the earlier of the third day after the date the organization receives the information necessary to make the determination or, with respect to:

(A) a review of a health care service provided to a person with a life-threatening condition eligible for workers' compensation medical benefits, the eighth day after the date the organization receives the request that the determination be made; or

(B) Makes no change to this paragraph; or

(2) for a situation, rather than condition, other than a situation described by Subdivision (1), rather than other than a life-threatening condition, not later than the earlier of the 15th day after the date the organization receives the information necessary to make the determination, or the 20th day after the date the organization receives the request that the determination be made.

SECTION 9. Provides that 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. Provides that 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 10. Effective date: September 1, 2015.