Amend **CSHB 2387** (house committee report) as follows:

(1) On page 13, line 14, strike "The change in law made by this Act applies" and substitute "The changes in law made by this Act to Chapters 1305, 4201, and 4202, Insurance Code, Chapters 408 and 413, Labor Code, and Chapter 151, Occupations Code, apply".

(2) Add the following appropriately numbered SECTIONS to the bill and renumber SECTIONS of the bill accordingly:

SECTION ____. Section 843.348(b), Insurance Code, is amended to read as follows:

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of health care services that [~~do not~~] require preauthorization and information concerning the preauthorization process.

SECTION ____. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows:

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the

preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria using Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

(i) physician or provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned on external appeal; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or

process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide each participating physician or provider written notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, waives the health maintenance organization's preauthorization requirements with respect to any health care service affected by the violation, and any health care service affected by the violation is considered preauthorized by the health maintenance organization.

Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. A waiver of preauthorization requirements under Section 843.3483 may not be construed to:

(1) authorize a physician or provider to provide health care services outside of the physician's or provider's applicable scope of practice as defined by state law; or

(2) require the health maintenance organization to pay for a health care service provided outside of the physician's or provider's applicable scope of practice as defined by state law.

SECTION ____. Section 1301.135(a), Insurance Code, is

amended to read as follows:

(a) An insurer that uses a preauthorization process for medical care or [~~and~~] health care services shall provide to each preferred provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

SECTION ____. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and 1301.1354 to read as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting

documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria using Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned on external appeal; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide to each preferred provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide each preferred provider written notice of the change in the

preauthorization requirement and disclose the change in the insurer's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, waives the insurer's preauthorization requirements with respect to any medical care or health care service affected by the violation, and any medical care or health care service affected by the violation is considered preauthorized by the insurer.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) A waiver of preauthorization requirements under Section 1301.1353 may not be construed to:

(1) authorize a physician or health care provider to provide medical care or health care services outside of the physician's or health care provider's applicable scope of practice as defined by state law; or

(2) require the insurer to pay for a medical care or health care service provided outside of the physician's or health care provider's applicable scope of practice as defined by state law.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

SECTION ____. The changes in law made by this Act to

Chapters 843 and 1301, Insurance Code, apply only to a request for preauthorization of medical care or health care services made on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed on or after that date. A request for preauthorization of medical care or health care services made before January 1, 2020, or on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed before that date 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.