BILL ANALYSIS

C.S.H.B. 1273
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

There are concerns that some health insurance providers may give prior authorization for a treatment and then, after the patient receives care, deny payment and leave the patient responsible for all or part of the cost of the treatment. C.S.H.B. 1273 seeks to address these concerns by prohibiting a health benefit plan issuer from denying or reducing payment for preauthorized health care services, with certain exceptions.

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. 1273 amends the Insurance Code to prohibit a health benefit plan issuer that has given prior authorization for health care services to be performed by a physician or health care provider from denying or reducing payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider materially misrepresented the proposed health care services or substantially failed to perform the proposed health care services. The bill exempts from that prohibition:

- a denial, recoupment, or suspension of or reduction in a payment to a physician or health care provider made by a managed care organization under the direction of the Health and Human Services Commission's office of the inspector general by its authority to prevent, detect, audit, inspect, review, and investigate fraud, waste, and abuse in the provision and delivery of all health and human services; or
- a recovery by a managed care organization on the basis of fraud and abuse.

C.S.H.B. 1273 establishes that nothing in its provisions limits the liability of a physician or health care provider in a Medicaid fraud prevention action or for a violation of state or federal law governing Medicaid, including Medicaid delivered through a managed care model or health benefits provided under CHIP.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1273 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes exemptions to the prohibition against a health benefit plan issuer denying or reducing payments under certain circumstances.

The substitute includes a provision establishing that nothing in the bill limits the liability of a physician or health care provider in certain specified situations.