BILL ANALYSIS

Senate Research Center

H.B. 2327
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Business & Commerce
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

H.B. 2327 amends current law relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

ARTICLE 1. PREAUTHORIZATION

SECTION 1.01. Amends Section 843.348(b), Insurance Code, as follows:

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

SECTION 1.02. Amends Subchapter J, Chapter 843, Insurance Code, by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484, as follows:

> Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) Requires an HMO that uses a preauthorization process for health care services to 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 HMO's Internet website.
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> (b) Requires the preauthorization requirements and information described by Subsection (a) to:
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> (1) be posted:
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> (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
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> (B) in a format that is easily searchable and accessible;
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> (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 HMO 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 HMO 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) certain 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.

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

(b) Requires an HMO, 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, to provide each participating physician or provider written notice of the change in the preauthorization requirement and disclose the change in the HMO's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

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

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. Provides that, in addition to any other penalty or remedy provided by law, an HMO that uses a preauthorization process for health care services that violates this subchapter (Payment of Claims to Physicians and Providers) 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 HMO'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 HMO.

Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. Prohibits a waiver of preauthorization requirements under Section 843.3483 from being 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 HMO 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 1.03. Amends Section 1301.135(a), Insurance Code, to require an insurer that uses a preauthorization process for medical care or health care services, rather than for medical care and health care services, to provide to each preferred provider, not later than the fifth, rather than the 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 1.04. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Sections 1301.1351, 1301.1352, 1301.1353, and 1301.1354, as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) Requires an insurer that uses a preauthorization process for medical care or health care services to 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) Requires the preauthorization requirements and information described by Subsection (a) to:

(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) certain 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.

(c) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Requires an insurer that uses a preauthorization process for medical care or health care services, except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, to 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) Requires an insurer, 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, to 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) Requires an insurer, not later than the fifth day before the date a new or amended preauthorization requirement takes effect, to 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. (a) Provides that, 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 (Other Provisions Relating to Payment of Claims) 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) Prohibits a waiver of preauthorization requirements under Section 1301.1353 from being 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

SECTION 2.01. Amends Section 4201.002(12), Insurance Code, to redefine "provider of record."

SECTION 2.02. Amends Sections 4201.151 and 4201.152, Insurance Code, as follows:

Sec. 4201.151. UTILIZATION REVIEW PLAN. Requires a utilization review agent's utilization review plan, including reconsideration and appeal requirements, to be reviewed by a physician licensed to practice medicine in this state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in this state.

Sec. 4201.152. New heading: UTILIZATION REVIEW UNDER PHYSICIAN. Requires a utilization review agent to conduct utilization review under the supervision and direction of a physician licensed to practice medicine in this state, rather than under the direction of a physician licensed by a state licensing agency in the United States.

SECTION 2.03. Amends Subchapter D, Chapter 4201, Insurance Code, by adding Section 4201.1525, as follows:

Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) Authorizes a utilization review agent that uses a physician to conduct utilization review to only use a physician licensed to practice medicine in this state.

(b) Provides that a payor that conducts utilization review on the payor's own behalf is subject to Subsection (a) as if the payor were a utilization review agent.

SECTION 2.04. Amends Section 4201.153(d), Insurance Code, as follows:

(d) Requires a utilization review agent, before issuing an adverse determination, to obtain a determination of medical necessity by referring a proposed denial of requested treatment to:

(1) creates this subdivision from existing text and makes a nonsubstantive change; or

(2) if the treatment is requested, ordered, provided, or to be provided by a physician, a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician. Deletes existing text requiring a denial of requested treatment to be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

SECTION 2.05. Amends Sections 4201.155, 4201.206, and 4201.251, Insurance Code, as follows:

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. (a) Creates this subsection from existing text and makes no further changes.

(b) Prohibits this section from being construed to release a health insurance policy or health benefit plan from full compliance with this chapter (Utilization Review Agents) or other applicable law.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Creates this subsection from existing text and makes conforming and nonsubstantive changes. Requires the agent, subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, rather than the medical necessity or appropriateness, or the experimental or investigational nature of a health care service, to provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine in this state the patient's treatment plan and the clinical basis for the agent's determination.

(b) Requires the opportunity described by Subsection (a), if the health care service described by that subsection was ordered, requested, or provided, or is to be provided by a physician, to be with a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician.

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. Provides that a delegation of utilization review to certain qualified personnel does not release the utilization review

agent from the full responsibility for compliance with this chapter or other applicable law, including the conduct of those to whom utilization review has been delegated.

SECTION 2.06. Amends Sections 4201.252(a) and (b), Insurance Code, as follows:

(a) Requires personnel employed by or under contract with a utilization review agent to perform utilization review to be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including licensing requirements.

(b) Makes a conforming change to this subsection.

SECTION 2.07. Amends Section 4201.356, Insurance Code, as follows:

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) Requires the procedures for appealing an adverse determination to provide that a physician licensed to practice medicine in this state makes the decision on the appeal, except as provided by Subsection (b) or (c), rather than except as provided by Subsection (b).

(b) Requires a health care service ordered, requested, provided, or to be provided by a physician, the procedures for appealing an adverse determination to provide that a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician makes the decision on appeal, except as provided by Subsection (c).

(c) Creates this subsection from existing text. Requires a health care provider who is licensed or otherwise authorized by the appropriate licensing agency in this state, among certain other qualifications, to manage the medical or dental condition, procedure, or treatment to review the decision denying the appeal.

SECTION 2.08. Amends Sections 4201.357(a), (a-1), and (a-2), Insurance Code, as follows:

(a) Requires a procedure for appealing an adverse determination to include review by a health care provider who:

(1)–(2) makes nonsubstantive changes to these subdivisions; and

(3) for a review of a health care service:

(A) ordered, requested, provided, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or

(B) ordered, requested, provided, or to be provided by a physician, is licensed to practice medicine in this state.

(a-1) Makes conforming changes to this subsection.

(a-2) Requires the physician deciding an appeal in certain circumstances to be licensed to practice medicine in this state and requires the health care provider making such a decision to be licensed or otherwise authorized by the appropriate licensing agency in this state.

SECTION 2.09. Amends Section 4201.359, Insurance Code, by adding Subsection (c), as follows:

(c) Requires a physician described by Subsection (b)(2) (relating to notice given of the specialty of the physician or other health care provider making denial of an appeal) to comply with this chapter and other applicable laws and be licensed to practice medicine

in this state. Requires a health care provider described by Subsection (b)(2) to comply with this chapter and other applicable laws and be licensed or otherwise authorized by the appropriate licensing agency in this state.

SECTION 2.10. Amends Sections 4201.453 and 4201.454, Insurance Code, as follows:

Sec. 4201.453. UTILIZATION REVIEW PLAN. Requires a specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, to be:

(1) reviewed by a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state; and

(2) makes a conforming change to this subdivision. Creates Subdivisions (1) and (2) from existing text.

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. Makes a conforming change to this section.

SECTION 2.11. Amends Sections 4201.455(a) and (b), Insurance Code, to make conforming changes.

SECTION 2.12. Amends Sections 4201.456 and 4201.457, Insurance Code, to make conforming changes.

SECTION 2.13. Amends Section 4202.002, Insurance Code, by adding Subsection (b-1), as follows:

(b-1) Requires the standards adopted under Subsection (b)(3) (relating to requiring the commissioner to adopt standards to ensure the qualifications and independence of each physician or other health care provider making a review determination) to:

(1) ensure that personnel conducting independent review for a health care service are licensed or otherwise authorized to provide the same or a similar health care service in this state; and

(2) be consistent with the licensing laws of this state.

SECTION 2.14. Amends Section 408.0043, Labor Code, by adding Subsection (c) to require a person described by Subsection (a)(1) (relating to a doctor performing peer review), (2) (relating to a doctor performing a utilization review of a health care service provided to an injured employee), or (3) (relating to a doctor performing an independent review of a health care service provided to an injured worker), who reviews the service with respect to a specific worker's compensation case, if a health care service is requested, ordered, provided, or to be provided by a physician, to be of the same or a similar specialty as that physician, notwithstanding Subsection (b) (relating to requiring certain persons to hold certain certifications).

SECTION 2.15. Amends Subchapter B, Chapter 151, Occupations Code, by adding Section 151.057, as follows:

Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) Defines "adverse determination," "payor," "utilization review," and "utilization review agent."

(b) Provides that a person who does the following is considered to be engaged in the practice of medicine in this state and is subject to appropriate regulation by the Texas Medical Board (TMB):

(1) makes on behalf of a utilization review agent or directs a utilization review agent to make certain adverse determinations;

(2) serves as a medical director of an independent review organization certified under Chapter 4202 (Independent Review Organizations), Insurance Code;

(3) reviews or approves a utilization review plan under Section 4201.151, Insurance Code;

(4) supervises and directs utilization review under Section 4201.152, Insurance Code; or

(5) discusses a patient's treatment plan and the clinical basis for an adverse determination before the adverse determination is issued, as provided by Section 4201.206, Insurance Code.

(c) Provides that, for purposes of Subsection (b), a denial of health care services based on the failure to request prospective or concurrent review is not considered an adverse determination.

SECTION 2.16. Amends Section 1305.351(d), Insurance Code, to authorize a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g) (relating to a requirement that the commissioner adopt rules regarding doctors who perform certain peer reviews), Labor Code, to only use doctors licensed to practice in this state, rather than authorizing a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter (Worker's Compensation Health Care Networks), including utilization review, or peer reviews under Section 408.0231(g), Labor Code, notwithstanding Section 4201.152, to only use doctors licensed to practice in this state.

SECTION 2.17. Amends Section 1305.355(d), Insurance Code, to authorize an independent review organization that uses doctors to perform reviews of health care services under this chapter to only use doctors licensed to practice in this state, rather than authorizing an independent review organization that uses doctors to perform reviews of health care services under this chapter, notwithstanding Section 4202.002 (Adoption of Standards For Independent Review Organizations), to only use doctors licensed to practice in this state.

SECTION 2.18. Amends Section 408.023(h), Labor Code, to make a conforming change.

SECTION 2.19. Amends Section 413.031(e-2), Labor Code, to make a conforming change.

ARTICLE 3. TRANSITIONS; EFFECTIVE DATE

SECTION 3.01. Makes application of Article 1 of this Act prospective to January 1, 2020.

SECTION 3.02. Makes application of Article 2 of this Act prospective.

SECTION 3.03. Effective date: September 1, 2019.