BILL ANALYSIS

C.S.H.B. 2327
By: Bonnen, Greg
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

There are concerns that preauthorization requirements are burdensome to physicians and providers and may have the potential to prevent patients from receiving essential services. C.S.H.B. 2327 seeks to address these concerns by, among other things, requiring a health maintenance organization (HMO) or insurer that uses a preauthorization process for medical care or health care services to post on the HMO's and insurer's websites preauthorization requirements and related information and to require certain notification of changes to those preauthorization requirements.

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. 2327 amends the Insurance Code to require a health maintenance organization (HMO) or 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 enrollees, insureds, physicians, providers, and the general public by posting the requirements and information on the HMO's or insurer's website. The bill requires such preauthorization requirements and information to:

- be conspicuously posted in a location on the website that does not require the use of a log-in or other input of personal information to view the information;
- be posted in a format that is easily searchable and accessible;
- be written in plain language that is easily understandable by enrollees, insureds, physicians, providers, and the general public;
- include a detailed description of the preauthorization process and procedure; and
- include an accurate and current list of the health care services for which the HMO or insurer requires preauthorization that includes certain specified information specific to each such service, including certain prescribed statistical information.

C.S.H.B. 2327 prohibits the preceding posting provisions, as they apply to insurers, from being waived, voided, or nullified by contract.

C.S.H.B. 2327, with respect to changes to preauthorization requirements:

- requires an HMO or insurer that uses a preauthorization process for medical care or health care services to, not later than the 60th day before the date a new or amended preauthorization requirement takes effect, provide written notice of the new or amended preauthorization requirement to each participating physician or applicable provider and disclose the new or amended requirement in the HMO's or insurer's newsletter or network bulletin, if any;
- requires the HMO or insurer to provide each participating physician or applicable provider written notice of the change in the preauthorization requirement and disclose the change in the newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect 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 enrollees, insureds, physicians, and providers; and
- requires the HMO or insurer, not later than the fifth day before the date a new or amended preauthorization requirement takes effect, to update its website to disclose the change to the preauthorization requirements or process and the date and time the change is effective.

C.S.H.B. 2327 prohibits the preceding provisions regarding changes to preauthorization requirements, as they apply to insurers, from being waived, voided, or nullified by contract.

C.S.H.B. 2327, with respect to automatic waivers of preauthorization requirements based on noncompliance with applicable law and the effect of that waiver:

- establishes that, in addition to any other penalty or remedy provided by law, an HMO or insurer that uses a preauthorization process for medical care or health care services that violates applicable law with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline, waives the HMO's or insurer's preauthorization requirements with respect to any service affected by the violation; and
- prohibits such a waiver from being construed to authorize a physician or provider to provide medical care or health care services outside of the scope of the physician's or provider's applicable license or to require the HMO or insurer to pay for a medical care or health care service provided outside of the scope of a physician's or provider's applicable license.

C.S.H.B. 2327 prohibits the preceding provisions regarding automatic waivers of preauthorization requirements based on noncompliance with applicable law and the effect of that waiver as they apply to insurers, from being waived, voided, or nullified by contract.

C.S.H.B. 2327 changes the nature of the list of services that an HMO or insurer using a preauthorization process is required to provide to a participating physician or applicable provider from a list of services that do not require preauthorization to a list of services that require preauthorization. The bill changes the deadline by which the HMO or insurer is required to provide the list and information concerning the preauthorization process from not later than the 10th business day after the date a request is made to not later than the fifth business day after the date a request is made.

C.S.H.B. 2327 applies 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.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2327 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 a requirement that the applicable information on the website be easily searchable and accessible and, in revising that information:

- includes as required information an accurate and current list of the health care services requiring preauthorization that includes certain information specific to each service;
- includes as information that must be specific to each such service the bill's required statistical information regarding approvals and denials; and
- revises that statistical information specific to each such service by specifying that the approval and denial rates are for the preceding year and for each previous year the preauthorization requirement was in effect and by expanding the statistical information to include:
    - provider types;
    - specific categories of denials; and
    - the total annual preauthorization requests, approvals, and denials for the applicable service.

The substitute does not include the following:

- a prohibition against a new or amended requirement taking effect before a website is updated; and
- a prohibition against an HMO or insurer that uses a preauthorization process for medical care or health care services from requiring a physician or provider that routinely submitted claims to the HMO or insurer that were consistent with national evidence-based guidelines and that were preauthorized by the HMO or insurer.

The substitute includes the following:

- a requirement that the HMO or insurer notify each physician or provider of a change in the preauthorization requirement before the change takes effect by a specified deadline;
- a deadline by which the HMO or insurer is required to update its website to disclose a change in such a requirement;
- prohibitions against the bill's waivers of preauthorization requirements from being construed to authorize a physician or provider to provide health care services outside of the scope of the applicable license or to require the HMO or insurer to pay for a health care service provided outside of the scope of the applicable license;
- prohibitions against applicable bill provisions with respect to insurers being waived, voided, or nullified by contract; and
- a specification that, for purposes of the applicability of the bill's provisions to a request for preauthorization of medical care or health care services made on or after January 1, 2020, the bill's changes apply to a request made under a health benefit plan delivered, issued for delivery, or renewed on or after that date.