

## **BILL ANALYSIS**

Senate Research Center  
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C.S.H.B. 2327  
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Business & Commerce  
5/20/2019  
Committee Report (Substituted)

### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

C.S.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, and 843.3483, 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.

(b) Requires the preauthorization requirements and information described by Subsection (a) to:

(1) be posted:

(A) except as provided by Subsection (c) or (d), 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) except for the screening criteria under Paragraph (4)(C), 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, which is authorized to include 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.

(c) Prohibits this section from being construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. Requires a health maintenance organization to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.

(d) Authorizes a health maintenance organization, if a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, to, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

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 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, and on the HMO's Internet website 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 notice of the change in the preauthorization requirement in the HMO's newsletter or network bulletin, if any, and on the HMO's Internet website 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. Requires 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, in addition to any other penalty or remedy provided by law, to provide an expedited appeal under Section 4201.357 (Expedited Appeal For Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions) for any health care service affected by the violation.

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, and 1301.1353, 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) except as provided by Subsection (c) or (d), 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) except for the screening criteria under Paragraph (4)(C), 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, which is authorized to include 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.

(c) Prohibits this section from being construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. Requires a health maintenance organization to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.

(d) Authorizes a health maintenance organization, if a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, to, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

(e) 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, and on the insurer's Internet website.

(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 notice of the change in the preauthorization requirement in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website, 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. (a) Requires 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, in addition to any other penalty or remedy provided by law, to provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.

(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 direction of a physician licensed to practice medicine in this state, rather than under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

SECTION 2.03. 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 and appropriateness 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 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 2.04. 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 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 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 2.05. 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 applicable licensing requirements.

(b) Requires personnel, other than a physician licensed to practice medicine, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols to be a nurse, physician assistant, or other health care provider qualified and licensed or otherwise authorized by law and an appropriate licensing agency in the United States to provide the requested service, rather than requiring personnel, other than a physician who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols to be a nurse, physician assistant, or other health care provider qualified to provide the requested service.

SECTION 2.06. 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, rather than a physician, makes the decision on the appeal, except as provided by Subsection (b).

(b) Requires a health care provider who 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 consideration for review and who is licensed or otherwise authorized by the appropriate licensing agency in the United States to manage the medical or dental condition, procedure, or treatment, if not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests a particular type of specialty provider review the case, to review the denial or the decision denying the appeal, rather than requiring a health care provider who 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 consideration for review, if not later than the 10th working day after the date an appeal is denied the enrollee's health care provider states in writing good cause for having a particular type of specialty provider review the case, to review the denial or the decision denying the appeal

SECTION 2.07. Amends Sections 4201.357(a), (a-1), and (a-2), Insurance Code, as follows:

(a) Requires the procedures for appealing an adverse determination to include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient, rather than a procedure for an expedited appeal of a denial of emergency care or a denial of continued hospitalization. Requires the procedure 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, 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 the United States; or

(B) ordered, requested, or to be provided by a physician, is licensed to practice medicine in the United States.

(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 the United States and requires the health care provider making such a decision to be licensed or otherwise authorized by the appropriate licensing agency in the United States.

SECTION 2.08. 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. 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 the United States.

SECTION 2.09. 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 2.10. Amends Sections 4201.455(a) and (b), Insurance Code, to make conforming changes.

SECTION 2.11. Amends Sections 4201.456 and 4201.457, Insurance Code, to make conforming changes.

SECTION 2.12. 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 2.13. 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 2.14. 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 2.15. Amends Section 408.023(h), Labor Code, to delete existing text creating an exception under Section 4201.152, Insurance Code, to the provision authorizing a utilization review agent or an insurance carrier that uses doctors to perform certain reviews to only use doctors licensed to practice in this state.

SECTION 2.16. Amends Section 413.031(e-2), Labor Code, to delete existing text creating an exception under Section 4202.002, Insurance Code, to the provision authorizing an independent review organization that uses doctors to perform certain reviews to only use doctors licensed to practice in this state.

### ARTICLE 3. JOINT INTERIM STUDY

SECTION 3.01. CREATION OF JOINT INTERIM COMMITTEE. (a) Creates a joint interim committee (committee) to study, review, and report on the use of prior authorization and utilization review processes by private health benefit plan issuers in this state, as provided by Section 3.02 of this article, and propose reforms under that section related to the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) Requires the committee to be composed of four senators appointed by the lieutenant governor and four members of the house of representatives appointed by the speaker of the house of representatives.

(c) Requires the lieutenant governor and speaker of the house of representatives to each designate a co-chair from among the committee members.

(d) Requires the committee to convene at the joint call of the co-chairs.

(e) Provides that the committee has all other powers and duties provided to a special or select committee by the rules of the senate and house of representatives, by Subchapter B (Legislative Reorganization Act), Chapter 301, Government Code, and by policies of the senate and house committees on administration.

SECTION 3.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) Requires the committee created by Section 3.01 of this article to study data and other information available from the Texas Department of Insurance, the office of public insurance counsel, or other sources the committee determines relevant to examine and analyze the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) Requires the committee to propose reforms based on the study required under Subsection (a) of this section to improve the transparency of and patient outcomes under prior authorization and utilization review processes in this state.



(c) Requires the committee to prepare a report of the findings and proposed reforms.

SECTION 3.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a) Requires the committee, not later than December 1, 2020, to submit to the lieutenant governor, the speaker of the house of representatives, and the governor the report prepared under Section 3.02 of this article. Requires the committee to include in its report recommendations of specific statutory and regulatory changes that appear necessary from the committee's study under Section 3.02 of this article.

(b) Requires the lieutenant governor and speaker of the house of representatives, not later than the 60th day after the effective date of this Act, to appoint the members of the joint interim committee in accordance with Section 3.01 of this article.

SECTION 3.04. ABOLITION OF COMMITTEE. Provides that the committee created under Section 3.01 of this article is abolished and this article expires December 15, 2020.

#### ARTICLE 4. TRANSITIONS; EFFECTIVE DATE

SECTION 4.01. Makes application of Article 1 of this Act prospective to January 1, 2020.

SECTION 4.02. Makes application of Article 2 of this Act prospective.

SECTION 4.03. Effective date: September 1, 2019.