By: Raymond H.B. No. 317

Substitute the following for H.B. No. 317:

By: Lucio III C.S.H.B. No. 317

A BILL TO BE ENTITLED

AN ACT

relating to the use of clinical decision support software and laboratory benefits management programs in connection with the provision of clinical laboratory services to certain managed care plan enrollees.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1451, Insurance Code, is amended by adding Subchapter L to read as follows:

SUBCHAPTER L. CLINICAL LABORATORY SERVICES

Sec. 1451.551. DEFINITIONS. In this subchapter:

(1) "Clinical decision support software" means computer software that compares patient characteristics to a database of clinical knowledge to produce patient-specific assessments or recommendations to assist a physician or health care provider in making clinical decisions.

(2) "Clinical laboratory service" means the examination of a specimen taken from a human body ordered by a physician or health care provider for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition.

(3) "Enrollee" means an individual enrolled in a managed care plan.

(4) "Esoteric molecular and genomic testing" means any test of a patient specimen analyzing multiple biomarkers of

deoxyribonucleic acid, ribonucleic acid, or proteins using a unique algorithm to yield a patient-specific prognosis or diagnosis.

(5) "Laboratory benefits management program" means a managed care plan issuer protocol or program administered by the managed care plan issuer or another entity under contract with the managed care plan issuer that directs or limits decision making of a physician or health care provider authorized to order clinical laboratory services. The term includes a requirement for a physician or health care provider to provide advance notice of an order for clinical laboratory services.

(6) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with physicians or health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred or exclusive provider benefit plan issuer; or

(C) any other entity that issues a health benefit plan described by this subdivision, including an insurance company.

(7) "National medical consensus guidelines" means applicable generally accepted practice guidelines that are:

(A) supported by peer-reviewed medical literature; and

(B) promulgated by the federal government or by a national professional medical society, board, or association.

(8) "Participating provider" means a physician or health care provider who has contracted with a managed care plan issuer to provide services to enrollees.

(9) "Physician" means a person licensed to practice medicine in this state.

Sec. 1451.552. CERTAIN REQUIREMENTS FOR CLINICAL LABORATORY SERVICES PROHIBITED; EXCEPTION. (a) Except as provided by Subsection (d), a managed care plan issuer may not require the use of clinical decision support software or a laboratory benefits management program by an enrollee's physician or health care provider before, at the time, or after the physician or health care provider orders a clinical laboratory service for the enrollee.

(b) A managed care plan issuer may not direct or limit the decision making of an enrollee's physician or health care provider relating to the referral of a patient specimen to a laboratory in the managed care plan network or a network otherwise designated by the managed care plan issuer.

(c) A managed care plan issuer may not limit, reduce, or deny payment for a clinical laboratory service based on whether the ordering physician or health care provider uses clinical decision support software or a laboratory benefits management program.

(d) Subsection (a) does not apply to an order for a clinical laboratory service if the specimen is not obtained in a hospital or ambulatory surgical center and:

(1) the order is for esoteric molecular and genomic testing; or

(2) there are national medical consensus guidelines

available for the clinical laboratory service ordered.

Sec. 1451.553. CERTAIN REQUIREMENTS FOR SECOND OPINION PROHIBITED. A managed care plan issuer may not routinely require a second opinion of a pathologist's finding from another pathologist unless the second opinion is medically warranted based on the specific clinical presentation of the enrollee or other clinical factors relevant to the enrollee.

Sec. 1451.554. CLINICAL DECISION SUPPORT SOFTWARE AND LABORATORY BENEFITS MANAGEMENT PROGRAM REQUIREMENTS. (a) A managed care plan issuer may only use clinical decision support software or a laboratory benefits management program that:

(1) is transparently based on published, peer-reviewed medical literature;

(2) is subject to timely and routine updates based on national medical consensus guidelines and the most current medical knowledge; and

(3) may be immediately overridden by a physician based on the physician's medical judgment.

(b) A managed care plan issuer may not use a laboratory benefits management program that is administered, created, or owned by an individual or entity with an interest in a clinical laboratory in the managed care plan network.

Sec. 1451.555. SUPERVISION BY COMPARABLE PROFESSIONAL REQUIRED. A managed care plan issuer may only use clinical decision support software, a laboratory benefits management program, or a prior authorization protocol for clinical laboratory services that is supervised by a physician of the same or a similar specialty as

the ordering physician or health care provider.

Sec. 1451.556. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH MANAGED CARE PLAN ISSUER. This subchapter applies to a person with whom a managed care plan issuer contracts to:

(1) manage or administer benefits for clinical laboratory services;

(2) process or pay claims;

(3) obtain the services of physicians or other health care providers to provide health care services to enrollees; or

(4) issue verifications or prior authorizations.

Sec. 1451.557. CONSTRUCTION OF SUBCHAPTER. This subchapter may not be construed to regulate the implementation or administration of clinical decision support software, a laboratory benefits management program, or a prior authorization protocol by an entity, including a health care entity, that is not acting on behalf of or at the direction of a managed care plan issuer in adopting the software, program, or protocol.

SECTION 2. Subchapter L, Chapter 1451, Insurance Code, as added by this Act, applies only to a contract between a managed care plan issuer and a physician or health care provider that is entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act 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.

SECTION 3. This Act takes effect September 1, 2019.